CONCEPTUAL DIMENSIONS OF

COMPASSION FATIGUE AND VICARIOUS TRAUMA

by

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ABSTRACT

Compassion Fatigue and Vicarious Trauma are diagnostic labels sometimes applied to

therapists who become traumatized following their work with victims of trauma. Four

distinct conceptual frameworks are offered to better understand Compassion Fatigue and

Vicarious Trauma: (1) The analysis of the Wounded-Healer metaphor and its connection

to the topic of the use of self in therapy, (2) Contextual family therapy (Boszormenyi-

Nagy) and the theory of systems, (3) Theravada and Zen Buddhism, with an emphasis on

the concept of self and, 4) an exploration of the concept of suggestibility in relation to the

"contagion" of symptoms phenomenon in CF and VT. These four approaches appear

useful to formulate distinct models for Compassion Fatigue and Vicarious Trauma, to

offer suggestions on the way these disorders might arise and develop, as well as to

propose mechanisms underlying the "contagion" of trauma symptoms between therapists

and their traumatized clients.

Keywords: Compassion Fatigue, Theory of systems, Buddhism, Hypnosis,

Wounded-Healer.

DEDICATION

To my father who was curious about everything

and always had a book in his hands.

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INTRODUCTION

Some new concepts, elaborated in the mid-80s and 90s and closely related to burnout and post-traumatic stress disorder (PTSD), have recently emerged in the field of traumatology. These concepts attempt to describe the personal experiences of helpers whose professional activity centres around the relief of their clients' suffering in the aftermath of trauma and the impact this activity has on their lives. Among the concepts mentioned in the literature to describe these experiences, we often find labels such as "Compassion Fatigue" (CF), "Vicarious Trauma" (VT), "Secondary Stress" and "Secondary Traumatic Stress Disorder" (STSD). Many of these concepts seem to overlap while others appear to be identical or equivalent, hinting to the need for the field of CF and VT to attract more conceptual research in order to develop greater theoretical clarity.

At the core however, all these terms convey a simple message: As a consequence of their service to traumatized clients, helpers are sometimes at risk of becoming traumatized themselves and suffer the disabling effects of indirect trauma in their personal and professional lives. How and why this happens, and what these disorders may have to teach us about the nature of trauma, were initially the questions which guided my interest in CF and VT.

The first chapter of this study is therefore devoted to the discussion of the concept of trauma, the history of this construct as well as the history and description of several

diagnostic labels (including CF and VT) referring to work-related stress disorders. It also explores the difference between CF and VT as well as the relationship between these disorders and constructs such as PTSD and burnout which appeared years earlier in the literature. The theoretical frameworks underlying these labels, the models proposed for the understanding of CF and VT as well as some of the theoretical difficulties they raise, are also part of this first chapter.

In the second chapter, I chose to momentarily distance myself from the medical model and to look at the person of the therapist more holistically. I was interested in researching ways in which helpers relate to their own emotional wounding, how they work at their own healing and how they contain both their own and their clients' emotional pain and work at transforming suffering into hope, peace and purpose. I decided to explore all these topics through the analyzis of the Wounded-Healer (WH) metaphor, a mythological and spiritual theme. Existing models using the WH metaphor are related in this chapter to the topic of CF and VT in order to propose an understanding of these disorders in the light of some psychodynamic concepts (such as projection, counter-transference and polarities).

Chapters 3 and 4 revisit the concepts of CF and VT from two very distinct theoretical frameworks: In Chapter 3, CF and VT are explored from a systemic viewpoint that takes into account not only the therapist/client dyad, but also the social and professional context in which their encounter takes place (Erikson's psychosocial stages of development contribute to this analysis by indicating possible stages where therapists may be at greater risk of suffering from CF or VT). Contextual Therapy (Boszormenyi-

Nagy) and its concept of "martyr's role" or "willing victimization" seemed particularly

appropriate to address the thorny issue of the "transmission" of trauma symptoms

between client and therapist; that is, the question of knowing through which possible

mechanisms therapists may become vicariously traumatized by their clients' narratives of

trauma (and show many of their symptoms) without, at any moment, having faced those

traumatic events themselves. Additionally, Chapter 3 challenges the common assumption

found in literature that it is therapists' deep ability to empathize with their clients which

puts them in harms way and makes them vulnerable to CF or VT.

In Chapter 4, I attempted to study CF and VT from a perspective combining

spirituality and psychology. Theravada and Zen Buddhism seemed to have lots to offer to

the understanding of the origins of mental suffering. In this chapter, I addressed issues of

free will, responsibility and ownership for our own mental processes; most importantly

however, I examined the issue of the nature of the human self and its central role in all of

our self-generated mental suffering. This chapter may be more "practical" than the

previous one, in the sense that many of the ideas developed in that chapter could be

developed as part of a training program for therapists.

Finally, in Chapter 5, I attempted to examine the phenomenon of "contagion" or

"transmission" of symptoms between client and therapist through the lens of some

Buddhist concepts in combination with the concepts of "consensus trance" (Tart, 1986),

and "suggestibility". In this last chapter, I argue that the literature supports the idea of a

link between vulnerability to trauma and hypnotic susceptibility; both this link and some

Buddhist theories about the mind led me to propose that CF or VT symptoms might

depend on mechanisms of self-suggestion, with full (although no conscious) participation

of therapists.

CHAPTER 1:
CONCEPTS OF BURNOUT, COMPASSION FATIGUE AND VICARIOUS TRAUMA

In this first chapter, I introduce and discuss the topic of stress in the helping professions; more specifically, the types of stresses faced by therapists who work with clients who have suffered a trauma (e.g., incest, torture, rape, and so on). Figley (1995) and McCann & Pearlman (1990) have observed that the narratives and re-enactments of traumatized clients can deeply affect these clients' therapists. Some of these therapists have described themselves as traumatized by these narratives and shown severe stress symptoms akin to the symptoms of Post-Traumatic Stress Disorder (PTSD), often in parallel to their clients' symptoms. These phenomena have been researched for a little more than a decade and constitute a young field of study. Attempts to conceptualize vicarious or secondary trauma in human service providers started in the mid-90s (Valent, 2002).

Two diagnostic labels applied to vicariously traumatized therapists are often referred to in the literature: Compassion Fatigue (CF) and Vicarious Trauma (VT). I chose therefore to explore these in greatest depth, and to present them in the context of a series of stress disorders studied since the 70s. Increasing interest in this topic is reflected

by the number of articles and books published in the last fifteen years and devoted to helpers' work-related stress.

CF and VT are related but different constructs which need to be understood in the context of their respective theoretical frameworks. Models for CF and VT have been developed between 1995 and 2004; they attempt to suggest mechanisms and mediating factors for the development of those disorders. In this chapter I will present these models as well as some of the questions and difficulties they raise. Finally, some relatively recent surveys provide information on the prevalence of these disorders among therapists doing therapy with the traumatized. I will mention some of these results in this chapter as well.

Challenges of the Helping Professions

Carl Rogers said, "I have always been better at caring for and looking after others than I have in caring for myself. But in these later years, I have made progress" (cited in Skovholt, Grier, & Hanson, 2001, p. 168). As therapists, it is likely that many of us can relate to this statement. It seems that therapists have a tendency to have very high self-expectations, to focus on their client's needs, neglect to pay attention to their own needs and sometimes deny their personal emotional pain (Freudenberger, 1990). Part of the reason for this therapist self-effacing characteristic may be that therapists are other-oriented people whose hope is to make a difference and relieve human suffering; these humanitarian goals are infused with great personal meaning and purpose and constitute an essential part of what seems to attract them to this field; indeed, the intrinsic rewards

of these professions can be enormous. Yet, studies also indicate that numerous challenges

are attached to the relief of other people's suffering.

Therapists' Work-Related Stress and Its Impact on Therapists' Practice

Therapists' vitality and enthusiasm can become impaired: depression, cynicism,

anger at patients, guilt and powerlessness, among others, may lead these therapists into

physical and mental disability (Freudenberger, 1990). This vulnerability can be related to

the numerous sources of stress therapists encounter in their professional life, such as

aloneness in the counselling practice, emotional draining, administrative and legal

demands related to the handling of cases, and so on. These can overwhelm helpers who

will not readily admit they may need help; many will often resist treatment even when

their emotional situation justifies it (Freudenberger, 1990).

Additional factors likely to increase therapists' vulnerability are, among others:

(a) unrealistic beliefs or expectations (for example, the belief that clients' problems—

although sometimes unsolvable—must be solved); (b) over-commitment; (c) uncertain

role boundaries and difficulty to say no (working too hard at helping the client); (d)

expressing empathy in a no-reciprocal care taking situation (the helper may become

emotionally drained by a therapeutic relationship that is focused on the client's problems,

i.e., without mutual give-and-take); (e) difficulty to handle the fact that success and

measures of success are elusive (it is often difficult to measure therapeutic success); and

(f) difficulty to encounter failure and let go (lack of success despite one's best efforts is

sometimes part of a reality that needs to be accepted by the helper) (Skovholt et al.,

2001). The large proportion of non-counselling responsibilities and increasing demands

attached to therapists' role may also represent important sources of stress (Boy & Pine,

1980) as well as over-identification with clients, lack of perceived control at work, lack

of feedback from colleagues and lack of social support (Savicki & Cooley, 1982).

These obstacles challenge helpers in the course of their careers. Increased

attention has been paid to these sources of stress in the last decade and the notion that

helpers may need help has gradually become accepted in academic literature. If helpers

are being helped, helpers' clients will indirectly benefit from it and therefore there is an

emphasis in literature on therapists' self-care and the need for helpers to find a balance

between clients' and self care, professional and personal life, in order for helpers to

provide the effective and ethical care clients have the right to expect.

General and Clinical Definition of Trauma

The Merriam-Webster Online dictionary (2005) defines trauma as: (a) "An injury

(as a wound) to living tissue caused by an extrinsic agent", and (b) "A disordered psychic

or behavioral state resulting from mental or emotional stress or physical injury".

There appears to be a consensus among authors that trauma is characterized by

overwhelming and intense stimulation accompanied by a sense of complete lack of

control (Cerney, 1995); this may occur when helpers' stress responses are unsuccessful to

help them regain the sense of inner balance they experienced before the traumatic events

(Valent, 1995).

In this thesis, I will frequently use the word "wound" in the way it is commonly done in the relevant literature, that is, as a metaphor referring to therapists' or clients' personal trauma and the cognitive or emotional negative after effects of the traumatic events.

Trauma can be defined generally (such as in the public definition of the term) or clinically (as part of the definition of Post-Traumatic Stress Disorder or PTSD). These definitions are related, but not identical and need to be distinguished for better conceptual clarity.

In the latest versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-IV and DSM-IV-TR, trauma is defined as: "1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and 2) the person's response involved intense fear, helplessness, or horror" (American Psychiatric Association, 1994). The 1987 revised version of the DSM, the DSM-III-R (previous version), already included the possibility for a third party to be traumatized vicariously, that is, through knowledge of a significant other's trauma. That is an important detail to keep in mind for the understanding of the concepts that will be presented later, which build on this possibility of vicarious trauma.

Is trauma therapy different from other forms of therapy? In some authors' opinion it is so (e.g., McCann & Pearlman, 1990; Pearlman & Maclan, 1995). Therapists working in the field of trauma are said to face the biggest share of personal and professional challenges and stresses; exposure to the graphically intense narratives of suffering that

are characteristic of survivors' experience are claimed to affect therapists in different and deeper ways than any other client encounter (Danieli, 1981; Haley, 1974). These therapists appear to be those for whom self-care becomes an ethical imperative, especially if they have a personal history of trauma; therapist therapy may then be indicated in order to protect clients from the negative effects of unresolved therapists' emotional suffering (Arvay, 2001; Brady, Guy, Poelstra, & Brokaw, 1999; Pearlman & Saakvitne, 1995).

It has been observed that therapists' ability to listen empathically may become impaired when they feel overwhelmed by the nature of their work (Gentry, Baranowsky, & Dunning, 2002). One of the signs of this impairment has been called the silencing response. It has been hypothesized that the silencing response could be a subcomponent of CF which manifests as an avoiding behaviour in the helper. Sometimes indeed, the professional helper prefers to avoid, ignore or redirect potentially distressing material in the client's story and to attend only to material that does not threat the helper's sense of competency or ability and desire to know and handle some of the client's information (Gentry et al., 2002).

Therapists working with trauma victims have been studied for more than a decade and their symptoms have been described as almost identical to those of PTSD (Figley, 1995). Different studies point to the profound and enduring transformation of the sense of self and beliefs or value systems of helpers following empathic engagement with traumatized clients and knowledge of their terrible stories (Pearlman & Maclan, 1995). The debate about the nature of these disorders, however, continues. Two of the most

important challenges in the field of traumatology the last ten years have been, first, to develop conceptual frameworks that make sense of the symptoms observed. Second, to explore the mechanisms of what has been called "the transmission" or "contagion" of trauma between therapists and client (Figley, 1995).

Categories of Helpers' Stresses

In order to better understand the evolution of concepts such as Compassion Fatigue and Vicarious Trauma, I found important to begin by reviewing several stress-related concepts. As will be seen, some earlier concepts lead the way to more modern conceptualizations of the way clients' narratives of trauma impact their therapists. A chronological account of these concepts will help the reader to better grasp how these concepts have gradually emerged in the academic literature.

In the next section, I will present a description of five categories of stress disorders that can affect helpers, including CF and VT. Each stress disorder description will include: (a) the definition and history of the concept, (b) the etiology, (c) symptoms and, (d) risk factors (see Table 1 for a quick descriptive summary of these disorders).

Table 1: ***Comparison of Stress Disorders***
(Burnout, PTSD, Compassion Fatigue and Vicarious Trauma)

Definition	Etiology	Symptoms	Risk Factors
Burnout			
A syndrome of symptoms whose key feature is emotional exhaustion. Occurs more often in human service providers, but can also affect family members.	Is said to result from a combination of emotional stress and long lasting involvement with clients.	Stress is expressed in intra and interpersonal issues. Four categories of symptoms: (a) Cognitive, (b) affective, (c) behavioural and (d) physical. The symptoms pervade the personal and professional life of the helper.	Accumulation of work demands and lack of free time. Client's mental health issues that are difficult to handle. Power differential dynamics in the workplace. Helper's characteristics. One-way caring relationships.
PTSD			
An anxiety disorder evolving in relation to a past experience of trauma.	The result of exposure to a traumatic event or the result of knowing or witnessing significant others being threatened in their physical integrity. Intense fear, helplessness or horror are caused by the traumatic event.	Recurrent experiencing of the traumatic event. Avoidance of stimuli related to the traumatic event. General numbing. Increased arousal.	Exposure to a traumatic event which has the ability to arise intense feelings of fear, helplessness or horror. OR Witnessing or knowledge of a traumatic event having happened to another.
Compassion Fatigue			
A stress disorder with two components: STS and Burnout. User-friendly term for STSD.	Identical to STSD: The stressor is the traumatized significant other to whose suffering we are exposed.	Symptoms encompass seven categories: cognitive, emotional, behavioural, spiritual, personal relations, somatic and work performance.	Identical to STSD: Exposure to and empathic involvement with a friend, relative or client who has suffered a trauma.
Vicarious Trauma			
A process of transformation that occurs within the therapist as a result of empathic engagement with client's trauma experience.	Exposure to client's narrative, graphic details or re-enactments combined to therapist characteristics (e.g. personal experience of trauma).	Deep disruptions in the sense of identity, core beliefs about others and the world and spirituality (loss of hope, purpose, meaning), Also, diminished self capacities, disrupted psychological needs and cognitive schemas, disrupted ego resources, disruptions in memory, intrusive imagery and STSD symptomatology.	Repeated professional exposure to traumatized clients. Probably too, personal history of abuse, negative coping, high number of victims of sexual violence in the workload, less experience, training or being new to the field.

Burnout

Concept history and definition.

The term burnout was first introduced in 1974 by Freudenberger (1990), who conceptualized it as a professional hazard, that is, the helper's role of caretaker ultimately takes a toll on him or her, independently of the helper's individual characteristics. Burnout has also been described as a syndrome resulting from the interaction between individual personality characteristics with the professional environment (Watkins, 1983). Authors agree that burnout is a work-related syndrome whose defining feature is a gradual increase of emotional exhaustion and is also characterized by cynicism. Burnout is said to occur more often in individuals who do some kind of "people work" (such as service providers) (Gentry et al., 2002; Maslach & Jackson, 1981).

Etiology.

Burnout is thought to result from repeated contact with irritants in the work place and continuous therapeutic work with individuals presenting emotional and personal problems (Watkins, 1983). Different authors claim that burnout results from a combination of emotional stress and long lasting involvement with clients (Pines, Aronson & Kafry, 1981, cited in Raquepaw, 1989).

Symptoms.

Burnout symptoms unfold gradually, increasingly impairing the professional as well as the personal life of the caretaker, in pervasive ways (Savicki & Cooley, 1982).

These symptoms are said to belong to four distinct categories: (a) Cognitive, (b)

affective, (c) behavioural and (d) physical (Patrick, 1979, cited in Watkins, 1983).

Burnout can be experienced as permanent fatigue, insomnia, gastrointestinal

disturbances, headaches and depression (Raquepaw & Miller, 1989). Intrapersonal issues

(such as feelings of emptiness and sadness) may coexist with interpersonal ones, such as

marital conflict, conflicts with colleagues, poor professional boundaries and indifference

or even hostility towards clients.

Risk factors.

Burnout can affect family members (whose relationships become unrewarding

and stressful) as well as any professional (Figley, 2000). Human service providers,

especially those who are the most devoted to their work or function in the rescue mode,

appear to be most at risk (Figley, 1995). Key factors in burnout are, for example,

working with difficult populations in situations involving emotional draining, repetitive

and stressful interactions (McCann & Pearlman, 1990; Raquepaw & Miller, 1989;

Savicki & Cooley, 1982).

Additionally, workers may become vulnerable to burnout because of workplace

characteristics such as the accumulation of job demands and lack of free time, workers'

feelings of lack of control on their environment, little or no recognition from colleagues,

general negative work atmosphere and clients' mental health issues that are hard to

handle (working with schizophrenic clients, for example).

Some authors believe that environmental characteristics and human systems dynamics account exclusively for burnout (Miller, Wagner, Britton, & Gridley, 1998). According to them, power differential dynamics affecting the newcomers, and losses (through relocation, for example) are important sources of stress. Manifested in feelings of uprootedness and cognitive dissonance, this stress in turn increases workers vulnerability to burnout. Burnout is claimed to exist on a continuum; in helpers, burnout has sometimes been called "the wounding of healers".

Other authors insist however, that some helpers' characteristics may contribute in important ways to burnout: Over-involvement with clients, disempowering beliefs about success and failure, maladaptive coping styles, excessive idealism and excessive positive expectations relative to client success in therapy appear to increase helpers' vulnerability to burnout (Savicki & Cooley, 1982).

Burnout has also been explained in relation to the dynamics of the therapists-client relationship and the therapist's task of having to engage in cycles of "repeated empathic attachments, active involvement and felt separations" (Skovholt et al., 2001, p. 167). The therapist's "caring cycle" (forming a bond with the client then letting him go when therapy is over and attaching to a new client, and so on) is described as a one-way caring process. This "caring cycle" hopefully benefits the client, but leaves sometimes therapists depleted emotionally and unable to attach to the next client. This difficulty is compounded by the fact that therapists often need to know they are being efficient; it is very difficult, however, to measure success in therapy, and successful outcomes are most often beyond a therapist's control (Skovholt et al., 2001).

Finally, some authors (e.g., Raquepaw & Miller, 1989) found that working part-time in an agency setting predicted higher burnout than private practice counselling. Their study, based on a survey, suffers however from some weaknesses, such as a small sample that makes it difficult to generalize the study results as well as unreported important correlation figures.

Post-Traumatic Stress Disorder (PTSD)

Concept history and definition of PTSD.

The diagnosis of PTSD, a mental disorder which often develops as a result of the experience of trauma, appeared for the first time in the DSM-III (Figley, 1995). With this inclusion, the field of traumatology was born. PTSD, an anxiety disorder, is closely related to the concept of trauma as defined by the DSM criteria and is diagnosed when an individual: (a) develops anxiety symptoms and tends to re-experience the event in several ways after having been exposed to a traumatic event (e.g., intrusive thoughts or imagery or nightmares), (b) persistently avoids stimuli connected with the traumatic event (e.g., efforts to avoid activities, places or people connected with the event), (c) demonstrates post-traumatic numbing (e.g., feelings of detachment from others or restricted range of affect) and post-traumatic increased symptoms of arousal (e.g., hyper-vigilance or exaggerated startle response). Two additional criteria for this diagnosis are: (a) These symptoms must persist for at least four weeks after the traumatic event to warrant a diagnosis of PTSD and, (b) the impact of anxiety on the individual must be clinically

significant and pervasive in all important areas of functioning (American Psychiatric

Association, 1994).

Etiology.

PTSD is claimed to be the result of exposure to a traumatic event or the result of

knowing or witnessing significant others being threatened in their physical integrity.

Intense fear, helplessness or horror caused by the traumatic event must be present to

bring about the development of this disorder (American Psychiatric Association, 1994).

Symptoms.

PTSD symptoms are characterized by: (a) recurrent re-experiencing of the

traumatic event (e.g., nightmares, intrusive thoughts or images), (b) avoidance of any cue

or stimuli related to the traumatic event and general numbing (the person becomes less

responsive after the trauma), and (c) symptoms of increased arousal (e.g., hyper-vigilance

or irritability and outbursts of anger) (American Psychiatric Association, 1994).

Risk factors.

Exposure to a traumatic event which has the ability to arise intense feelings of

fear, helplessness or horror or knowledge (or witnessing) of such an event happening to a

significant other are the most important risk factors (American Psychiatric Association,

1994).

Secondary Traumatic Stress Disorder (STS, STSD)

Concept, history and definitions.

The DSM acknowledges secondary traumatic stress without further elaboration regarding the meaning or implications of what this "other's stress" represents for the person vicariously affected. From the DSM recognition of vicarious stress gradually emerged a family of related concepts in the field of traumatology. In 1983, for example, the term "secondary victimization" appeared in the literature, described as a form of burnout (Figley, 1995). Further conceptualization efforts persisted during the 80s and 90s, aiming to capture "the least studied and least understood aspect of traumatic stress: Secondary traumatic stress" (Figley, 1995, p. 7).

STS and STSD are among the earliest terms found in the literature describing secondary traumatic stress in accordance with the DSM notion of vicarious stress. Coined by Figley (1995), STS was defined as "the cost of caring", a natural consequence of empathizing and trying to assist the significant other (relative, friend or client) whose trauma is known to us and whom we are trying to help or support. Secondary stress responses are described as the reactions to the stress response of another (Valent, 1995) while STSD is claimed to represent the culmination of STS, when coping mechanisms fail and the overwhelming stress of caring for another develops into a helper's disorder (Figley, 1995). Rooted in the DSM diagnosis of PTSD, the STS and STSD focus of definition is less on the context and etiology than on the symptoms (Pearlman & Saakvitne, 1995).

Etiology.

The stressor at the source of STSD is not direct harm or threat to one's own physical integrity, but exposure to a significant other's trauma and suffering (be it a client, relative or friend), as well as to his or her narratives graphic details (Figley, 1995).

Symptoms.

The syndrome of STSD has been described as almost identical to PTSD, with the exception that the symptoms of STSD are related to the trauma affecting the significant other (vs. the person directly affected by the traumatic events). The re-experiencing of the traumatic event in STSD, for example, concerns what happened to the significant other, that is, the significant other will demonstrate hyper vigilance for the traumatized person, will recollect or dream about the victim's traumatic event or be distressed when reminding his or her trauma and the images, feelings or thoughts of the victim in relation to it (Figley, 1995).

Metaphors such as "infection" and "virus" are frequently used in the literature in relation to STSD symptoms (Figley, 1995, 2002; Stamm, 2002; Gentry et al., 2002; Valent, 2002). These metaphors originated in Figley's studies of how trauma-related stress may spread in families. Kishur, one of Figley's students, used the expression "crossing over" as a metaphor to describe how traumatic stress seemed to "infect" the entire family system after appearing in just one family member for the first time. The metaphor of "crossing over" relates to the chromosomal transmission of information existing between pairs of chromosomes during cell division. This notion of

"transmission" of stress led to the description of STSD as a parallel process between the

person primarily affected by trauma (and displaying PTSD symptoms) and the relative,

friend, counsellor, nurse or significant other, trying to assist the victim and whose

impaired coping abilities develop into symptoms akin to PTSD symptoms, a disorder

called STSD (Figley, 1995).

Risk factors.

One is at risk to develop STSD when exposed to significant others who happen to

be traumatized. Exposure, knowledge of or witnessing the traumatic event and empathic

involvement with the traumatized individual are all risk factors for STS and STSD

(Figley, 1995, 2002; Gentry et al., 2002; Stamm, 2002; Valent, 2002).

Between 1991 and 1996, several empirical studies (cited in Arvay, 2001) using

quantitative measures explored secondary traumatic stress in therapists. The statistical

results they obtained, demonstrated lack of agreement in several areas. For example, the

study of the level of symptomatology in therapists with previous history of trauma

reported equivocal results. Indeed, two studies (Munroe, 1991, cited in Arvay, 2001;

Schauben & Frazier, 1995) indicated that therapists' personal trauma did not lead to

greater symptomatology while the contrary was reported by three other studies

(Chrestman, Duncan, Sullivan, & Kamen, 1995, cited in Arvay, 2001; Kassam-Adams,

1995; Pearlman & MacIan, 1995). The three last studies reported PTSD-like symptoms,

disrupted cognitive schemas and general distress. Figley's research (1995) equally

supports the idea of a greater vulnerability to develop stress-related disorders in therapists with personal history of trauma.

There has not been enough empirical research to date however to ascertain what factors are significant in predicting STSD in therapists, and the available studies often present contradictory information (Arvay, 2001). There is one exception however: STSD seems positively related to the number of traumatized clients in the therapist's workload (Arvay, 2001).

Compassion Fatigue (CF)

History of the concept and definition.

The term "compassion fatigue" was first used by Joinson in 1992 (cited in Figley, 1995) in his discussion of burnout in nurses. The term was later defined as identical to secondary traumatic stress disorder (STSD) and " nearly identical to PTSD" (Figley, 1995, p. 8). Terms such as "the cost of caring" and "compassion fatigue" were first used in Figley's seminal research (1995, p. 1) as the user-friendly, less pathologizing descriptions of STSD. Compassion fatigue is presented in the literature as the natural consequence of caring intensely for another, that is, "not necessarily a problem, but a natural by-product of caring for traumatized people" (Figley, 1995, p. 11; 2002, p. 2). Compassion Fatigue has also been described as "a form of burnout, a kind of 'secondary victimization'" (Figley, 1995, p. 2).

The most recent definition of compassion fatigue states that CF is "one form of burnout" (Figley, 2002, p. 5) and also that it includes two different components: Burnout and STS (Figley, 2002; Figley, personal communication, June 21st, 2004). This conceptual shift, that is, from "Compassion Fatigue is one form of burnout", (Figley, 1995, 2002) to the idea that burnout is a component of CF, is not made really clear in the literature and some conceptual steps seem to be missing, or in need of elaboration.

Finally, a recent article by Figley (2002), states that CF is associated with therapists' cognitive schema; cognitive schema is defined in that article as "social and interpersonal perceptions of morale", (p 3).

Etiology.

As mentioned above, compassion fatigue is understood as a user-friendly term for STSD. The etiology of these two disorders is therefore identical.

Symptoms.

Contrary to burnout which is described as emerging gradually from a state of emotional exhaustion, compassion fatigue is described as emerging abruptly, as the consequence of even only one experience of work with a trauma survivor, an experience which becomes all at once overwhelming for the helper. Yet, the recovery rate for compassion fatigue is said to be faster than recovery from burnout (Figley, 1995). These descriptions are in agreement with studies reporting that STS and burnout are different constructs (McCann & Pearlman, 1990; Pearlman & Maclan, 1995; Schauber & Frazier, 1995).

The recent definition of compassion fatigue as including a component of burnout (Figley, 2002) has led to the description of a list of CF symptoms that encompasses seven dimensions or categories, that is, (a) cognitive (e.g., rigidity, lowered concentration, decreased self-esteem, and so on), (b) emotional (e.g., powerlessness, anxiety, guilt, numbness, and so on), (c) behavioural (e.g., irritability, moodiness, accident proneness, and so on), (d) spiritual (e.g., questioning the meaning of life, anger at God, loss of purpose, and so on), (e) personal relations (e.g., withdrawal, mistrust, isolation from others, and so on), (f) somatic (e.g., sweating, breathing difficulties, dizziness, and so on) and, (g) work performance (e.g., low morale, low motivation, absenteeism, and so on). A total of 76 symptoms can be found listed in a chart called "compassion fatigue/burnout syndrome" (Figley, 2002).

Risk factors.

Given that STSD and Compassion Fatigue are considered identical in the literature, the risk factors of these two disorders are understood to be identical as well.

Vicarious Trauma (VT)

History of the concept and definition.

"Vicarious Traumatization" is a term coined by Pearlman and Maclan in 1990. A first attempt to operationalize this concept was attempted by the same authors in 1995. The theoretical framework for the concept is CSDT, or Constructivist Self Development Theory.

CSDT is a developmental framework that combines self-psychology and object-relations theory with social cognition theories. In this framework, the self appears to be viewed as a core or individualized essence that can be wounded emotionally and in its belief system. Trauma survivors' personality characteristics are said to interact with important aspects of the traumatic event, resulting in unique adaptations to trauma. Individual psychological responses exist, says the theory, inside the boundaries of the social and cultural contexts of the individuals being studied or helped (McCann & Pearlman, 1990). Vicarious traumatization (VT) is defined) as a process of:

> transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments. (Pearlman & Maclan, 1995, p. 558)

The authors note that VT is also characterized by profound and sustained changes in the therapist experience of self as well as other people and the world.

There is agreement among several authors that empathy and empathic engagement are necessary if therapists want to develop strong working alliances with their clients and be able to help them (Figley, 1995, 2002; Pearlman & Saakvitne, 1995; Thomas & Wilson, 2004); these authors also agree that these qualities are in the same time what makes the therapist vulnerable to the negative effects of VT, STSD and CF. In the latest definition of VT, therapists' "incomplete empathic engagement with trauma survivors and their trauma material" is believed to be key to the understanding of how VT develops (Pearlman, personal communication, June 21st, 2004). What this means is

that, in some cases, helpers (including therapists) attempt to understand and empathize with the traumatized client without possessing a solid theory (or philosophy) that would enable them to know "what to do" with the strong feelings the client's story evokes in them. When helpers attempt to go ahead with therapy in these conditions, they may sometimes become really anxious or scared about the intensity of their own feelings (in relation to the client's narrative). When this happens, helpers sometimes dissociate, intentionally or not, from the pain associated with the victims' narratives and block compassion in themselves. "Incomplete empathic engagement" is then said to happen (the flow of empathy is interrupted by the therapist's fears).

Etiology.

Exposure to situational variables (e.g., trauma re-enactments, graphic details of cruelty) combined to therapist characteristics (such as personal experience of trauma) are said to be important contributing factors to the development of VT (Brady et al., 1999).

Like compassion fatigue, vicarious trauma may develop in therapists who work with victims of trauma and are empathically attuned to them; contrary to CF however, VT is said to develop after long term exposure to these clients' suffering, memories and narratives (cumulative across time and relationships) (McCann & Pearlman, 1990).

Symptoms.

VT is said to result in deep disruptions of the sense of identity, core beliefs about the world and others and spirituality (Brady et al., 1999; Pearlman & Saakvitne, 1995; Pearlman, personal communication, June 21st and 22nd, 2004). The importance of

spirituality for therapists doing trauma work and also their clients has been emphasized by different authors (Neuman & Pearlman, 1996, cited in Brady et al., 1999; Sargeant, 1989; Wittine, 1994).

According to those who pioneered the concept, disrupted spirituality is the hallmark of VT. It is understood as a pervasive sense of existential loss, loss of meaning in one's life, loss of hope and disillusionment and a feeling of disconnection from others.

To date, there seems to be a lack of empirical studies exploring therapists' spirituality in the context of work with the traumatized. An interesting exception deserves to be mentioned however: A survey explored vicarious traumatization in 446 women psychotherapists, ranging from 24 to 73 years working with victims of sexual abuse (Brady et al., 1999). This survey demonstrated that the participants showed mild symptoms of intrusion and avoidance, with a low level of intensity. Only a few participants showed a high level of distress. Perception of self, others, the world and belief system appeared to be undisturbed, indicating that long-term impact of this type of work should probably not be expected. No difference in vicarious traumatization appeared to be connected to work with either children or adults, victims of sexual abuse. The authors mention the hypothesis that identification with the victim, rather than age, could explain heavier symptomatology. A good number of participants mentioned positive aspects of their work with the victims, such as witnessing human resiliency and courage, the joy of being instrumental in these victims healing and the personal growth attached to this type of work. Interestingly, those participants who had the heaviest loads

of survivors were also the ones reporting the higher levels of satisfactory spiritual life

(Brady et al., 1999).

Working with trauma victims is known to evoke intense personal questioning

about the meaning of life, good and evil, and many other existential dilemmas; these

same authors hypothesize that such an intense confrontation may actually enhance the

practitioners' spiritual life and increase their resiliency. After a period of destabilization

due to the shock of the encounter with traumatic material, it was hypothesized that these

therapists may have grown stronger, as if "purified by fire" (p. 392). Another hypothesis

offered by this survey was that therapists who are attracted by work with the traumatized

may be individuals who are already solidly grounded in their own philosophical system.

The study concluded by stating that a clear link exists between trauma therapy and

spirituality and that therapists should be encouraged to explore this link as they believe

they could benefit from this exploration (Brady et al., 1999).

Besides disrupted spirituality, additional VT symptoms are diminished self

capacities (reduced self-esteem and ability to handle strong emotions), disrupted

psychological needs and cognitive schemas (safety, esteem, intimacy, control, trust),

disrupted ego resources (e.g., impaired judgment, difficulty establishing appropriate

boundaries with others), disruptions in memory, intrusive imagery as well as the usual

STSD symptomatology described previously.

McCann and Pearlman's (1990) theoretical framework defines symptoms as

attempts to adapt and cope, and trauma as the subjective experience of the survivor, that

is, victims construct personal meanings around the events they experience.

Risk factors.

Besides repeated professional exposure to traumatized clients, some specific

factors are claimed to possibly increase vulnerability to VT in therapists; these factors

are: Personal history of abuse, negative coping (Follette, Polusny, & Milbeck, 1994), a

high number of victims of sexual violence in therapists' workload (Schauben & Frasier,

1995) and to be new to the field of trauma therapy, less experienced or to have received

less training (Pearlman & MacIan, 1995).

Conceptual Links

VT and CF

Like compassion fatigue and burnout, VT is an occupational hazard that has

effects on helpers' personal and professional lives; contrary to compassion fatigue

however, VT is said to be the result of cumulative exposure to clients who have been

traumatized (it does not arise after just one exposure to a survivor and is said to result

exclusively as a consequence of working with survivors of trauma) (Pearlman, personal

communication, June 21st, 2004). The VT concept goes beyond a focus on symptoms and

emphasizes the way empathic engagement with a victim of trauma affects the therapist's

cognitive schema, sense of identity, beliefs and spirituality, that is, meaning, purpose and

hope (Pearlman & Saatvikne, 1995; Thomas & Wilson, 2004).

VT and STSD (or CF) are said to partially overlap; VT is said to include the

symptoms of STSD, but differ from STSD "in focus and context" (Pearlman &

Saakvitne, 1995). Indeed, STSD is rooted in the DSM conceptualization of PTSD, and

therefore the concept focuses essentially on symptoms and less on context or etiology.

VT takes in account the whole individual in the relationship context as well as the

subjective meanings of trauma involved. The kind of treatments that are suggested for

STSD are said to be appropriate for VT (Pearlman & Saakvitne, 1995).

VT and Burnout

VT and burnout are related, that is, work with the victims of trauma may elicit

symptoms of burnout due to the situation or client mental health or difficulties; on the

other hand, burnout is said to relate mostly to the situation while VT involves an

interaction between the situation and the individual (McCann & Pearlman, 1990;

Pearlman & Saakvitne, 1995).

Burnout, compassion fatigue and secondary traumatization are said to be related

but also different constructs from VT (Brady et al., 1999; Pearlman & MacIan, 1995;

Thomas & Wilson, 2004). Different authors however, use sometimes the STS and VT

labels interchangeably while differentiating VT from burnout (Arvay, 2001; Stamm,

2004).

Existing Theoretical Frameworks

Vicarious Trauma

As previously mentioned, Constructivist Self Development Theory (CSDT) is VT theoretical framework. This developmental framework combines self-psychology and object-relations theory with social cognition theory.

Among the mechanisms hypothesized to account for VT, the literature identifies counter-transference (understood as all of the fantasies, thoughts, feelings about the client and also the thoughts and feelings about all of the above), and "incomplete empathic engagement", or the attempt by helpers to distance themselves emotionally from the client in order to protect themselves against the strong impact clients' narratives have on them (Pearlman, personal communication, June 21st, 2004).

The concept of VT however, goes beyond the concept of counter-transference in that VT is claimed to alter dramatically therapists' cognitions (beliefs, values, worldview, and so on) (McCann & Pearlman, 1990). The available literature does not yet provide detailed elaboration on these mechanisms, but several authors insist on the urgent need to develop theories able to help better conceptualize CF and VT and their mechanisms (Figley, 1995; Pearlman & Maclan, 1995; Pearlman, personal communication, June 21st, 2004).

STSD and Compassion Fatigue

A brief review of Figley's two successive models related to the development of CF in the therapist will be presented next in order to clarify the author's recent changes in emphasis and direction research on this concept. Figley's two models (1995, 2002) appear to be, to date, the most elaborated models for CF.

The Compassion Fatigue and Stress Model

In this early model (1995), therapists' empathic ability, empathic concern and exposure to the client are preconditions for the existence and the quality of therapists' empathic response. The demands on the therapists to provide consistent empathy and understanding may cause the professional to experience compassion stress, a variable moderated by both Detachment (or Disengagement) and Satisfaction which both are said to decrease compassion stress. A certain level of residual compassion stress might remain however, something that can lead to compassion fatigue in case of prolonged exposure to trauma-related material, and when personal trauma history and other stressors (or life disruptions) are present. As is apparent, burnout is not explicitly mentioned in this model.

The Worker-Client Transmission of Stress and Satisfaction Model

In this broader model, an effort has been made to emphasize the positive aspects of the care taking process, namely, workers' satisfaction with their task. This model draws upon the social and psychological research on ego resiliency, the concept of "crossover" stress, systemic stress in families and interpersonal theory. It considers work-

related trauma as trauma that affects professionals in their personal and professional lives (vs. workplace related trauma) and emphasizes the interdependence between therapist and client. This interdependence is said to be demonstrated in the way satisfaction as well as stress are "transmitted" from client to therapist and vice-versa (C.R., Figley, personal communication, June 21st, 2004).

In this broader model, worker or client's stress/satisfaction are mediated by ego resiliency (among other personal moderating variables), stressor mediating variables (non-specified) and interpersonal mediating variables (such as the connection or working alliance between therapist and client). Two assumptions underline this model: (a) The process is simultaneous, that is, therapists and clients are claimed to experience satisfaction or stress in parallel, and (b) although workers' compassion fatigue might be high, simultaneous high levels of compassion satisfaction may coexist; when that is the case, compassion satisfaction contributes to keep workers actively involved in their profession while allowing them to perform at good levels of efficiency. This parallel process between client and therapist is said to be a form of emotional contagion, the natural consequence of the fact that therapist and client are emotionally attuned to each other. As can be seen, this last model sees the therapist-client dynamic as very important and emphasizes each person's resiliency and ability to recover.

This emphasis on the positive aspects of caring appears to derive from a joint effort of reflection between Figley and Stamm regarding ego resiliency and hardiness. Their collaboration resulted in the creation of several scales that attempted to

operationalize and measure two variables believed to be related to compassion for the traumatized, that is, fatigue and satisfaction (Stamm, 2002).

None of these models provides detailed elaboration on how CF and VT develop, how "contagion" of trauma occurs between therapist and client, and so on. More research appears to be needed to present accurate models for these disorders and better operationalization of the constructs used in the literature.

Conceptual Difficulties

The existing conceptualizations of CF, STS and STSD present several difficulties which have to do with contradictions among authors, problems inherent to the logic underlying some of the statements about this topic or lack of sufficient empirical data to support some study claims. I will next consider some issues and complexities raised by the diagnostic labels presented so far.

Compassion Fatigue: Pathology or Professional Hazard?

While the idea that compassion fatigue is a disease that needs treatment is prevalent in the trauma literature, some researchers equally maintain that compassion fatigue is an occupational hazard that does not involve pathology in the therapist. This raises the question of why a natural consequence of caring would be labelled a disorder and be categorized as a syndrome of symptoms equivalent to PTSD. Metaphors used in describing the origin of CF such as "transmission" or "contagion" reinforce the impression of an ambivalent use of the medical model; CF is indeed presented in the

literature as rooted in the DSM description of PTSD (and therefore implying pathology) while the label is somewhat normalized through friendly-user terms such as "cost of caring" or " the by-product of caring".

Relationships Between CF, STS and Burnout

Another level of conceptual ambiguity is exemplified by the definition of CF. Some authors (Figley, 2002; Gentry et al., 2002) present STS and burnout as components of compassion fatigue without referring to the previous conceptualization of CF as another term for STS or STSD (Figley, 1995), nor making clear for the reader how from being a synonym for compassion fatigue, STS has now become a component of compassion fatigue. In a different study (Thomas & Wilson, 2004), CF is presented as the friendly-user term for STS and STSD and no mention is made of burnout as a structural component of compassion fatigue. The same study states that "empathy and empathic strains lead to three distinct and separate response patterns that have been referred to as Compassion Fatigue, STS and Vicarious Trauma" (Thomas & Wilson, 2004, p.82). Some confusion remains therefore as to the relationship between compassion fatigue, STS and burnout.

Another problem adding confusion to this discourse appears in a study by Gentry et al., (2002) where the definition of CF is reported as the combination of: (a) PTSD symptoms (contributing to the STS part) and (b) burnout. The authors report this definition as having appeared in a 1996 publication (that does not appear in their

reference list); yet, no available study prior to 2002 appears to report burnout as a component of Compassion Fatigue.

Empathy or Cognitive Schema?

The initial definition of STS was based on the idea that the caretaker can be traumatized by the knowledge of the traumatic event hurting a significant other (Figley, 1995). The definition of STSD (or CF) is, as previously noted, based on the DSM description of PTSD which includes the mention that one can become traumatized by learning that a significant other has been traumatized and by having knowledge of what happened to that person (American Psychiatric Association, 1994).

It has also been asserted however that "those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress" (Figley, 1995, p. 1) and that "empathy is a key factor in the induction of traumatic material from the primary to the secondary victim" (Figley, 1995, p. 15). This point of view is echoed by recent research stating that empathy is "the key to understanding the phenomena which have been described as compassion fatigue, STS and vicarious traumatization" (Thomas & Wilson, 2004). Compassion and empathy are also mentioned as being the "vehicle whereby helpers make themselves open to absorption of traumatic information" (Valent, 2002) and "what puts the helper in harm's way" (Stamm, 2002). Compassion fatigue has repeatedly been associated since 1982 with the "cost of caring for others in emotional pain" (Figley, 2002, p. 3). It appears that the weight of these two variables (empathy and cognition) as they influence the development of STSD and CF deserves

more clarification. While 76 symptoms of compassion fatigue are reported under the compassion fatigue/burnout syndrome umbrella (Figley, 2002), the cognitive domain appears as only one among seven categories of symptoms, including only nine symptoms. This does not seem to point to the cognitive domain as a paramount aspect of compassion fatigue.

Operationalization of CF and STSD

On the surface, the concepts of compassion fatigue, STS and STSD seem interconnected and appear to refer to the same phenomenon. Some studies seem to suggest that that is the case (Arvay, 2001; Figley, 1995). An examination of the research findings on STS reveals, however, a general absence of agreement among research findings (Arvay & Uhlemann, 1996; Arvay, 2001). A comparison of these research findings reveals, for example, disagreement at the following levels: differentiating the STS and burnout constructs, relationship between STS and trauma caseload, age, experience or exposure to traumatized clients, significance of therapist's personal history of trauma, and more.

Several dilemmas exist in relation to all these labels (STS, STSD, CF) in that they do not offer solid explanatory frameworks for the symptoms observed nor do they suggest how or why the client's trauma appears to be "transmitted" to the therapist. Are the STSD patterns of symptoms almost identical to those of PTSD (as asserted in Figley, 1995)? Some authors doubt it (Thomas & Wilson, 2004) and others recommend that important construct validity questions related to these concepts be addressed (Stamm,

2002). It was also my impression while doing my literature review that more research is needed to define these constructs more accurately and to operationalize them in ways that allow for fruitful empirical studies.

Conclusion

There is uncertainty when it comes to the dynamics, cause-effect relationships, moderators and contributing factors of compassion fatigue: These are issues which have recently been compared to a "black box" (Figley, personal communication, June 22nd, 2004). There seems to be a definite need to develop solid theoretical frameworks that better account for the variety of symptoms being observed as well as the phenomenon of "contagion" which, to date, is little understood. The general lack of agreement in research findings equally points to the necessity to develop stronger conceptual frameworks about these disorders.

What Is Next?

The exploration of these disorders evokes many questions related to the healing function, such as: What does it mean to heal; what does it mean to be a healer for another; can someone be definitely healed; who owns this healing power and where is it "located"; can we acquire it or is it a natural talent some people have and others do not; is it possible to lose it after having acquired it?...and many more.

In order to explore these questions, I decided to look for the kind of literature which would elaborate on these themes. Although I did not find research associating the

study of the healing function in relation to CF and VT, I was delighted to find several articles on the theme of the Wounded-Healer. This theme and several of its mythological and spiritual connections, allowed me to start thinking about CF and VT in ways not provided by the literature on these disorders. What comes next is the result of my exploration of the Wounded-Healer theme and the connections I made between this topic and the topic of CF and VT in order to gain a broader understanding of these disorders.

CHAPTER 2:
THE WOUNDED-HEALER

"Like the proverbial fools, they enter in where angels fear to tread."

(Groesbeck, 1975)

Trauma work may reawaken a personal history of trauma along with badly healed

wounds and therapists may find themselves emotionally drained or wounded anew in the

context of their work, as reflected in cases of compassion fatigue or vicarious trauma.

Exposure to their clients' narratives may sometimes overwhelm therapists' capacity to

safely absorb and handle the information in therapeutic ways. Healers may therefore be

or become wounded in the course of their careers (Brady et al., 1999; McCann &

Pearlman, 1990).

In the following sections, research dealing with the issue of therapists who are

also 'wounded-healers' will be presented. Some of the existing models integrating the

Wounded-Healer (WH) metaphor support the idea that therapists develop into healers

through stages; gradually, it is claimed, they learn to accept and get acquainted with the

wounded aspects of themselves; hopefully, they also succeed in using their selves and

their emotional wounds to connect empathically and therapeutically with their clients

(Groesbeck, 1975; Kirmayer, 2003).

In the final section of this chapter I will connect the topic of CF and VT to previous research on the WH theme (Groesbeck, 1975; Kirmayer, 2003; Miller & Baldwin, 1987; Miller, Wagner, Britton & Gridley, 1998). I establish this connection in a model I propose which I chose to call "the CF & VT/WH model". The goal of this model is to suggest fresh ways to think about CF and VT, borrowing from psychodynamic concepts such as the unconscious, projections, polarities and counter-transference.

What Is a Wounded-Healer (WH)?

The terms "wound" and "woundedness", repeatedly used in this thesis, are metaphors referring to an individual's (client or therapist) personal trauma; it includes the cognitive and emotional sequelae following individuals' lived experience with a traumatic event.

In the existential sense we are all "wounded", those who have a history of trauma as well as those who do not. Existential anxiety is humanity's incurable disease according to existentialists; it is also a basic human condition, according to Sartre. The intensity of trauma however, only affects some of us and does not affect everyone in similar ways: According to literature, trauma appears to be an intimate, personal experience whose intensity is appraised individually and subjectively (Pearlman & MacIan, 1995). It seems therefore that the idea of wounding in healers should be seen along a continuum rather than as a black-and-white concept (Miller et al., 1998).

Wounded-Healer Stories

The oldest Western mention of a wounded-healer can probably be found in Greek mythology (Kirmayer, 2003). A most important healer figure in Greek mythology was Asklepios, a physician whose mother was accused of adultery by Asklepios' father, Apollo, then sentenced to death and murdered. Snatched from his mother's womb after her death, Asklepios was entrusted to Chiron the Centaur (the guide to the underworld) who raised and mentored the child in the arts of hunting, music and medicine. It was believed that Chiron suffered from an incurable wound, something that also represented the source of his power to heal. When Asklepios attempted to resurrect the dead, he was struck by lightening by Zeus as punishment. After a change of mind, however, Zeus brought Asklepios back to life and the latter joined the Pantheon, raised to the status of a semi god. From Chiron and Machaon (Asklepios' son), several generations of compassionate wounded-healers made their way in Greek mythology, inspiring Western medicine and psychology (according to the myth, Machaon became wounded too while assisting injured soldiers) (Groesbeck, 1975; Kirmayer, 2003).

The wounded-healer is a metaphor and an archetype and this theme can also be found in the writings of Jung (1954). This archetype is believed to become activated when the sick or distressed individual looks for a therapist or a doctor, that is,[1] a source of healing outside him or herself (Groesbeck, 1975; Miller & Baldwin, 1987).

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[1]   An archetype could be defined as "Jung's concept that refers to the contents of the collective unconscious. Archetypes, also called primordial images or collective symbols, represent psychic patterns of inherited behaviour and are thus distinguished from instincts, which are physical impulses toward action" (Feist & Feist, 1998).

The figure of Christ appears to represent a powerful enactment of this archetype. Moreover, a comparison of Christ and Asklepios reveals interesting similarities: Both Jesus and Asklepios are said to be of divine ascendancy; however, both their mothers' fidelity to their husbands is questioned at some point while the circumstances of the children's birth is surrounded by extraordinary and dangerous events. Both Jesus and Asklepios are claimed to have had miraculous healing powers. Just like Asklepios, Christ is an "ultimate healer" [if we refer to Groesbeck's (1975) terminology]; that is, both gave their lives to save others from death (physical or spiritual) and, in doing so, could not avoid encountering death for themselves. Like Asklepios, Christ is elevated to the rank of God after his resurrection. Christ's suffering and death are claimed to have redemptive and healing power for anyone seeking physical and spiritual healing from him. Asklepios, on the other hand, gives birth to a generation of great healers after being raised from the dead by Zeus (Kirmayer, 2003).

The primitive healer or shaman, both physician and priest, represents a different account of the Wounded-Healer image. Like Chiron, shamans are in contact with good and evil spirits, heaven and hell. Shamans are believed to have been chosen by their ancestors to perform healing because of their previous experience with death or life threatening sickness (Kirmayer, 2003).

The Wounded-Healer is also present in "middle tales" (fairy tales addressing adult issues), such as "The Stoning", a Moroccan tale. The 1980 Hollywood movie "Resurrection" represents a modern version of "The Stoning" story. In "Resurrection", a

woman accused of adultery is shot by her lover and nearly dies. She recovers however to discover that she now has the power of healing the sick (Chinen, 1992).

What Do Wounded-Healers' Stories Have in Common?

One major theme running through all these stories is that healing and wounding are inextricably bound together, two facets of a same reality. Moreover, as conveyed by the Greek myth of Asklepios, in the ancient times, the powers to inflict sickness and to cure were believed to belong to the gods. The priest-physician in Ancient Greece was considered at once the illness and the remedy. These two concepts were indistinguishable.

The paradox of wounding as the other facet of healing is reflected in modern therapeutic endeavours: Remedies and medical interventions often appear to be double-edged swords, while many connections between healing and sickness still retain their share of mystery. Among several daily-life illustrations of how healing and wounding connect, the following are well known: (a) the bacteria able to cause serious illness to a human body may be used to prevent the same illness when adequately prescribed in the form of a vaccine, (b) the Law of Similars in homeopathy (the substance that made a person ill is prescribed in minute doses to promote healing), (c) the treatment of phobia anxiety through exposure or "flooding" to what caused fear in the first place and (d) surgery and the scalpel of the surgeon (a word derived from "Chiron" as noted by Kirmayer, 2003) which can heal and wound, depending on the surgeon's skill. Like the bacteria, the chemical or the scalpel, healers' interventions can heal or wound; their

positions and status in clients' lives give them access to implement the healing function or to use their power to further wound already vulnerable clients. It makes therefore sense to think that the "no harm" ethical motto of physicians is relevant to any helping service provider.

In compassion fatigue and vicarious trauma, it is therapists' empathy which is claimed to be the double-edged sword vehiculating both healing and wounding. Therapists' empathy allows healing to take place in the client, but is also claimed to be the "carrier" (sic) of traumatic stress which sometimes appears to be transmitted from the traumatized client to the trauma therapist (Gentry et al., 2002).

What then can therapists do when wounded in the course of helping another? It seems that a constructive, growth-enhancing way to deal with one's inner pain or emotional struggle is to work at transcending it and use one's self to bridge the worlds of illness and health; this approach seems to allow real compassion to enter the therapeutic setting (Baldwin, 2000; Miller et al., 1998; Rogers, 2000; Satir, 1987). "How to" do that is the question at the core of the dilemma presented by the phenomenon of compassion fatigue and the present chapter.

Stories of wounded-healers have sometimes heroic undertones (as in Asklepios' and Christ lives stories); this is related to the fact that the healer has to struggle to face and transcend pain and suffering, sometimes even death. This second theme, healers' task of accepting and transcending their pain, underlines the necessity for healers to have to work hard to acquire lasting healing powers (a third theme). In shamans' case, for example, it is the encounter with serious illness which gives them intimate knowledge of

what disease is and which ultimately represents the source of their healing authority

(Kirmayer, 2003). Similarly, it is their relationship to their own suffering that seems to be

key to therapists' competence and authority. Indeed, as quoted by Groesbeck (1975, p.

133), it is only:

> when the doctor has been deeply touched by the illness, infected by it,
> excited, frightened, shaken, only when it has been transferred to him,
> continues in him and is referred to himself by his own consciousness-only
> then and to that extent can he deal with it successfully. (Jaspers, 1964)

After transcending their pain, healers may be transformed but not totally "cured" (a

fourth common theme in wounded-healers' stories). This belief, vehiculated by several

wounded-healer stories, that the wounded-healer remains "forever both patient and

healer" (Miller & Baldwin, 1987, p. 147) points to the possibility that the pursuit of self-

healing in the therapist may be an ideal never fully realized but constantly sought.

This paradox, that is, the one who heals is also incurably wounded, is tied to the

notion that, in order to mediate healing, the one who heals has to been intimately

acquainted with his/her own source of pain. The wounded-healer archetype and metaphor

carry the notion that trauma and emotional wounds deeply transform us, for better or

worse, but also that they are not something whose imprint on our being we can erase:

"It's only man's wounds that can be healed not man himself. Machaon [Asklepios'

mythological son] wounds and heals, but in essence he is incurable" (Kerenyi, 1959, cited

in Groesbeck, 1975).

Wounded-Healers and Trauma Therapists

Could the awareness of being wounded be a major factor motivating students to become professional healers (counsellors or therapists)? And should anyone care if an important number of wounded-healers, ex-substance abusers or individuals with histories of psychiatric disorders are being attracted to the healing professions? The answer to both questions is most probably yes. The reasons are, first, that a personal history of unresolved suffering seems determinant for this type of careers (Figley, 1995; Gentry et al., 2002; Miller & Baldwin, 1987; Miller et al., 1998). Second, although wounded-healers can be expected to have a great potential to deeply understand, identify with and empathize with their similarly wounded clients (given their own experience with trauma), therapists' unresolved history of suffering may also have negative consequences for clients. Therapists' significant mood shifts, feelings of isolation or vulnerability may negatively impact clients (Cain, 2000); or, therapists risk for example to over-identify with their clients and assume that clients' issues are identical to their own, stop listening carefully, and impose methods on clients which worked for these therapists but could be inappropriate for their clients (Figley, 1995). Unresolved trauma in the therapist raises therefore ethical dilemmas in regard to the quality of the care these therapists provide to their clients (Arvay, 2001).

How can therapists avoid to compromise clients' treatment and how can their sense of emotional depletion be transformed into a healthy sense of richness and renewed ability for compassion? To begin considering the options, I found useful to start by

examining the kind of stance helpers maintain towards their emotional wounds and the impact of this relationship on the therapeutic encounter.

An interesting approach to this topic is offered by Kirmayer (2003) who identified five stages in the development of helpers (who are also wounded-healers) and their relationship to their own emotional wounds; Kirmayer also identified five additional stages in relation to the way the wounded-healer later enters in relationship with the other-wounded (the traumatized client). Before going further however, I think it is important to clarify some of the theoretical assumptions on which the ideas that will be presented next are built. It is also important to specify that many of these ideas appear to be based on Jungian analysis, and more specifically, on the notion of archetypes.

The Wounded-Healer Archetype and the Therapeutic Relationship

The archetypal image of the wounded-healer is thought to include two complementary aspects, that is, wounding (or being wounded) and healing (or being healed). Rather than opposites, these aspects are in reality, complementary unconscious roles or polarities. These polarities are said to be present in both client and therapist and to be able to become activated (clients' woundedness will, for example, activate the wounded polarity in their therapists). This activation will operate in the form of projections leading to transference and counter-transference (Groesbeck, 1975; Miller & Baldwin, 1987). The "split" between polarities, i.e., their lack of integration as aspects of a same reality, create a state of tension and a need for reconciliation. When harmony is

not found, further projections and their consequent damage to the therapeutic relationship can be expected. Regarding client's transference, Jung was of the opinion that it is a common occurrence for therapists to become "psychically infected and poisoned" by clients' projections; Jung understood this problem as being a transference issue (Jung, 1954).

Beyond conscious interaction between therapist and client, unconscious communication might play important negative and positive roles. Through projection of hidden parts of the self, for example, therapists' wounded selves can be denied and projected onto their clients. In regard to the positive aspects of this communication, helpers' role is to activate the "inner healer" in their clients, in order for real healing to take place. The "inner healer" can be understood as another metaphor for what has been defined as the "dormant or malfunctioning mechanisms of healing and resilience in the patient" (Kirmayer, 2003, p.250).

Through conscious attention to their own sense of woundedness and vulnerability, therapists might succeed in establishing unconscious connections to their clients, connections which might allow the activation of the "inner healer" in their clients.

Throughout this chapter, the main argument—based on the literature—is that, it is only when therapists accept to remain deeply involved with both their clients' and their own problems or illnesses (to "keep their hands in the soup" in Groesbeck terms), that healing has a chance to occur both in clients and themselves, (Groesbeck, 1975; Kirmayer, 2003; Miller & Baldwin, 1987).

The above models centre around the challenge for therapists to face and handle some of their most tender and vulnerable spots in ways that have a chance to provide self and clients' healing. I cannot think of the mastery of such a clinical skill as anything else than as the product of a gradual maturation, at both the personal and professional levels. Kirmayer (2003) supports this notion of a gradual maturation and connects it to 10 developmental stages. In his developmental framework, Kirmayer delineates the journey of therapists in training, hypothesizing possible steps through which these therapists integrate the Wounded-Healer metaphor in their personal lives and professional practice. I will next summarize these 10 stages and their meaning for professional practice.

Therapists' Stages of Professional Development

Kirmayer defined the first five developmental stages as follows:

1. As an apprentice, therapists identify with the power of healing, refusing or being unable to connect to their own woundedness. As healers, they think of themselves as different from the clients they help. This could be summarized, I suggest, as a "they (clients) have a problem, not me" attitude, not necessarily conscious.

2. Training in counselling (or initiation phase) brings self-awareness of the repressed vulnerability and hidden suffering. Apprentice-therapists can't avoid the awareness of their flaws and vulnerabilities.

3. Therapists in training identify with their suffering and look outside for help. Overwhelmed by the "dark side" they find in themselves (the pain, the negativity,

personal flaws, and so on), they start to think of themselves as patients, rather than as a healers (Kirmayer, 2003).

4. Therapists accept their condition while secretly doubting their legitimacy in the role of healers. The acceptance of their inner wounds presents the advantage of evoking in themselves what could be called the "inner healer" (or internalized therapist, so to speak).

5. Therapists realize that their wounds will never be totally healed. In this acceptance of their unfinished state, therapists find the strength to explore all the dimensions of their unresolved pain. They understand that their path implies to stay in touch with their "dark side" (where the pain and the confusion resides) and to accept their strengths and limitations for what they are. By staying in touch with their unresolved suffering, therapists develop their power to heal others.

Once therapists have created this connection between their inner wounds and their "inner healer", a sort of parallel process operates between them and their clients; Kirmayer (2003) posits five additional stages preceding the establishment of this parallel process:

1. Therapists in training have approached the counselling career with humanitarian concerns, perhaps because of specific family experiences. However, the role of professional healer is not familiar to them yet.

2. At the contact with their clients, apprentice therapists are exposed to cumulative doses of suffering; having been wounded before, therapists become wounded

again (their old emotional pain reawakens when their clients evoke images of suffering that are difficult to bear).

3. Therapists identify with their clients' wounds, especially if both, therapists and clients, have had similar experiences. Therapists then doubt themselves in their role of healers and apprehend their clients' expectations of them.

4. Therapists look inside themselves for strength and, having found the "inner healer" use it for the benefit of themselves and their clients. At this point, woundedness is contained in both therapists and clients; many therapists consider this stage satisfactory enough and stop developing further.

5. In this last stage, the patient-as-healer is acknowledged or, we could say, "the healer accepts the patient's own healing capacity as an equal participant in the healing transaction" (Kirmayer, 2003, p. 268), that is, clients are acknowledged as able to take the necessary steps to promote their own healing.

In this view, clients' healing requires that therapists keep acknowledging and accepting their own vulnerability and also that they work at developing the ability to accept and heal themselves. If therapists project their own woundedness onto clients and attempt to protect—albeit unconsciously—their "healer persona" (competence, power, skills, reputation, authority, and so on.), both clients and therapists run the risk to enter an interaction where each manipulates the other to bring the other to conform to a stereotyped role of "client" or "therapist", compromising all chances of healing (Groesbeck, 1975).

The ideas that have been expressed so far about the wounded-healer archetype (Groesbeck, 1975; Kirmayer, 2003; Miller & Baldwin, 1987) are based on psychodynamic constructs of projection and introjection or internalization (e.g., the client incorporates the values of self-acceptance and self-care that have been observed in the therapist), expressed through metaphors that can be somewhat challenging and difficult to operationalize. This theoretical framework does not appear to have been validated empirically but represents, I think, a useful conceptualization framework for therapists in training.

How Does Healing Occur According to Kirmayer's Developmental Framework?

The distinction between Kirmayer's (2003) last two stages seems to be the equivalent of the difference between coping with and transforming woundedness, an idea to which I will come back later in this chapter. The idea developed in the last stage (true healing is a process which, when successful, goes both ways between therapists and clients), relates to the claim that wounded/healer polarities exist in parallel in both therapists and clients.

In what could be described as a parallel process, clients might wound therapists (through the narrative of their suffering and negative projections) but they may also promote therapists' healing (by giving them an opportunity to work on their own unresolved pain and find ways of transcending it for their clients' sake and their own) (Kirmayer, 2003). But how specifically does this happen?

Through exposure to clients' vulnerability, therapists' "wounded polarity" is activated. By "wounded polarity", the literature seems to suggest something akin to a metaphorical mental and emotional space where thoughts, feelings and memories of painful events are located and whose emotional power can be awakened through therapist-client interaction; if therapists have acknowledged, accepted and integrated this aspect of themselves, the activation of their own vulnerability may in turn activate clients' healer pole (understood as all of clients' dormant or malfunctioning inner resources, strengths and abilities to heal themselves), a necessary step to actualize healing in clients. When both polarities are consciously perceived and acknowledged intra and interpersonally, both therapists and clients experience increased wholeness. This suggests that healing in clients might often result in therapists' healing as well (Groesbeck, 1975; Miller & Baldwin, 1987), if healers keep continuously in touch with the strong feelings clients' woundedness evokes in them and learn from them. This stance requires that the self of the therapist be able to handle intense emotional states (Prosky, 1996).

Sometimes, unfortunately, the "wounded polarity" in therapists has been denied or repressed, and the latter may see clients as solely wounded or project their own sense of woundedness onto their clients. On the other hand, clients who feel wounded may solely look for healing in therapists, ignoring the existence of their own "inner healer". Both, therapists and clients may collude at this point projecting their unacknowledged polarities onto the other. Projections are usually unconscious and are most likely to happen if there are similarities in therapists and clients' background and that therapists

tend to (over) identify with the client. When this happens, clients' healing process is
compromised (Groesbeck, 1975; Miller & Baldwin, 1987).

The essential idea developed by this theoretical framework appears to be that
these projections are fostered by both exposure to sickness and repression (or denial) of
any of these polarities. Projections of this kind keep the healing process stuck, that is,
healing is delayed or does not happen. It is only when projections are withdrawn and that
clients are able to consciously access their ability to heal themselves (to use the "inner
healer") that healing has a chance to occur. Denial of therapists' vulnerability or
repression might result in lack of professional vitality, additional projections and burnout.
Acknowledging sickness and health in both therapist and client presents the additional
advantage of a redistribution of power in the clinical situation that also contributes its
share to the healing process (Miller & Baldwin, 1987).

Support for this Model

This theoretical conceptualization finds support in the thought and practice of
therapists and authors of varying orientations (Cristy, 2001; McCann & Pearlman, 1990;
Pearlman & Maclan, 1995; Satir, 1987). Healing, as a therapist/client parallel process,
seems to be rooted in the necessity for clients and therapists to meet at a level of depth
that allows the acknowledgment of vulnerability on both parts, creating a context of trust
where change is possible (Satir, 1987); therapists may, for example, choose to disclose
the existence of a chronic illness to their clients based on the belief that sometimes
"conscious and unconscious distortions can potentially be created if certain reality factors

are not validated" (Cristy, 2001, p. 36). Furthermore, therapists themselves may need this disclosure in order to be able to work effectively with their clients. When this context of mutual trust exists, the activation of clients' healing potential, an essential therapy goal, needs then to be implemented (Satir, 1987).

The idea of a parallel process between therapists and clients has also been conceptualized as the interdependence existing between them. This interdependence or mutual attunement to each other could manifest in the simultaneous process of experiencing satisfaction or stress in parallel, a process that has been compared to emotional contagion (Figley, personal communication, June 21st, 2004). The empirical validation of this way of conceptualizing the parallel process in therapy has just begun.

The impression that emerges from the parallel process model is that, although therapists and clients process of healing may unfold in parallel with both of them acknowledging and integrating the wounded-and-healer polarities, the situation is not totally symmetric. The priority for clients appears to be, first, to connect with their healing potential, while therapists are urged to begin by accepting, integrating and remaining aware of their woundedness. It seems necessary that both explore and enhance the polarity left in the background as therapists and clients play their social roles accordingly. Therapists do not seem to have much choice in the matter: They need to avoid compromising clients' treatment by projecting their own woundedness on them, over-identify with them, and lose objectivity. Therapists' disconnection with their own difficult inner experience (in order to minimize the pain related to their work) comes with a personal and professional cost; these are sometimes expressed as disruptions in self-

intimacy, inability to understand counter-transference and inability to enjoy solitude (McCann & Pearlman, 1990).

It is possible to suggest that in compassion fatigue and vicarious trauma, the effort trauma therapists contribute to their clients' healing may activate therapists' own healing although the mechanisms of this parallel process still need to be explored and better understood, (Pearlman & MacIan, 1995). Once again, there is a need for more adequate operationalization and empirical validation of the CF and VT constructs.

In conclusion, there seems to be a clear value in continuous self-assessment for therapists who wish a healthy and successful career and an ethical practice. This point is often emphasized. Self-assessment may sometimes feel threatening; what one may observe in oneself may be difficult to accept. Yet, self-assessment and the ability to extend genuine compassion, care and commitment to another might be connected (Hulnick, 1977). Self-assessment alone, however, may not be sufficient to avoid the negative impact of trauma work. A possible path to avoid vicarious traumatization could be to integrate the Wounded-Healer metaphor to one's own therapeutic practice experientially. All this seems to boil down to the notion of therapists using their selves, rather than relying on the use of techniques, as the tool to promote healing. Jung has argued that "every psychotherapist not only has a method, he himself is that method" (1966, cited in Kirmayer, 2003). It is possible to suggest therefore that the skilful use of self, in the context of the work with traumatized clients, rather than just the implementation of any specific technique, might be what therapists need in order to avoid vulnerability to compassion fatigue and vicarious trauma.

Use of Self in Therapy: What Does this Mean?

The topic of the use of self appears connected to the theme of the Wounded-Healer and is also a popular and widely studied subject of inquiry. Freud, Rogers, Nathan Ackerman, Virginia Satir, Karen Horney and Bowen, among others, have been proponents of the importance of training the "person of the therapist" in order for the helper to use a self, or personhood, as the primary tool for change. Family therapy and psychoanalysis have particularly emphasized the use of the therapist self in therapy as well as promoted (or imposed) self-assessment and personal therapy.

A definition of what is meant by "the use of self" is necessary at this point, since different definitions are being offered by different authors. The "use of self" concept can be subsumed under two basic questions (the second being subordinated to the first): (a) which observable behaviours indicate that the therapist is using his or her self in session, and (b) which methods or practices are available that have the potential to enhance the person of the therapist in order for his or her development as and individual to promote change and healing in clients? (Prosky, 1996). This process of development of the self appears to be idiosyncratic. That is, we can't rely too much on general rules or principles; its quality depends on how well grounded in the present moment therapists are able to be and their ability to respond to the task at hand at a level corresponding to their highest potential, that is to use their "best selves" rather than a narrowly defined "professional self" (or as Jung would put it, a professional "persona") behind which they might feel safe and protected. This "best self" could be described as corresponding to the mature, differentiated individual, able to attach and detach from his/her clients, and one that does

not attempt at anonymity or encourages transference in the client, as in psychoanalysis

(Prosky, 1996).

Satir (1987) describes her use of self in therapy as follows:

> When I am in touch with myself, my feelings, my thoughts, with what I
> see and hear, I am growing toward becoming a more integrated self. I am
> more congruent, I am more 'whole', and I am able to make greater contact
> with the other person. (p. 23)

Here again, a concept of wholeness and the harmonious integration of all the different

aspects of the therapist is being emphasized. The positioning of these authors appears to

be subordinated to the belief in an adherence to the metaphor of an integrated self. This

notion of an integrated self is one among other existing metaphors that attempt to capture

the essence of what we call Self and represents, as such, a useful conceptual tool

(Hoskins & Leseho, 1996). The metaphor of the integrated self relies on concepts of

wholeness, coherence, authenticity and the acknowledgment of all the facets, good or

evil, of our personality, all embraced and accepted as parts of the meaningful puzzle we

call "I".

I believe the exploration of the Wounded-Healer metaphor and its implementation

in therapeutic practice can benefit from the integration of therapists' stages of

development with the use of the integrated-self metaphor. The metaphor of the integrated

self is also what better represents my way of thinking about the therapeutic use of self.

Besides the notion of an integrated self, relevant to therapeutic practice,

philosophical views of the self exist which contribute to enrich the field of

psychotherapy. Although the focus of this study is not the exploration of that specific

topic, I find useful to briefly point to Baldwin's (2000) mention of Buber's philosophical influence in relation to the concept of a self-in-relationship (including therapy).

Buber's description of what the I-Thou relationship entails—fullness of presence to the other, fundamental honesty and engagement in the relationship—as opposed to the manipulative and disqualifying I-it relationship, stands in agreement with the ideal of the "best use of self" in therapy. For Buber, the I-Thou relationship is best exemplified in the mutual confirmation present in the interaction between two people. Buber's idea of mutual confirmation, however, does not imply the therapists-client parallel process mentioned previously. Indeed, Buber believed the therapeutic relationship to be asymmetric, that is, non-reciprocal, because, according to Buber, the therapist-client dialog is not a dialog between equals (Baldwin, 2000). Despite this power differential, existentially-oriented therapists offer themselves to their clients in response to the entrenched existential anxiety manifesting itself through their clients' symptoms. Although they believe therapy cannot cure our basic human condition, they also believe that they may stand as symbols of hope and confirm their clients' existence in a process of self-discovery. To confirm another is indeed at the core of the use of self in therapy, according to Baldwin (2000). Therapeutic methods that favour an I-it approach are likely to coexist with settings where therapists deny or repress their vulnerabilities. That is hypothesized to lead therapists to burnout.

In the way of a tentative conclusion, I suggest to remember Rogers' (2000) description of his use of self in session. He said:

When I am the closest to my inner, intuitive self-when perhaps I am
somehow in touch with the unknown in me-when perhaps I am somehow
in a slightly altered state of consciousness in the relationship, then,
whatever I do seems to be full of healing. Then simply my "presence" is
releasing and helpful. At those moments, it seems that my inner spirit has
reached out and touched the inner spirit of the other. Our relationship
transcends itself, and has become part of something larger. Profound
growth and healing and energy are present. (p. 36)

The Compassion Fatigue and Vicarious Trauma/Wounded-Healer Model (CF&VT/WH)

In this last section, I will attempt to integrate together the concepts developed

previously, that is, the Wounded-Healer metaphor, therapists' stages of development and

the therapeutic use of self in the therapist. I have tried to integrate these concepts in a

model based in part on: (a) what research says about secondary traumatic stress disorders,

(b) the hypotheses presented before in regard to the Wounded-Healer archetype, its

impact in the therapeutic relationship and, (c) the concepts of transference, counter-

transference and projection and the way these impact the parallel process between

therapist and client.

The goal of this model is to offer a conceptualization of the development of CF

and VT that includes a possible explanatory framework for the mechanisms of therapists'

symptom development in the therapist/client parallel process. I have called this model the

Compassion Fatigue and Vicarious Traumatization/Wounded-Healer Model, or to

simplify, the CF&VT/WH Model.

Model Premises

The CF&VT/WH Model is based on the idea that therapists' ability to handle the impact of clients' traumatic narrative in parallel to their own emotional woundedness, may result in two different therapy processes with two different outcomes: One, positive (I suggest to call it the "mutual healing process"), the other, negative (which could be called the "stress escalating process"). The positive scenario refers to healing happening for client and therapist alike, following a parallel process as described before. The negative scenario, on the other hand, refers to the possibility that the therapeutic encounter result in the development of symptoms of secondary traumatic stress in the therapist (while the client's therapy success is compromised).

This model is based on three assumptions or premises regarding: (a) the connections between empathy and identification, (b) the emotional and cognitive dimensions of empathy, and (c) homeostasis. These premises will first be clarified.

First premise.

My first premise refers to the fact that identification with another precedes the emergence of empathy (as it is impossible for me to feel compassion for anything that I cannot relate to as belonging to the human order, or that at least shares some important human characteristics (such as the capacity to experience pain, pleasure, hunger, and so on). It is probably when we feel connected to others and can intuitively relate to them in what they are thinking or feeling that we can access our deepest feelings of compassion.

Genuine empathy also appears to include caring feelings and the desire to relieve

another's suffering (Vreeke & van der Mark, 2003).

Second premise.

My second premise for this model is that our capacity for empathy is both rooted

in our first-hand experience with suffering (what we have experienced personally), as

well as what we know, can imagine or interpret, about that which is susceptible to cause

physical or emotional pain and the way we perceive or imagine its possible impact on

another (given the type of injury, the victim's history, sensitivity, life circumstances, and

so on).

There is a cognitive aspect to empathy which has to do with individuals'

assessment of the nature of reality. This assessment relies strongly on individuals'

perception and subjective evaluation; clients' suffering will therefore be perceived

through therapists' "filters" made of existing cognitive schemas, belief systems, life

experiences, education, and so on. Empathy appears to be therefore an element of

communication that does not necessarily require the accurate interpretation of another's

feelings, but rather the anticipation and understanding of how she/he might be feeling or

thinking (Vreeke & van der Mark, 2003).

Additionally, I see the ability to be able to "suffer with" another, i.e. to experience

compassion, and to sense what this other is feeling, to see life events through another's

perspective (while retaining our individuality) as related both to the way we process our

own experiences of pain as well as to the level of self-other differentiation we have

reached. Both the emotional and cognitive domain seem therefore involved in the process of empathizing.

Because our ability for empathy and empathic identification are often likely to evoke an element of personal pain in the empathizer, especially when it comes to trauma (the therapist or family member will "feel bad for" the other who suffers), these two elements—empathy and the difficult feelings evoked—appear linked in the present model.

Third premise.

It is generally accepted that an organism submitted to stress, strives to return to a condition of stability, that is, homeostasis (Thomas & Wilson, 2004). The word "homeostasis" refers, according to the Merriam-Webster Online Dictionary (2005) to "a relatively stable state of equilibrium or a tendency toward such a state between the different but interdependent elements or groups of elements of an organism, population, or group". Repeated attempts to adapt to adversity, or allostasis, may physically and psychologically overwhelm the trauma therapist due to emotional overload of exposure to graphic details and shocking stories. This situation of disequilibria, if it lasts, might induce stress-related symptomatic states in helpers, leading sometimes to compassion fatigue or vicarious trauma.

These three propositions related to the sources of empathy, empathic identification and the role of homeostasis in stress-related states, underlie the wounded-healer model that follows.

Hypothesized Model Processes and Outcomes

In order to understand Figure 1, some of the symbols need to be first clarified. In the following diagram, therapist and client are each represented with their source of resiliency, or "inner healer" (H), and their woundedness (W). The symbol which stands for each person's capacity for empathy is connected to the wounded part of the self (signalled by the letter "W"). Arrows of different levels of thickness indicate therapist/client transactions that evolve according to some kind of healthy or unhealthy pattern. Thicker bold arrows indicate counterproductive or damaging interactions (see Figures 1 and 2).

The mutual healing process (positive scenario).

In this scenario, a cycle of repeated patterns of interactions takes place as follows:

1. Traumatized clients expose their therapists to their suffering (and project their "inner healer" onto those therapists).

2. Therapists' empathy is activated and empathic identification with clients takes place.

3. Through this exposure and the empathic identification that is taking place, therapists' own suffering is evoked, consciously or not.

4. Simultaneously to stage 2, therapists' "inner healer" is activated by clients' and the pain they are expressing. Sensitive to their own needs, these therapists accept to stay in touch with their own pain without denying or repressing it. Through conscious acknowledgment of the elements of pain evoked in them through therapy with the

traumatized, these therapists strive to integrate their own woundedness and avoid

projecting it on their clients. A "channel of communication" is then established between

therapists' "healthy" and "wounded" aspects of themselves and psychic energy flows.

Figure 1: **The CF&VT/WH Model—The Mutual Healing Process (or Positive Scenario)**

H ⟶ H

Therapist's Self   Client's Self
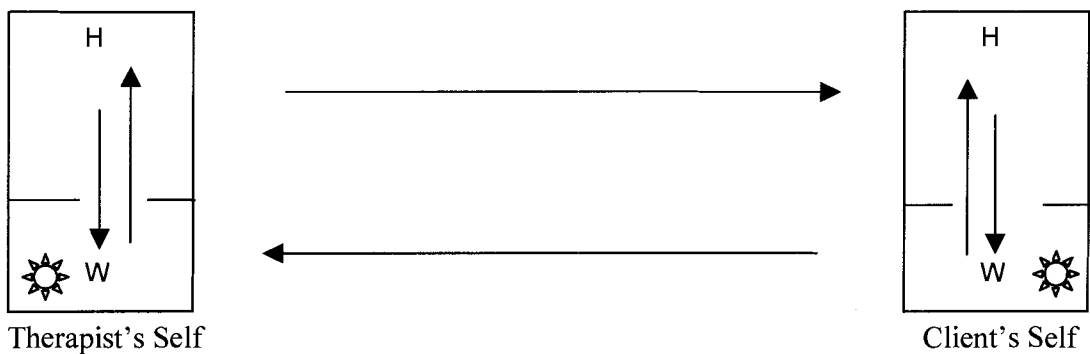
Figure 2: **The CF&VT/WH Model—The Stress Escalating Process (or Negative Scenario)**

H   H

Therapist's Self   Client's Self
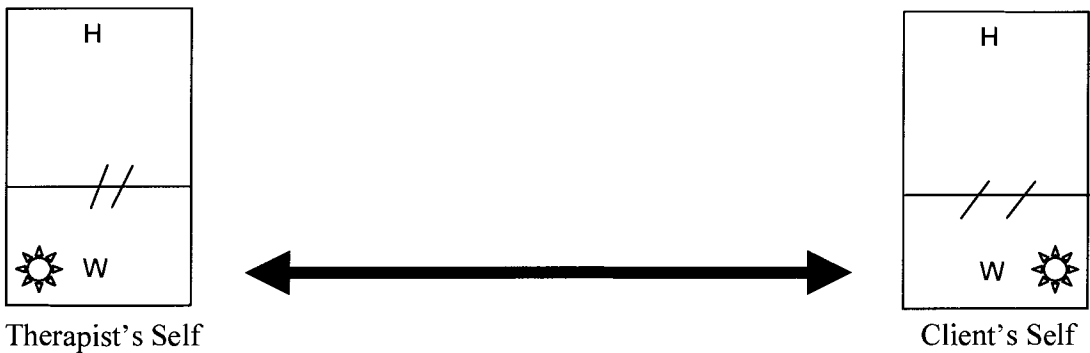
    5. Therapists' acknowledgment and acceptance of their own feelings strongly

evoke clients' "inner healer". Clients start to realize that therapists mediate healing, but

do not "cure". It progressively dawns on clients that they have what it takes to help

themselves.

6. Clients become aware of the dormant power of their "inner healer". This realization initiates a slow process of healing in clients (there is a flow of energy between clients' "healthy" and "wounded" aspects of themselves).

7. The process recycles all these steps, session after session, resulting in therapists' and clients' increased wholeness and mutual healing.

This positive scenario is in harmony with the concept of transformation (or transcending) of pain, beyond the "quick fix"; it is probably also the most challenging option for the trauma therapist.

The stress escalating scenario (negative scenario).

In contrast with the previous schema, a negative scenario leading to the development of symptoms in therapists could unfold as follows:

1. Traumatized clients expose their therapists to their suffering (and project their "inner healer" onto those therapists).

2. The therapist's empathy is activated and empathic identification with the client takes place.

3. Through this exposure and the empathic identification that is taking place, therapists' own suffering is evoked, consciously or not.

4. Therapists wish to relieve the pain of their clients, but repression or denial operate on that aspect of a therapist's private woundedness evoked by the client's. Therapists are still trying to extend compassion to their clients, but their own suffering evoked in session has not being acknowledged or accepted. No "channel of

communication" is established between therapists' "healthy" and "wounded" aspects of themselves and psychic energy does not flow. The system becomes stuck, that is, therapists' "wounded" and "healing" polarities are not integrated and this "split" between them creates a state of tension or allostasis.

5. Therapists operate in the reactive mode, trying to extend empathy but over-identifying with the client, unaware of the counter-transference that is taking place. Without knowing it, therapists project their woundedness onto clients. Clients may become pathologized or their dependence encouraged (Kirmayer, 2003).

6. Projection and over-identification continue; because each exposure to clients' narratives of pain reawakens therapists own unresolved stories of suffering, interactions result in therapists' empathic strain. Therapists striving to return to a state of equilibrium does not succeed. Every exposure to client's stories and graphic details becomes a new threat to therapists' sense of balance. That is difficult for therapists and therefore they may start blocking access to their source of compassion as well as block identification with clients in order to protect themselves. I suggest that that is akin to what has been called "incomplete empathic engagement" by Pearlman, a form of dissociation, increasing therapists' vulnerability to vicarious traumatization (Pearlman, personal communication, June 21st and 22nd, 2004).

7. Prolonged and repeated exposure to client's trauma results in a stress-related response such as compassion fatigue, vicarious traumatization or secondary traumatic stress disorder. These responses may be accompanied by affect dysregulation, anxiety states, disruption of cognitive schemas and disruption of spirituality (Thomas & Wilson,

2004). At this point, therapists feel disconnected from themselves (although they are essentially focused now on their own sense of woundedness) and may withdraw in isolation. Therapists may also rigidify their selves in order to protect themselves against the pain; in doing so, they may demonstrate cynicism and hopelessness; neither therapists nor clients find wholeness or healing. If therapists avoid seeking the help they need, both therapists and clients may end up damaged by their encounter.

Support for the CF&VT/WH Model

Some authors (e.g., Peabody & Gelso, 1982) claim that links can be established between empathy, identification and counter-transference. They argue that (partial) identification with the client precedes empathic and counter-transference feelings, and that counter-transference (understood as the "withdrawal of personal involvement by therapists") tends to appear when the process of identification with the client goes wrong (unresolved conflicts in therapists are activated by client's transference). They further posit that highly empathetic therapists are likely to be especially sensitive to their own emotional reactions and needs. These ideas seem to be compatible with and/or support the previous model.

Additionally, Pearlman's notion previously defined of "incomplete empathic engagement", appears to agree (at least partially) with a definition of counter-transference as "the withdrawal of personal involvement by the counselor" (Peabody & Gelso, 1982, p. 244). Both these notions of "incomplete empathic engagement" and counter-

transference have been related to negative therapeutic outcome in the form of

vulnerability to vicarious trauma or emotional detachment from the client.

The CF&VT/WH Model is also in agreement with Cain (2000) and Peabody and

Gelso's (1982) belief that, although inevitable, counter-transference internal reactions can

be used positively, that is, to promote healing in the client. According to some findings,

therapists who have a high empathic ability are also among those who seem to

demonstrate the highest sensitivity to their internal reactions and openness to examine

conflictual counter-transference feelings. High empathic ability, therefore, seems to

mediate both therapists' stance towards their emotional reactivity and the way this

reactivity translates in overt behaviour.

Based on these findings, it is possible to suggest that high empathic ability may

operate as a double-edged sword, supplying therapists with the "tools" they need to

handle counter-transference in ways that will enhance healing in the client, but only as

long as therapists accept to make a conscious use of this empathic ability for their own

benefit, that is, to examine, accept and integrate the conflictual or painful feelings that

arise from the counter-transference process.

It is important to finish this section by mentioning that most therapists working in

the field of trauma seem to be doing very well (Brady et al., 1999); what makes these

empathic and engaged therapists different from those who get deeply wounded through

their compassionate work with trauma victims? Is the construct of Satisfaction sufficient

to account for this difference? If such a distinct construct really exists, I propose that

satisfaction that is derived from the successful operations of integrating the pain and

transforming it (as the wounded-healer model suggests), associated with the intrinsic rewards of therapy work, is probably one that holds significant promises for trauma therapists.

Summary

The focus of this chapter was on therapists with a history of trauma and ways in which they may choose to relate to and process their private, and sometimes unresolved, suffering. I argued that the nature of this processing is likely to impact positively or otherwise the quality of the therapeutic work with their traumatized clients, as well as contribute (or not) to their own healing, in parallel to their clients'.

My review was guided by the psychodynamic theoretical framework and the concepts of unconscious, polarities, counter-transference and archetypes. I attempted to articulate these concepts around two main metaphors: The Wounded-Healer and the Integrated Self. In doing so, I hoped to gather support for the main message of this chapter, that is, the necessity for therapists to acknowledge, accept and integrate all aspects of themselves in order to mediate healing effectively. I see these aspects as including all of the vulnerabilities and scary emotional places they may find in themselves as well as their ability to respond to their own needs with compassion and to develop their own self-healing potential.

The analysis of these two metaphors, The Wounded-Healer and the Integrated Self, led me to emphasize the skilful use of therapists' selves as the main tool promoting self and other healing. The fine-tuning of this primary tool for change is, I argued, what

also allows real compassion to enter the therapeutic setting. To be "whole", to avoid

repression or denial to operate on therapists' woundedness seems to be essential to

prevent functioning in the reactive mode when facing challenging material in clients.

Therapists' reactivity—and the stress often related to it—appears to be part of what

threatens to isolate therapists from their clients, increasing the likelihood of negative

counter-transference, and the use of defensive mechanisms (such as withdrawal and

projections).

The CF&VT/WH Model appears to be useful to offer an understanding of CF

andVT tied to the idea that these disorders may arise in response to therapists' difficulty

to thoroughly process all of the feelings and thoughts evoked in them by their clients'

narratives and to make this processing an ongoing permanent background to the

therapeutic work with their clients. This last argument parallels my conviction that there

is no real danger of "victimization" in trauma work, contrary to what is commonly

asserted in the literature. Rather, my reflection on the healing function leads me to

recognize and value each individual's personal responsibility for his/her own personal

growth and ongoing development.

Finally, I examined the role of empathy in regards to CF and VT. What is

considered in literature to be the "vehicle" for these disorders—therapists' ability to

deeply empathize with their clients—emerged for me as a much more complex and multi-

faceted picture. High empathic ability in therapists seems to be at once what mediates

therapists' positioning in regard to their inner emotional reactivity, as well as what shapes

the overt expression of this reactivity. Moreover, empathy appears to be a double-edged

sword vehiculating both healing and wounding in self and others. While supplying

therapists with tools to handle counter-transference positively, empathic ability appears

of benefit to the client to the extent that therapists are able to use their empathic ability to

first facilitate self-acceptance and self-healing.

The role of empathy and compassion and their potential for therapeutic power

seem therefore tightly related to the adequate use of self in therapy and concepts such as

wholeness, authenticity as well as to the art of transcending and transforming the pain

into positive and constructive energy.

CHAPTER 3:
SYSTEMIC DIMENSIONS OF
COMPASSION FATIGUE AND VICARIOUS TRAUMA

In the present chapter I focus on exploring the concepts of CF and VT through the lens of systems theory, that is, to add conceptual tools to the understanding of these disorders by reflecting on ways trauma therapists' professional systems impact these therapists.

In the aftermath of trauma, some family members are sometimes "traumatized by concern", that is, vicariously; when this happens, post-traumatic stress in one member can spread to family members who have not suffered the traumatic event and who nevertheless begin to show symptoms of PTSD. Similar dynamics have been observed in therapists who work with victims of trauma (Figley, 1995). Literature also reports on the power of family, friendly and community networks in helping victims of trauma to recover and heal.

So far, there seems to be no research available describing ways in which trauma therapists' professional contexts may impact them and eventually contribute to symptoms of CF and VT. We do not know yet if these disorders can be related to some kind of system dynamic or how this could happen.

The theoretical framework for this chapter will borrow from Contextual Therapy

theory (Boszormenyi-Nagy 1984; 1986) to explore mechanisms through which trauma

therapists may lose their status of helpers and become symptomatic (VT or CF

diagnosis), unable to perform professionally and in need of professional help.

From Contextual Family Therapy to Trauma Therapy

Three research questions motivated the exploration of the contextual model

presented in this chapter: First, are empathy and empathic engagement necessary

concepts to understand therapists' development of CF or VT symptomatology? Second,

what is the origin of CF and VT? And finally, how can we explain the "transmission" of

symptoms from client to therapist?

There is general agreement in the literature that therapists' empathy and empathic

engagement with traumatized clients are central to understand the development of

secondary traumatic stress leading to CF or VT symptoms in therapists (Brady et al.,

1999; Figley, 1995, 2002; Pearlman & Saakvitne, 1995; Stamm, 2002; Thomas &

Wilson, 2004).

In this chapter I offer alternative answers to these questions by using

Boszormenyi-Nagy family systems theory (Contextual Therapy) as well as Erikson's

stages of psychosocial development. This model provides a theoretical framework with

two essential characteristics. First, it incorporates VT and CF symptomatology while

suggesting the concept of loyalty (rather than empathy) as directly related to the

development of therapists' symptoms. More precisely, the concept of loyalty is extended

and understood as therapists' conscious and unconscious commitments to what they understand or perceive to be the expectations of the professional system they belong to (including the expectations they hold for themselves in their helpers' roles). I propose that therapists' loyalty to this system may in some cases be expressed indirectly (and unconsciously) through CF or VT symptoms which are similar to those of the traumatized client.

Second, this theoretical framework includes a description of mechanisms through which the therapist becomes symptomatic. These mechanisms operate in the context of a system and are mediated by the interactions between: (a) therapists' personal characteristics (including life developmental stage), (b) work-related characteristics, and (c) interpersonal dynamics.

These concepts, borrowed in part from Contextual therapy theory, will later be augmented with Erikson's stages of development. Erikson's psychosexual development stages are useful in providing a point of reference in locating differences in ego strength which are present at different stages of personal maturation and could account for differences in vulnerability to secondary traumatic stress. I argue that it is during these stages of greatest vulnerability to secondary traumatic stress that impairment is likely to take place.

Last, I will provide a brief review of Boszormenyi-Nagy's contextual therapy in order to facilitate the understanding of concepts representing the "core" of this model.

Contextual Family Therapy: Theoretical Background Review

Boszormenyi-Nagy developed an approach to family therapy that extends the psychodynamic model. He also hoped to integrate within this model, both systems theory and existential phenomenology (he was strongly influenced by Martin Buber). Contextual therapy emphasizes relational ethics and commitment, that is, the context of rights and obligations between family members, the importance of relational justice and the way impact of lack of justice can be observed through the generations. He argues that relational ethics (including trust, loyalty and mutual support) is a given of human existence, rather than a moral or religious concept. They are the "glue" that keeps families together, healthy and happy. Family loyalty is also anchored in consanguinity: We are indebted to our parents and ancestors for the gift of life and the care we received as children and are expected to give back to the younger generations (Heireman, 1989). Justice and loyalty represent therefore two key concepts to understand Contextual Therapy theory. They also represent central concepts to comprehend the dynamics and structure of any social group where reciprocity, equity and mutual responsibility favour a climate of justice, a condition for group survival (Boszormenyi-Nagy & Spark, 1984).

It can be argued that the therapeutic encounter is a domain where justice and loyalty play an important role, in part through re-enactments of earlier family dynamics (manifested through transference feelings and behaviours). But how specifically do relational ethics impact the therapist facing a client going though the turmoil of a trauma aftermath?

An answer to this question needs an appreciation of how some of the concepts applied in Contextual family therapy may be extended and applied to the relationship between therapists and clients, therapists and the professional systems they belong to. I will first briefly review several of these concepts. Next, I will examine how these concepts can be transposed to the counselling situation.

Loyalty, Justice and Reciprocity

The concepts of loyalty, justice and reciprocity are tightly linked in Contextual Therapy theory. Justice underlies the concept of loyalty by establishing the basis of the conscious and unconscious commitments experienced by each family member towards the family group expectations. These commitments arise from the give-and-take expected to exist between family members and imply the existence of invisible "ledgers", an account of what is being taken from and given to others, as well as everybody's past and present obligations. Reciprocity regulates trust between adults and peers; only in circumstances when the ledger is balanced can the relationship be considered symmetric. This excludes relationships between children and parents (or caregivers) however; these relationships are said to be asymmetric because of children's dependency for survival on those who raise them. The child is assumed to be born with unearned rights to care and protection (the child is said to experience "existential indebtedness"). Because of this, justice and not reciprocity is expected between children and their parents or caretakers; that is, the care children will later provide to the next generation will legitimate them and contribute to establish a balance in the accounts between their generation and the next.

Loyalty is a powerful regulator of the family system and it operates homeostatically, that is, any betrayal (or possibility) of disloyalty will induce proportional amounts of guilt, a feeling that will usually reinforce compliance to the family implicit or explicit rules and solidarity (Boszormenyi-Nagy & Spark, 1984).

Multipersonal Loyalty Fabric and Invisible Loyalty

Multipersonal Loyalty Fabric represents the web of expectations, implicit or explicit, facing every family member through the generations and the ways in which everyone has responded to them (positively or by betraying those expectations). This web, or "loyalty fabric", constitutes powerful motivational determinants in families. As an assumption, individuals are usually considered basically loyal toward their family group and family roots. If this loyalty cannot be expressed openly, for whatever reason, it is claimed that loyalty will be expressed as if in disguise (i.e., enacted unconsciously, the meaning of the symptoms or behaviours that express loyalty will not be apparent to anyone in the system, including the individual expressing loyalty in indirect ways). Loyalty can therefore be expressed overtly and positively or covertly; scapegoating and adopting the martyr's role (willing victimization) may be ways to express invisible loyalty (Boszormenyi-Nagy & Spark, 1984).

Merit Bookkeeping, Ledger of Justice and Retributive Justice

Individual "bookkeepings" (or personal accountings) form the basis of groups' ledger of justice, a metaphor for the balance of all family members' accounts of merits.

Like loyalty commitments, merit bookkeeping may operate outside conscious awareness; it consists in the personal "registering" of one's own and others' earned and unearned merits. Damages inflicted and suffered remain embedded in the system's individual accountings until reparation has occurred. Merit Bookkeeping is also a self-regulatory principle, independent from the law and falling along lines of consanguinity. The family ledger is transgenerational and invisible in nature (Boszormenyi-Nagy & Spark, 1984). Keeping the ledger in balance is very important for the family well-being; indeed, a breakdown of trust and equity in the family ledger may lead one or more members to become symptomatic. The rebalancing of accounts can be expressed in different ways, for example by trying to avoid or correct the mistakes of the past (to "right the wrong"), such as striving to be a better father to one's children than one's own father (Heireman, 1989).

As previously mentioned, serious harm done to another in an existing relationship remains embedded in the system as an unredeemed "debt", unless it has been repaired; if acknowledgment and repair of the damage does not occur, the "debt" may sometimes be presented to the younger generations (principle of retributive justice). The attempt to rebalance the accounts of justice through blaming the innocent or scapegoating are two examples of retributive justice. Individuals may be very vulnerable to this compelling family system force, in part because it tends to operate at an unconscious level. Retributive justice is also known as the principle of the "revolving slate" (Boszormenyi-Nagy, & Spark, 1984).

Injury to the Human Order and Existential Guilt

A concept borrowed from Buber, injury to the human order needs to be understood in a relational context. Every individual's interaction with another is a contribution to the "human order of being". When humans contribute to humanity in fair reciprocal exchanges, justice is being fulfilled. To harm somebody, however, to be unjust, is like harming the whole human race or human order (Heireman, 1989). Harm done to someone in a family leads the perpetrator to become invested with existential guilt, independently of the fact that the perpetrator is able to get rid of these guilt feelings or not. Existential guilt, another Buber's concept, is always conscious and represents a real situation of indebtedness which can only be affected through action aimed at repairing the damage (Boszormenyi-Nagy & Spark, 1984).

This type of guilt also refers to the burden someone carries for somebody else's deeds in a system. This refers for example to obligations accumulated in the past, e.g., collective responsibility of contemporary Canadians towards the First Nations—or responsibility of today's North Americans towards African Americans—because of the damages these minorities incurred. Existential guilt occurs when the human order has been injured and is relevant to any social group where the perception is that too many people are able "to get away with murder" (Boszormenyi-Nagy & Spark, 1984, p. 77).

Are these Concepts Relevant to the Counselling Situation?

This question can be answered by first examining some of the characteristics of the counselling system. In this chapter, I define the counselling system as four interconnected levels of social organization, that is, (a) the client/therapist relationship, (b) the client's significant others, (c) the agency who hired the therapist, and (d) any organization or government association who monitors, assists or regulates the professional activities of the therapist and the agency she/he belongs to and which also has the power to impact them by their regulations or decisions. This system represents a field of mutual interactions ruled by explicit and implicit expectations (see Figure 3).

Some relationship dynamics belonging to the counselling system will be explored next as well as therapists' understanding and expectations regarding their roles as healers to the traumatized.

Characteristics of the Counselling System

The Therapist/Client Relationship

Asymmetry, which characterizes the parent/child relationship in the family, also characterizes the therapist/client dyad, although for different reasons. Asymmetry is present, not only because of the professional persona of therapists, their expertise and experience, but also because of the obligations and give-and-take dynamics specific to this type of human encounter. Indeed, therapists and clients meet together to address

some of clients' needs in a context of individual, social and legal expectations. Therapists' mandate includes nurturing a professional close relationship based on trust and dependability with clients and to foster their emotional development, while refraining from attempting to have their personal needs met by clients. Clients are on the receiving end of the relationship, that is, the therapist-client bond rests on a one-way caring relationship, where the client's psychological needs are the focus. Here, the quality of the services received and the personal commitment and investment of therapists are only repaid, in psychological terms, by the satisfaction of seeing clients feel better and more empowered (and hopefully also by clients' gratefulness). When therapy is successful, clients' environment (family, colleagues, and so on.) indirectly benefits from therapists' work and clients' growth. That is, it is likely that clients will, like the adult family child, give forward what they received (in terms of better care of their children, improved ability to communicate, new acquired social or emotional skills, and so on). The therapist/client relationship with its demands and qualities of trust, dependability, accountability and commitment creates a context where feelings and issues of loyalty are likely to arise and impact the dyad. When examining issues of loyalty in this type of relationship it seems important to remain aware of the existing asymmetry as well as of the power differential between therapist and client (arising from a potential for exploitative behaviour on the helper's side).

Issues of loyalty and fairness may also arise in connection with clients' significant others. Even if absent in the therapy room, family members and significant others may have expectations and/or fears regarding therapists' interventions and their impact on the

counsellee (and the dynamics of their relationships); in consequence, they may support

clients' emotional growth or resist it (and even sabotage it).

Figure 3:   Family and Counselling Systems

Family Multipersonal
Loyalty Fabric

Counselling System Multipersonal
Loyalty Fabric

Extended family and
previous generations

Client
and his/her
nuclear family

Professional Associations
and Government Bodies

Agency

Client's
Significant Others

Therapist/
Client Dyad
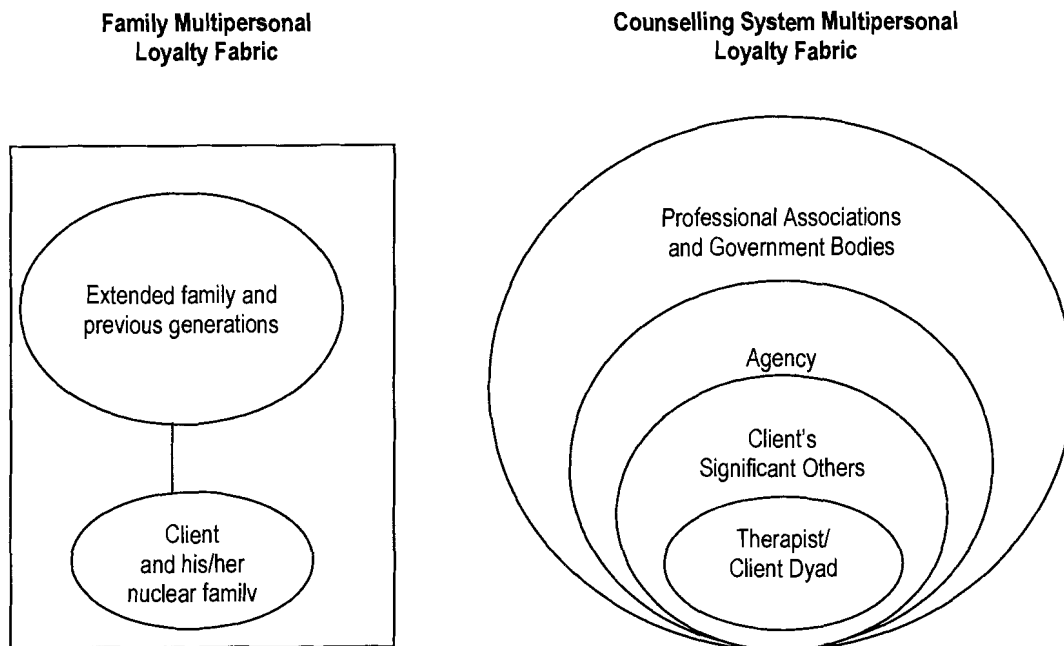
The Counselling System

In addition to the previous type of group expectations, society's professional and

legal expectations concerning therapists' role, contribute to create a frame of reference in

which issues of justice, loyalty and ethics automatically emerge. Professional obligations

legally defined, contracts, professional code of ethics, and so on, represent a social

context regulated by explicit (and implicit) expectations towards the counselling role and

what is supposed to happen (or not) in the counselling relationship. Compliance with or

betrayal of these expectations have consequences for the health or breakdown of this "loyalty fabric" as well as for the ability to trust those in charge of clients in situation of emotional vulnerability.

Therapists' own role expectations play a role as well. As an integral part of the system, therapists have a certain understanding of what it means to be a competent helper; their professional training, personal values, and history (including sometimes personal experience with trauma) are all important determinants of: (a) the way they understand and express commitment, fairness and loyalty as well as (b) the way they perceive their environment expectations.

In summary, the existence of individual and group expectations arising from the counselling context implies that the therapist-client dyad exists and evolves within a "multipersonal loyalty fabric" constituted by those involved in the therapy process and playing personal or professional roles around them. As in the family, members of such a group will likely display degrees of commitment to these expectations.

What does this mean for the therapist to be part of this "loyalty fabric"? As previously noted, a strong emphasis exists on therapists' professional behaviour and its consequences, given the asymmetry of the situation. It probably makes sense to suggest that a system where strong expectations converging on therapists' role coexist with the repeated experience of asymmetric relationships will experience homeostasis in specific ways. One of those, I suggest, could be that guilt input (a regulator of the system homeostasis) will likely be powerful. On the other hand, society's expectations of ethical conduct, non-judgmental attitude, acceptance and warmth on the part of the therapist,

represent a strong foundation for hope and trust. Because these elements are considered

givens of the therapeutic relationship, therapists' commitment and loyalty to their clients

may sometimes be taken for granted, seen as sine qua non conditions of this special

relationship; the downside of this situation might be that the impact of the system's

relational ethics on therapists and the way they affect therapists' self-concept, self-

expectations and loyalty commitments may go ignored or remain minimized, as if in the

background.

Contextual Therapy Concepts and the Counselling System

Merit Bookkeeping and Ledger of Justice

The suggestion that the counselling situation represents a "multipersonal loyalty

fabric" raises the question of how relational ethics are being expressed at the different

levels of the counselling system. This question has mostly been answered so far in

reference to the ways in which justice and ethical conduct manifest at the level of social

organizations (agency, government bodies and their members) as well as at therapists'

level (one-way ethical responsibilities and power differential). Although asymmetry

exists between therapists and clients (where emotional needs and ethical imperatives are

concerned), it is clear that clients' significant others' behaviour (in some cases), but

mostly clients' behaviour contribute to an atmosphere of mutual respect and trust.

Responsible use of the agency services, timely fee payment, be in time and cancel

appointments in time, commitment towards agreed upon goals, and so on are all

important elements in the give-and-take that establishes relational justice and contributes to the "loyalty fabric" in the counselling situation.

Injury to the Human Order

Several authors (e.g., Danieli, 1981; Haley, 1974) believe that therapy with victims of trauma impacts therapists differently from the work with other difficult populations; they believe that the narratives of the traumatized victims expose the therapist to shocking images heavily loaded emotionally. I would add that the nature of the traumatic event usually feels unfair, even cruel; "compensations" or perpetrators' judgment and condemnation may not occur or may be unable to "undo" the victim's felt sense of devastation. It seems possible to say that trauma therapists are constantly exposed to what Buber called an "injury to the human order". Most of us, in the Western world at least, have been raised considering "human rights" and the uniqueness and intrinsic value of every human, givens of our existence. Yet, traumatic events such as crimes or child abuse may lead to a personal and communal sense of injury to human dignity, an "affront to the sense of self" (Cerney, 1995) and the feeling that basic human expectations about each other have been violated. Injustice is a rip caused to the multipersonal loyalty fabric of any social group. As emphasized in Contextual Therapy, the harm done to the victims remains "embedded" in the social system (of which the counselling system is a part) where the need for repair and reconciliation is deeply felt. This specific aspect of the nature of trauma has consequences in helpers' lives; yet, they do not seem to have received all the attention it deserves.

Frequent exposure to trauma also affects therapists' perception of the social "ledger of justice", which may seem to be chronically tilted negatively and out of balance, because of what appears to be hopeless exploitation of the weakest in society or too much suffering of innocents. Although objective data about victimization and its effects are usually available, perception remains a personal thing and therapists' ways of "digesting" the information may be influential in the therapy process.

Unresolved emotional wounds in therapists' own family history having to do with breakdown in trust, inequity or unbalanced merit accounts may be among the factors impacting therapists' perception of evil and the suffering of innocents. It could be speculated that a biased perception would translate in specific observable characteristics. Helpers' characteristics referred to in the literature that seem to correspond to this type of biased perception are the "God syndrome" (Beaton & Murphy, 1995) and the "Lone Ranger" pattern of personality (Munroe, Shay, Fisher, Makary, Rappaport, & Zimering, 1995); these are mentioned in the literature as increasing helpers' vulnerability to CF or VT. This topic will be developed later, along with CF and VT mediating factors.

Guilt and the Therapist

Group expectations, especially if they seem reasonable and legitimate, lead every member to feel a sense of responsibility to comply. Bonding and trusting result from this shared (and sometimes tacit or non-conscious) set of internalized agreed upon requirements. As previously mentioned, guilt regulates the homeostatic functioning of

groups' loyalty commitments. An individual's betrayal of his or her group's expectations, therefore, often results in guilt.

Literature distinguishes between "real" guilt (following violation of social or moral principles) and "imagined" or "passive" guilt (without harmful wrongdoing). In both cases, individuals blame themselves and may have the desire to harm themselves or reject and punish another (Nader, 2001). Guilt is also mentioned as being the complex component of a traumatic response and one of the symptoms of therapists suffering from a secondary traumatic stress disorder (Figley, 2002; Valent, 2002; Yassen, 1995). Guilt may go unrecognized; it may also represent an unconscious attempt to avoid facing deeper issues or fight feelings of hopelessness. Indeed, guilt is underlined by the assumption that one had choice and could have made a difference.

According to Nader (2001), people in positions of authority and those with a high sense of responsibility for others are vulnerable to experience guilt. As a consequence of their positions and personality traits, these people may want to rescue others and feel guilty for failing (even if the possibility to rescue or save did not exist). There appears to be a connection therefore between guilt, the traumatic response of the therapist suffering from CF or VT and personality characteristics such as the "God syndrome" or functioning in the "rescue mode".

Three types of guilt are described in literature which are more specifically relevant to the present chapter: (a) survivor's guilt, (b) bystander's guilt and (c) existential guilt. Survivor's guilt may occur in those who escaped a killing or injury while others in the same circumstances did not. It is also related to the inability, at the time of

the tragedy, to rescue someone who was left to die. Survivor's guilt is sometimes

considered the result of a coping strategy failure; it is also a symptom of STSD, (Valent,

1995).

Bystander's guilt describes the feelings of a person being witness to the suffering

of others while she herself remains sheltered and safe. It is also associated to feelings of

helplessness for being unable to free another of the emotional sequel of trauma. This

reaction is similar to what has been called "witness guilt" or "clinician guilt"; these three

types of guilt are categorized as secondary stress responses in helpers (Dutton &

Rubinstein, 1995).

While survivor's guilt and bystander's guilt have been recognized as part of the

trauma symptomatology, existential guilt is not currently mentioned in the literature

about CF or VT. I propose however that existential guilt is not only likely to affect the

trauma therapist, but that it might also be a most powerful regulator of loyalty

commitment affecting the helper/client's relationship. To clarify this, the next section

will cover some possible connections between existential guilt and retributive justice

("the revolving slate" principle); in that section, I will also explore circumstances in

which existential guilt could affect the trauma therapist.

Existential Guilt and Retributive Justice

As previously mentioned, the importance of relational ethics in social groups

cannot be underestimated. Ultimately, relational ethics have everything to do with the

survival of any group. Not surprisingly, mechanisms related to survival (physical,

emotional or social) can be extremely powerful and do not necessarily appear rational or even just. Retributive justice, in Contextual Therapy theory, is one of those mechanisms operating at a very basic—and unconscious—level of "tit for tat" (the talionic measure of punishment or reparation for the offence or crime). Existential guilt, tightly connected with retributive justice, appears to have the destructive capacity of a time bomb, that is, the harm done which has not been repaired remains hidden in the social system as an active "debt" which has to be paid. I suggest that it makes sense to consider both the injury and the "debt" linked to it as existing on a continuum of varying degrees of severity. In time, this "debt" can acquire a destructive capacity by turning into prejudice or scapegoating. The question that is relevant to this chapter is: Can the "revolving slate" affect the therapist? And if yes, how?

Retributive Justice and Therapists' Personal Histories

I propose that circumstances in therapists' own family history may predispose them to be vulnerable to the principle of retributive justice. Among these, two types of positioning in the "loyalty fabric" of their family of origin could be traced to this vulnerability (although more than two may exist). These are, first, to have experienced personally what it is like to be on the receiving end of the "revolving slate", and second, to be part of a family system where destructive legitimization patterns exist and have been acted upon against other family members or innocent outsiders. The concept of "destructively legitimized" or entitled person refers to an individual whose unearned rights to care, protection and love have been denied in childhood, a person whose original

trust and dependency needs were betrayed and responded to with exploitation or neglect. As an adult, this individual may feel that the world owns him or her for this irreparable injustice. Feeling over-entitled, the destructively entitled person may not feel remorse for treating innocent others unfairly and make them "pay" for the original injury (usually an unconscious mechanism) (Boszormenyi-Nagy & Krasner, 1986).

The first situation is one in which therapists have experienced scapegoating, been blamed for adult failures in relationships, been victimized or discriminated against. Abuse in one form or another may have led the victim to identify to a negative image of self and therefore be prone to excessive guilt or to adopt a martyr's role. It may also have led the victim to rebel against the unjust treatment and to have a tendency to identify with other victims of similar abuse because of common patterns of victimization. This type of experience may partly explain over-identification and over-involvement with the traumatized client.

In the second scenario, an individual may have been part of a family or social system guilty of abusing, discriminating other family members, innocent outsiders or the members of a different racial or religious group. When existential guilt becomes embedded in the system, one or several group members may feel that they "carry" the burden of the "debt" and the need to repair the damage, to atone for it. When such a family role has been internalized, therapists may find themselves attentive and prompt to "right the wrongs" and "fix" innocent suffering around them.

Existential Guilt and the Trauma Therapist

Writing about the therapist/client relationship and the art of healing, Buber

describes the professional therapist as one "whose task is to be the watcher and the healer

of sick souls", one who "again and again confronts the naked abyss of man, man's

abysmal lability" (Buber, 1999, p. 17-18). He adds:

> the abyss does not call to his confidently functioning security of action,
> but to the abyss, that is to the self of the doctor, that selfhood that is
> hidden under the structures erected through training and practice, that is
> itself encompassed by chaos, itself familiar with demons, but is graced
> with the humble power of wrestling and overcoming, and is thus ready to
> wrestle and overcome anew. (p. 19)

Answering the client's call for help changes therapists, that is, if they are able to

encounter another genuinely. Sometimes however, therapists may find that they are not

(or no more) psychologically or philosophically "equipped" to be healers for the clients

who have been entrusted to them and who are in a great state of vulnerability.

Confronting "the naked abyss" of the traumatized other calling on therapists' selves and

being unable to answer the call may arise existential guilt. This point will be further

elaborated, but for the moment, I argue that it is important to look at some developmental

factors that may hinder (or facilitate) therapists' ability to answer this call.

Erikson's Stages of Development

Erikson's theory provides a useful point of reference in locating developmental

stages where individuals may have acquired and develop those ego abilities and strengths

which provide them with the inner resources to face and cope with the hardest existential

dilemmas. In the light of Erikson's theoretical framework, it makes sense to infer that the following personal characteristics emerge late in the maturation process (typically from 65 years old on). These are: (a) specific ego strengths such as to be able to maintain a sense of wholeness, coherence and identity in the face of progressive physical and mental decay; (b) the ability to confront human existential issues such as death, meaning, purpose, suffering and loss (issues of spirituality, as defined by the literature on VT), while maintaining hope alive; (c) to face the stress and deep questioning which these existential issues usually lead one to experience with wisdom and "detached concern". Erikson defines wisdom as "informed and detached concern with life itself in the face of death itself" (Erikson, 1982, cited in Feist & Feist, 1998, p. 248).

These qualities and strengths that are the sign of maturity appear to be the psychological tools trauma therapists often need to handle their clients' narratives with a minimum of stress for themselves. The problem is that many younger therapists who feel attracted to work with trauma victims may be unprepared developmentally to face the issues their clients will bring to their attention, psychologically and also philosophically. That is, they may not have matured yet a philosophical or religious theoretical framework useful to help them face situations of unusual great suffering. This suggests that younger trauma therapists could be more susceptible to become symptomatic than older ones. I also suggest that it is during these stages of greatest vulnerability to STSD that the mechanisms leading to impairment (as described in the next section) are likely to take place.

Empirical studies on the phenomenon of CF or VT are rare and often disagree (Arvay, 2001). There is general agreement among researchers however on the fact that trauma triggers the confrontation with issues of purpose and meaning (Brady et al., 1999). Two studies so far have found that younger therapist were at increased risk for secondary traumatic stress (Arvay & Uhlemann, 1996; Munroe, 1991, cited by Arvay, 2001). More research is needed therefore to assess the importance of therapists' developmental stage in relation to vulnerability to CF or VT.

The section that follows represents an attempt to apply Contextual Therapy concepts as well as Erikson psychosocial stages of development to the research questions outlined in the beginning of this article. These were: (a) Are empathy and empathic engagement necessary concepts to understand therapists' development of CF or VT symptomatology; (b) what is the origin of CF and VT; and (c) how can we explain the "transmission" of symptoms from client to therapist?

The "Suffering Servant" model[2] proposed next is offered as a tentative answer to these research questions. In this model I suggest: (a) three types of mediating factors for the development of CF and VT and (b) five possible stages of symptom development.

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[2]   See the Appendix for explanations regarding the choice and origin of this model name.

The Suffering Servant Model

Mediating Factors

Three types of factors may be said to mediate the mechanisms through which

therapists could become symptomatic: (a) situational or work-related factors, (b) personal

factors, and (c) interpersonal factors. I propose that these factors are relevant to any

therapist working in the field of trauma and that they will be expressed differently in each

case. Separately and together (in interaction), they are likely to impact therapists'

vulnerability to CF or VT and increase the demand on the therapist for greater personal

growth, self-awareness and training.

Work-related factors include: (a) the type of professional responsibilities of

therapists, (b) the type of environment and the conditions in which they work, and c)

work-load and degree of exposure to high levels of suffering in clients.

Among many possible influential personal factors, those mentioned below could

mediate the mechanisms of symptom development more powerfully because of their

connection with a meaning-making process affecting therapists' commitment to their

work and to the client's cause. These are:

- Therapists' developmental stage and maturity level (in the light of Erikson's theoretical framework).

- The presence/absence and depth of a personal philosophical framework representing a satisfactory and congruent thought system which provides meaning and hope in the face of suffering, evil and injustice.

- The existence of unexamined stories of injustice or loyalty in therapists' family of origin which could "spill over" in counter-transference.

- Level of emotional reactivity related to personal unresolved story of trauma.

- A highly developed sense of justice and responsibility.

- Highly idealist and unrealistic self-expectations ("God syndrome" and "the Lone Ranger" pattern of personality): The "God Syndrome", a personal disposition known among emergency workers, represents the extreme of an unrealistic self-expectation that one should be successful in rescuing and saving every victim (Beaton & Murphy, 1995). The "Lone Ranger" pattern is a metaphor for therapists who perceive themselves as if on a mission to fight a hostile world (for clients' benefit), a world populated by bad guys. This negative pattern has the unfortunate effect of modeling a view of the world that emphasizes victimization (Munroe et al., 1995).

  These personality characteristics may predispose therapists to inaccurate perceptions of exploitation as well as to emotional and cognitive biases in their appraisal of society's evils and their own responsibility in the healing process. The biased perception of a never-ending violation of society's ledger of justice may lead therapists to experience strong anger and sorrow and the desire to fight clients' battles. These emotions are said to be most likely in therapists who function in a rescuing mode (Pearlman & Saakvitne, 1995), or those caught in the "Lone Ranger" pattern (Munroe et al., 1995).

- Attachment style of the therapist: A study of a population of female therapists working with adult trauma survivors (Marmaras, Lee, Siegel, & Reich, 2003) explored the relationship between therapist attachment style and the development of vicarious traumatization symptoms. A previous study (Hazan & Shaver, 1987) had claimed that secure attachment is a protective factor in dealing with trauma, that is, it enhances individuals' abilities to deal and cope with stress and minimizes symptomatology. The study on vicarious traumatization (Marmaras et al., 2003) showed a positive relationship between attachment style and symptoms of trauma such as intrusion, hyper-arousal, avoidance and disrupted cognitive schemas; these symptoms were best predicted (positively correlated) in therapists whose attachment style was of the fearful-avoidant style (i.e., those therapists who had a negative working model of perception of self and others).

In view of these findings, it could be tentatively suggested that those therapists' earliest experiences which relate to the ability to trust and feel safe in close relationships may have an influence, not only on vulnerability to vicarious trauma (as suggested by Marmaras et al., 2003), but also on the degree of commitment to shared codes of group loyalty. This last point can be argued if we take into account Contextual Therapy claims that tight connections exist between both: (a) the development of the ability to commit to family loyalty (a precursor to other forms of loyalty) and (b) the ability to enter relationships of mutual trust, to whether the infant had his/her emotional and physical needs properly met (Boszormenyi-Nagy & Spark, 1984). It is possible to carefully speculate that therapists' attachment style, along with all other interpersonal factors emphasized in this chapter could mediate loyalty commitments, that is, the system's expectations towards the healing role and the specific ways in which these expectations are conveyed (explicitly or implicitly) and perceived.

Stages Leading to Impairment

What follows is a conceptual model of CF or VT in the trauma therapist which: (a) makes use of Contextual Therapy theory and its concepts (explored previously), and (b) suggests five stages of symptom development. A reflection on how these symptoms might present secondary benefits for the therapist as well as for the system is provided thereafter (see Figure 4).

Stage 1.

Therapists' exposure to the details of their clients' narratives and re-enactments confronts therapists with questions of meaning, purpose and hope. For some, exposure to clients' shocking information becomes, at some point, overwhelming and difficult to "digest" (for some or all of the reasons elaborated previously). Secondary traumatic stress may appear at this stage (not yet CF or VT): Therapists become overwhelmed and realize the gap existing between clients' neediness, their vulnerability and trust investment and the fact that they, therapists, can not comfortably handle the emotions and questioning evoked in them by their clients' stories (although they accepted the responsibility of therapy).

Stage 2.

The stress evoked by clients and their trauma is compounded by the fact that therapists perceive themselves as ineffectual, unable to fulfill their responsibilities or to be responsive to the system's expectations (including their own). They no longer experience themselves as dependable healers for their clients and start to fear that they might be "letting clients down", as well as failing those who entrusted these clients to them.

Stage 3.

As a result of their perceived inability to respond adequately to the counselling system's perceived expectations regarding clients in great distress, therapists feel disloyal to their clients, to the system and to their own mission as helpers. They may not be able

to verbalize these feelings yet. Therapists' perception of self as "impostors" increases their level of stress and may at this point begin to affect the therapeutic process and the therapeutic relationship negatively. Aware of the negative direction therapy is taking, therapists' level of stress may start to escalate.

Stage 4.

Therapists develop existential guilt for failing their clients in moments of great vulnerability and dependency. Other forms of guilt may arise as well (e.g., bystander's guilt). Therapists may also find themselves "caught" in existential guilt in response to repeated painful perception of injury to their clients (injury to the human order in their clients).

Stage 5.

Unresolved feelings of guilt and a sense of powerlessness may lead therapists to feel that they have reached an impasse; this situation blocks their ability to express loyalty directly, through positive action. Loyalty may at this point be expressed indirectly and in negative form through the unconscious adoption of the "martyr's role" (i.e., the therapist becomes the sufferer, that is, symptomatic). That is consistent with Boszormenyi-Nagy's belief that in the absence of direct ways to express loyalty to the system, the group member may express it through symptoms (Heireman, 1989).

It is useful to consider these stages as a flexible framework rather than as rigid invariable steps; each individual case is unique and stages may well overlap, two stages

could appear to combine or, in some cases, we could also imagine these stages as divided in sub-stages.

The Martyr's Role: Function and Secondary Benefits

Describing the "martyr's role" (or "willing victimization") in the system, Boszormenyi-Nagy states that through the adoption of the martyr's role and the self-inflicted suffering it involves, a family member may feel an alleviation of guilt originating in past, present or even future disloyalty (Boszormenyi-Nagy & Spark, 1984). I propose that, by endorsing the martyr's role, therapists may unconsciously and indirectly demonstrate loyalty to the system and therefore be relieved, at least in part, of their sense of guilt. I also propose that, unable to acquire merit through the positive act of healing, therapists may protect their need to feel and appear loyal to the system by developing symptoms similar to their clients'. At the metaphorical level, their symptoms may convey the message that, rather than letting clients down, therapists deeply partake in their suffering, to the point of "taking on" or incorporating clients' symptoms.

Therapists who find themselves "caught" in existential guilt are not aware of the way loyalty commitments play out in the systems to which they belong (own family and counselling system for example). Unbeknownst to them however, their impairment may also respond to a need in the system for "rebalancing" the accounts of justice.

This may be the result of a too great difficulty for the system (including the therapist) to cope with the type of evil and damage encountered by the trauma survivors

(especially if these are children). By "taking on" clients' suffering, therapists may enact some sort of "redemption" of the debt which is silently embedded in the system.

Finally, therapists' symptoms may also represent a call for help to the counselling system, a muted but powerful way to attract additional and more effective assistance for the client while maintaining a sense of loyalty to the client and system.

Figure 4:   The "Suffering Servant" Model:
Stages of Symptom Development and Mediating Factors

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Exposure to client's trauma. The therapist feels overwhelmed and realizes the gap between the client needs and his/her own resources to answer the call. The therapist may develop Secondary Traumatic Stress (STS).	The therapist perceives him/herself as ineffectual; she/he also feels unable to respond to the system's expectations. As a consequence, the therapist may feel that she/he is "letting down" a very vulnerable client. This thought raises the therapist's anxiety.	The therapist feels anxious but also disloyal to the counselling system and his/her own mission as healer. The therapist comes to perceive him/herself as an "impostor". The level of stress increases. The way the therapist feels and perceives may start to impact the therapeutic process negatively.	The system's homeostasis is out of balance. Existential guilt sets in the therapist.	Unresolved guilt and powerlessness in the therapist block the path to express loyalty in direct ways. Loyalty can only be expressed indirectly, as if in "disguise" (in order to re-establish homeostasis). ↓ The therapist develops symptoms that "mimic" the client's, that is, adopts the "martyr role" (or "willing victimization" in Contextual Therapy terms). The therapist now fits a CF or VT diagnosis.

Mediating Factors		
Situational or Work-related Factors	Personal Factors	Interpersonal Factors

Summary

The model proposed does not exhaust other possible explanations for the development of the symptoms of CF or VT. In comparison to most current models however, this model presents some important differences:

- It moves beyond a focus on symptoms and pathology, cultural context or individualized stress responses, and it explores the phenomena of CF and VT in the context of the counselling system.

- This model is focused on concepts of relational ethics, loyalty, betrayal of expectations and guilt.

- The emphasis is on the concept of loyalty (rather than empathy) as a vulnerability factor in the therapist impairment.

- The therapist symptoms emerge from the context of a system and its relational ethics and are mediated by a number of situational, personal and interpersonal factors which shape his/her loyalty commitments.

- Symptoms are not adaptations or signifiers of an underlying disorder. Rather, they convey relational/ethical meanings.

- Symptoms are understood as: (a) conveying relational meaning and (b) "located" both in the space "between" therapists and their surroundings (the interpersonal relational space) as well as "within" therapists' subjectivity (intrapsychic space). That is in agreement with Contextual Therapy theory where there is an emphasis on integrating individual psychology within relationships and systems dynamics (Boszormenyi-Nagy & Spark, 1984).

Willing Victimization and the Cost of Caring

In this section, I want to address two questions: How do the concepts of "willing victimization" and the "cost of caring" connect to each other? And also, do they convey

similar messages? As referred to in the first chapter, the "cost of caring" is a concept

referring to secondary traumatic stress and compassion fatigue (Figley, 1995). This

concept implies that empathizing with and attempting to relieve the suffering of a victim

of trauma comes with a cost to the human provider. Compassion fatigue (or STSD)

represents a high price to pay due to the personal and professional impairment that could

be the consequence of the helper's involvement with the victim's post-traumatic levels of

stress.

Literature on CF contains numerous metaphors related to currency or investment

such as "empathy has a price" and "it costs to help" (Hakansson & Montgomery, 2003, p.

282). Speaking about compassion fatigue and compassion satisfaction, another author

asks, "Can the currency flow both ways?" He immediately adds, "to understand the

"negative cost of caring, it is necessary to understand the credits or positive 'payments'

that come from caring" (Stamm, 2002, p. 109).

The words "infection", "virus" and "transmission" of traumatic stress, are also

commonly found in the literature; these other metaphors suggest that traumatic stress is a

sort of contagious disease (Figley, 1995, 2002; Gentry et al., 2002; Stamm, 2002; Valent,

2002). These two different metaphor categories (the "cost" and the "disease") used

conjointly in relation to the same phenomenon seem to convey two messages. First, that

CF or VT represent a "cost" which is unjust or absurd in nature (following empathic

involvement, secondary traumatization threatens the helper's integrity in the way of a

random and brutal viral attack). There is the intriguing (and more philosophical) question

of who the "creditor" might be. If such a "creditor" exists, however, she/he or it still

seems too abstract to be clearly defined or understood. If CF and VT are the natural

consequences of helpers' active empathy, who is the "cost of caring" "paid" to?

The second message being conveyed by these metaphors is that there is a danger

to the healing role. Here, however, there appears to be some confusion about the origin of

this danger: The "disease" model seems to refer to a danger whose source is extraneous

(e.g., "virus", "transmission", "contagion"). On the other hand, "the cost of caring", that

is, the "price" to pay for being empathically attuned to the victim, suggests that it is the

helper's empathy ability, that is, an "inner" characteristic or skill, which puts the helper

in harm's way. The existing models of secondary traumatization seem to struggle with

this conceptual ambiguity.

While the disease model seems de-emphasized in Contextual Therapy—the

relational ethics framework being given predominance—both the current literature on CF

and VT as well as the model presented in this study (which extends Boszormenyi-Nagy's

key concepts to the understanding of CF and VT) share a terminology which seems to

belong to a common discourse on some sort of "economics of care" in relationships. The

"cost of caring" on one hand, and the concepts of "rebalancing of accounts",

"unredeemed debt", "accounting" and "bookkeeping" (as related to the family and

counselling system dynamics) on the other, point to the notion that symptoms and

personal suffering in the therapist is indeed a type of "currency" connected to the healing

function.

The theory of systems model presented in this study (based on Boszormenyi-

Nagy's concepts) as well as the DSM model adopted by Figley (1995, 2002) and others

agree on both: (a) the importance of the dynamics between therapist and client, (b) the

perception that the therapist-client interaction may lead to some sort of "victimization" in

the therapist (the "martyr's role" and "willing victimization" refer to a similar

phenomenon in the Contextual Therapy framework) and, (3) that the mechanisms leading

to therapists' impairment are non-conscious or even unconscious.

The "willing victimization" and Figley's (1995) "cost of caring" concepts are

fundamentally different however. The idea of "willing victimization", as applied in this

study, responds to the justice principle; it arises from a feeling of existential guilt which

demands that a situation of indebtedness be honoured, one way or another. The "cost of

caring" could be said to be closer to the idea of "redemption" in the sense of the payment

of a "ransom" in order to free another from the consequences of events which reclaimed

and enslaved his/her vital forces and abilities. In this sense, the "cost of caring" is closer

to the principle of love while "willing victimization", as applied in this study, could be

seen as closer to the strict principle of the relational ethical law.

The Suffering Servant Model
and the CF&VT/WH Model

I wish now to compare the models I presented in the previous and present chapter

and to answer the following questions: How do the "Suffering Servant" and the

"CF&VT/WH" models connect to each other? Do they have different clinical

implications?

The Greek myth of Asklepios portrays the healing function as tightly linked with the ability to wound and to become wounded. Greek mythology reports several generations of devoted healers who become and remain wounded as part of their mission to relieve other people's suffering (Groesbeck, 1975; Kirmayer, 2003). Sometimes, healers go so far as to offer their lives to redeem humanity's suffering: When Asklepios attempted to resurrect the dead, for example, Zeus punished him by death (and later brought him back to life). Christ, whose story can be read as a re-enactment of the wounded healer archetype, dies to redeem the consequences of humanity's sin, that is, suffering and death. After his resurrection, Christ is said to stand as a saviour for those who put their faith in his redeeming power. These types of healers have been called the "ultimate healers" (Groesbeck, 1975).

It is their relationship to their own woundedness, according to literature, that allows healers to "contain" clients' pain empathically and effectively (Groesbeck, 1975; Kirmayer, 2003; Miller et al., 1998). There is a strong emphasis in the Wounded-Healer model, therefore, on ways in which therapists handle their own sense of woundedness when clients' sufferings strongly evoke their own.

At first sight, it could seem that the concept of "willing victimization" (or "martyr's role") as applied in the present thesis and the CF&VT/WH Model refer to similar mechanisms. Although some common ground can be found between them, important differences exist in the way therapists' symptom development is said to occur in each model. A brief examination of these similarities and differences will hopefully

clarify the specific contributions of these two models to the understanding of therapists'

symptoms.

In both theoretical frameworks, exposure to clients' suffering as well as to clients'

projections of the "inner healer" on therapists (i.e., clients' desire to be healed by

therapists, they trust and have expectations regarding therapists' healing power), impact

these therapists (Groesbeck, 1975; Kirmayer, 2003; Miller & Baldwin, 1987). Indeed,

this exposure is likely to evoke empathy in therapists, the desire to relieve clients'

suffering, as well as evoke therapists' own sense of woundedness. Woundedness can be

understood here as therapists' unresolved grief in relation to similar experiences to

clients', as well as their difficulty in handling clients' narratives, graphic details,

projections and expectations. In both models, an intrapsychic conflict is assumed to

develop following exposure to one or several traumatized clients. This conflict may end

up in additional suffering for the therapist and also in professional impairment. Some

important differences worth exploring exist between these models however.

In the CF&VT/WH Model the focus is on concepts of projection, over-

identification and counter-transference; only the therapist/client dynamics are explored.

In this model I suggest that therapists' challenge is to avoid repressing or denying their

own woundedness and rather to acknowledge, accept it and get intimately acquainted

with it for the benefit of themselves and the client. When therapists struggle with their

own unresolved pain, their focus may turn inward, in an attempt to maintain a personal

sense of balance (and distance themselves from the client who represents the "aggressor",

i.e., the source of stress); projection of therapists' own suffering onto the client may

happen in order to solve their dilemma. Difficulty in integrating harmoniously their

"wounded" and "healing" aspects may ultimately result in therapists' inability to extend

compassion to the trauma victim and become symptomatic.

The "Suffering Servant" model takes the whole counselling system into account

as well as everyone's expectations regarding the healing role. In this model the focus is

on concepts of relational ethics, loyalty to the system's expectations and guilt following

betrayal to what is perceived as the group (and therapists' own) expectations and loyalty

commitments. Therapists' challenge in this model is to be able to acknowledge, tolerate

and accept the feelings of powerlessness, ineffectiveness and guilt linked to the

perception that they may not be the dependable healers the system and themselves expect

them to be. Their task is to work therapeutically with the personal woundedness brought

about by these feelings for their own and their clients' benefit. When therapists struggle,

however, and become overpowered by their own sense of betrayal, their focus and mental

energy may turn to maintain a self-concept that includes honouring their loyalty

commitments (conscious and unconscious). Total acceptance of their perceived

limitations becomes very difficult because this might mean that they are failing clients in

states of great vulnerability who trust them and look up to them for help (as well as those

who entrusted these clients to them). The conscious integration of their woundedness and

the resolution of their dilemma is blocked by the way therapists perceive their loyalty

commitments. This ultimately may lead therapists to express invisible loyalty to the

system in the form of symptoms similar to their clients'. As can be seen, the "Suffering

Servant" model and the CF&VT/WH Model diverge when it comes to explain the

meaning of therapists' symptoms in the light of the mechanisms at play in each model. They both share the important concept however that therapists' failure to acknowledge, accept and assimilate their own suffering in ways that are therapeutic (for themselves and their clients), whatever feelings or painful perceptions this suffering may encompass, is the real threat to therapists' well-being and work satisfaction. It remains a very challenging task however to become aware of how system forces impact one's own perception and behaviour; yet, to learn to identify and disentangle the mechanisms, mostly unconscious, that shape one's own projections, identifications and interactions with others, in a dyad as in a system, has the potential to help therapists navigate the troubled waters of the healer's journey.

Clinical Implications

What kind of approach could one suggest in order to prepare and help trauma therapists cope with the difficulty of their mission? Although prevention and treatment are beyond the scope of this thesis which is more conceptual than practical in focus, I would like to sketch some directions which I think are relevant to the topics developed here.

As mentioned before, therapists who deal with traumatized clients on a regular basis may develop biased perceptions regarding the extent of society's exploitation of the weakest; it was equally mentioned that this situation may affect therapists' perception of the social "ledger of justice" and lead them to feel high levels of grief and anger regarding the suffering of innocents.

Therapists' perspective on the nature and *raison d'etre* of their work is an important part of the philosophical framework they need to develop to work successfully with the traumatized. Buber's thought may contribute to enhance a perspective on the therapeutic relationship which validates every effort on the part of the therapist, even if this effort does not lead to positive therapeutic outcome in every case; it may in the same time allow the therapist to grow greater internal tolerance and acceptance for those aspects of life (violence or client's choices) which are out of his/her direct control.

Buber's notion of the "human order of being" suggests an invitation to consider humanity's interconnectedness and mutual responsibility. Through every traumatized client, the therapist encounters this "human order of being", in its positive and also painful reality. Moreover, the task of therapy may come to be felt as engaging in a difficult "caring cycle of empathic attachment, active involvement, and felt separation" (Skovholt et al., 2001, p.168), something which, it is claimed, has the potential to lead therapists to depletion and burnout. A more positive outcome of the therapeutic experience could be however that, through conscious commitment and loyalty to human survival and welfare, therapists choose to devote their efforts to the "human order of being", in Buber's terms, while developing an attitude of "detached concern" with each individual client. The notion of "detached concern" is understood in the literature as a balanced mid-point lying between helper's over-involvement and depersonalization or loss of concern (Savicki & Cooley, 1982). It necessitates that therapists sustain a healthy dosage of caring and empathy towards clients, while striving to keep emotional involvement at a level where an attitude of objectivity is equally possible. A shift in

therapists' perception that includes a "bigger picture" (working to relieve humanity's misery vs. facing repeated individual cases of intolerable suffering) could be part of what might make a difference in their sense of well-being.

How does one give to the "human order of being"? Buber believed that to harm somebody else, to be unjust, was like harming the whole human race (Heireman, 1989). It probably makes sense to extend this idea and suggest that to contribute to someone's healing is like working for the healing of the whole human race. This implies that, through every particular client and situation, therapists may choose to grasp the opportunity to repair a tear in this human fabric. They may choose to look at the "big picture" as one where the "ledger of justice" is (and probably will always seem) unbalanced, and to accept to contribute to a collective mending work. In a different metaphor, therapists may choose to look at their work and the work of all the other human service providers as the work of the body white cells, endlessly repairing the body wear and tear, preventing greater harm, in a relentless daily confrontation with integrity threats. Sometimes the wound will heal; sometimes not; and often scars will remain.

The collective mending work that attempts to remediate the wounds inflicted to the human fabric through violence and abuse may appear to some both a necessary as well as a futile endeavour (because it does not seem to have the potential to address the source of human violence at its roots and eliminate it for good). Yet, I suggest that the validation of therapists' contribution is to be found in the daily gift of their expertise to humanity's misery, whatever individual failure they may encounter along the way. Additionally, witnessing and acknowledging clients' stories of resiliency, heroism and

survival helps us appreciate the importance of victims' power to contribute an important share to their own healing process. Political and social activism may be additional avenues for therapists who wish to openly and consciously assert their loyalty to the oppressed and the traumatized into positive action.

Our ability to tolerate failure and confront the "dark side" of humanity seem to be useful tools for trauma therapists to develop. The acquisition of these abilities appears to partly depend on our ability to acknowledge and tolerate our own "shadow" side (in Jungian terms) and to enter a compassionate dialog with our own emotionally wounded areas, as suggested by the Wounded-Healer model.

As a conclusion, I find it important to suggest that an empathic and useful attitude towards those therapists "caught" in the web of invisible loyalty commitments (and unaware of the processes that keep them impaired), could be to openly acknowledge and validate their contributions to the counselling system, in whatever form they are being expressed. To train future therapists to recognize how the counselling system forces may affect them personally and professionally appears to be another valuable goal. Additional research on ways in which loyalty commitments impact therapists in the course of their careers also seems essential to better understand the phenomena of CF and VT and to address trauma therapists' impairment in all its complexity.

CHAPTER 4:
IN THE LIGHT OF BUDDHISM

A certain number of therapists have explored and privately practiced Zen

Buddhism (e.g., D. Brazier, C. Mruk, J. Hartzell, and M. Epstein, among others); some

argue that Zen practice is a form of psychotherapy (Brazier, 1995). The reason for this

seems simple: The aim of Buddhism is to free the mind from suffering or mental disease.

Zazen, a meditative practice, is claimed to be a useful vehicle to quiet the mind and gain

insight into ourselves (McClain & Adamson, 2004). For these reasons, these therapists

claim Zen Buddhism to be a useful contribution to Western psychotherapy.

Buddhist psychology also provides useful and different conceptualizations of

what, in the Western medical model, we call "symptoms" of mental turmoil or disorders.

Additionally, Buddhist teachings on self-generated mental pain, empathy and compassion

offer Western researchers tools to clarify the existing links between our thought

processes, level of self-awareness and our ability to extend deep compassion without

compromising our own mental health in the process. I found therefore that the Buddhist

approach to suffering, its study of the mind and its concepts of compassion and

equanimity were useful for the understanding of CF and VT.

In this chapter I examine Buddhist theories in relation to the concepts of self and

ego and the way these two concepts are linked to mental disturbance. I thereafter offer a

model to propose an understanding of the role of emotional reactivity in the development

of symptoms of CF or VT in trauma therapists; this model, which I called "the hurricane

model", takes Buddhist teachings on the mind and mental suffering (as transmitted by

several Western Buddhist therapists and researchers), into account.

First, some brief historical highlights are presented in order to introduce

Buddhism and some of the differences existing between several Buddhist schools of

thought.

Historical Highlights

Buddhism starts with Siddharta ("the fulfilled wish") Gautama, a prince born in

India in 560 B.C. who later became known as the Buddha ("The Awakened One").

Buddha taught the "dharma" (path or doctrine) in India for 45 years, traveling by foot and

making many disciples (McClain & Adamson, 2004).

There exists many different schools of Buddhism, but two important schools

predominate, each emphasizing different aspects of the teachings. The "old school"

follows Buddha's original teachings and encourages a monastic lifestyle as well as

individual search for enlightenment. Communities of this type developed essentially in

Southern India. This branch of Buddhism has been called Theravadan Buddhism.

Vipassana meditation or insight meditation, is at the heart of Theravada Buddhist

practice.

The "New School" embraced the Boddhisatva ideal, that is, working to free all

beings from suffering and enlightenment. This school is also called Mahayana or "the

great vehicle" because of its more inclusive outlook. The "New School" called Theravada

Buddhism Hinayana, a word carrying the disparaging notion of a "narrow vehicle",

because of Theravada Buddhism emphasis on monastic life and aspiration for individual

enlightenment. These two schools represented rival factions. The Mahayana school

developed in communities in Korea, China, Japan, Nepal, Tibet and Mongolia (Gach,

2004). Spreading to the West, the "Great Vehicle" led to the Zen, Pure Land and Lotus

Sutra schools.

In China, Confucius and Lao-tse, the founder of Taoism, were born roughly

around the same time as the Buddha. All three men were key reformers. Shinto, the

original religion in Japan, blended with Chinese Buddhism after Korean Buddhists

brought the Buddha's teachings to Japan; Korean Zen, called "Son" (McClain &

Adamson, 2004), has been a prevalent practice during Korea golden age (1140-1390). In

time, Japan developed its own versions of Buddhism, that is, Shingon and Amidism. The

Japanese version of Zen, developed in Japan around 1185, was first practiced by the

samurai, the military elite. Zen is believed to be the branch of Buddhism the most

resilient to historical changes (Gach, 2004).

Buddhist teachings are presented in the form of organized principles such as "The

Four Noble Truths", "The Eightfold Path", or the 18 theories of conditioning of the mind.

Buddhist psychology can be found in the Abhidharma, a Buddhist sacred text, which

explores the nature of the human mind. One of the Abhidharma writings, the Book of

Origination, analyzes the theories of conditioning of the mind (Brazier, 1995), an

important point of reference in this chapter.

To appreciate how Buddhism could contribute to the understanding of forms of secondary traumatization such as CF and VT, an exploration of some basic Buddhist teachings about mental suffering is necessary.

Buddhism and Human Suffering

The Universal Nature of Suffering

What is Buddhism? Is it a religion, a philosophy, a lifestyle? Buddhism has been claimed to be all of this in the same time. Buddhism is also claimed to be a form of therapy for the most common human disease, "dukkha". Dukkha, a Sanskrit term, can been translated as life's "pervasive unsatisfactoriness" (Epstein, 1995, p. 46) or, more colloquially, the fact that "life will always be a bumpy road" (Gach, 2004).

The issue of suffering is central to Buddhism, be it death, grief, physical illness, deprivation or frustration and disappointment. Suffering is universal; it seems to be inherent to our human condition and it seems inescapable. Buddhism distinguishes between two kinds of suffering, that is, (a) the one over which we have no control (caused by natural catastrophes, death, loss of a loved one to sickness, and so on), and (b) what is understood to be self-generated or neurotic suffering. Self-generated suffering, claims Buddhism, can be extinguished, progressively and with some effort. Theravada Buddhism considers mental and emotional suffering the result of maladaptive mental processes and cognitions centered around our notion of a self thought of as an essence, a separate, solid, permanent and unique core. This self-concept is understood as being both

an unavoidable developmental construction and also an illusion and the cause of much

mental chaos (Safran, 2003).

"Who am I" and "why do I suffer?" At the core of these questions resides the key

to the extinction of self-generated suffering. These "tricky" questions concern every

human being and, according to Buddhism, most of us get trapped constructing reality out

of misconceptions about the self or what life is about; we are therefore all "in the same

boat" and self-generated suffering is tackled by Buddhism as a universal, collective

problem (Safran, 2003). Individualized forms of mental suffering or pathology, it is

important to note, do not appear to be explored in original Buddhist teachings.

The Four Noble Truths

At the heart of Buddhist teachings we find four propositions called "The Four

Noble Truths", "Four Holy Truths" or "Four Worthy Hypotheses" (Gach, 2004). These

are:

1. Life is full of dukkha or suffering. Human condition is difficult and may even

feel humiliating (due to our little or lack of control over the processes of aging, sickness

and death, for example). Realizing the full extent of what this proposition means is an

incredible challenge to our narcissism. Peace of mind and equanimity come with the

development of total acceptance of what life is, and what we are, with all the

uncertainties and ambiguities this entails (Epstein, 1995).

2. There is a cause to this suffering: Trishna or attachment. The Sanskrit word

"trishna" is also translatable as thirst, craving, clinging, desire or grabbing (Gach, 2004).

Two kinds of cravings are described in the literature: (a) The craving of sensual pleasures and, (b) narcissistic craving, the desire "to be something", to maintain a certain image of ourselves. To the question "what is the nature of self?", the Buddha is claimed to have answered that "there is neither self nor no-self". The question itself implied that something like a self—a separate entity—exists, something the Buddha came to see as an illusion (Epstein, 1995).

3. It is possible to end suffering. We can transcend the neurotic aspects of our mind: They can be extinguished. Because the negative mind processes that create so much pain are self-generated, they can also be sublimated or transformed (Epstein, 1995).

4. There is a path to freedom (liberation or nirvana). This path is the "Eightfold Path", a plan for life and healing, Buddha's medicine for dukkha. The Eightfold Path represents eight life principles which attempt to integrate body, mind and spirit harmoniously. These eight principles can be regrouped in three categories: (a) "Wisdom", (b) "ethical conduct", and (c) meditation or concentration. The transformation of suffering that occurs when these principles are followed is claimed to be accompanied by the growth of insight and genuine compassion (Safran, 2003).

The Roots of Suffering

Buddha's spiritual journey led him to the conclusion that human misery arises from our minds. Most of our suffering is self-generated and this state of affairs is so common to all of us that he thought of it as a disease whose agent does not reside outside ourselves, but in our most intimate perceptions and thoughts processes (Brazier, 1995).

The "Wheel of Life", also called the Wheel of Samsara, is a useful Buddhist

visual tool to express this notion that suffering is self-generated. Represented in the form

of a Mandala, the wheel depicts six "worlds" under the domination of death. These six

worlds or realms traditionally represent the cycle of rebirths and are used by Buddhists to

teach the notion of Karma (merit and how our actions affect the next birth) (Epstein,

1995).

Each realm in the wheel can be understood as a metaphor for a different mental

and emotional state of being. The whole wheel is a tool for introspection and appraisal of

who we are. The most important message related to the wheel is probably that suffering

does not reside in any realm of existence per se, even if some realms names would lead

us to think so (e.g., "the Hell Realm", or "the Realm of the Hungry Ghosts"). Each Realm

depicts a state of mind that can lead to suffering but also to freedom from suffering. In

essence, individuals' attitude and their choices determine the outcome of their encounter

with each Realm. As one author puts it "one of the most compelling things about the

Buddhist view of suffering is the notion, inherent in the Wheel of Life image, that the

causes of suffering are also the means of release" (Epstein, 1995, p. 16) and also,

"Nirvana is Samsara…release from suffering is won through a change in perception, not

through a migration to some kind of heavenly abode" (Epstein, 1995, p.18). This notion

of suffering and release from suffering as two facets of a same reality agrees with one of

the central themes in most Wounded-Healer stories, that is, the notion that wounding and

healing are inextricably linked, like two sides of a same double-edged sword.

An important source of suffering is, according to Buddhism, the avoidance of and estrangement from who we are, including our fears, grief and other painful states of mind. To push suffering away only creates more turmoil for ourselves (Mruk, 2003).

Real healing, in Buddhist teachings, requires both an accurate knowledge of how our minds work as well as the development of self/others compassion. True compassion is understood as involving action, that is, the active involvement in the relief of suffering in us as well as others.

Accepting and Embracing Suffering

For reasons that appear truly pragmatic, Buddhism encourages us to embrace suffering. The existence and inescapable reality of suffering is the first Noble Truth. Avoiding it compounds and complicates our pain, allowing it to keep us trapped in it. Another reason for the validity of the acceptance of suffering is, according to Buddhism, that the denial or repression of it requires us to use defence mechanisms which further affect and hinder a genuine perception of reality. Acceptance of our pain, moreover, develops our awareness of suffering in others and allows us to become more compassionate (Mruk, 2003).

Like the grit in the oyster, dukkha—but in particular our attitude towards it—can lead to the transformation of all irritants into accomplished states of mental freedom if we stop trying to get rid of it. Dukkha then becomes a teacher and an opportunity (Brazier, 1995).

What does Zen offer to achieve this? Rather than a method to "get the dragon into its cave", "Zen....offers dragon-riding lessons, for the few who are sufficiently intrepid" (Brazier, 1995, p. 14). Mindfulness training (meditation), a central practice in Zen, is claimed to promote equanimity, purposeful living and mental health.

The trauma therapist faces more than one dragon however. Cases of child abuse, homicide, and so on, bring tough moral and philosophical issues into the therapy room. When individuals have been maliciously hurt, especially children, therapists need tools to understand the evil done to their clients; they also need some kind of framework to integrate it cognitively and emotionally. What does Buddhism say about this?

The Problem of Evil: Does it Exist?

Buddhist theory does not seem to have an evil vs. good concept; what we consider evil is thought of in Buddhism as ignorance (or conditioning). Fundamentally, negative feelings or "bad" states of mind are, in Buddhism, the result of a mind that is "closed up" or confused; the seemingly destructive energy that leads to inner turmoil or selfish acts is, according to Buddhist thought, good energy that is simply misguided and needs proper channelling (Brazier, 1995). Buddhata, the transcendent reality of all things (our identity with the cosmos), resides equally in each and every being according to Buddha. Buddhata is our "real self", human's collective, authentic and non-individualized "core" and it is also seen as essentially good. It is in this unity of all things and beings that actualization can be found and it is also the basis for Zen ethics, that is, when not obscured by ignorance, our nature is considered to be naturally ethical (Brazier, 1995).

Tied to this notion of the fundamental good nature of everything is the belief in

free will and personal responsibility. "The western concept of a person has become more

and more that of a victim", stresses Brazier (1995), "whereas the Buddhist view is that

everyone is the gardener of their own life. This latter perspective is held particularly

strongly in Zen" (p. 113). The Zen notion of personal responsibility for our thought and

emotional processes strongly contrasts with most current literature on CF and VT where

the view is that therapists are being "victimized" by their empathic involvement with

their clients and referred to as "survivors" in the context of their therapeutic involvement.

Self and Ego in Buddhist Psychology

To define the Self, in Buddhist terms, is a difficult task. That is because, in

Buddhist thought, to ask what the self is, is an erroneously formulated question; such a

question implies indeed that the possibility of an individual "core" or separate entity

exists (Epstein, 1995). To this question the Buddha is reported to have answered that

there is neither "self" nor "no-self". Buddha's paradox refers to the idea that although

individuals perceive themselves as distinct from others and the world (something true to

some extent) this does not involve the existence of anything in us that could be said to be

unchanging, something with a distinct identity or a "core" that could be called a self; it is

just a common human illusion. That is what Buddhism refers to as "emptiness", that

which cannot be relied on (Gach, 2004). What constitutes us, psychologically as well as

physiologically, is claimed to be neither fixed nor consistent. In essence, self is unreal, in

the metaphysical sense of the word; it is what we identify with, something which is

perpetually changing. What we understand by "self" is said to be "the collective noun for all our conditioning" (Brazier, 1995, p. 81).

In this context, the quest for one's "true self" appears to be equally irrelevant (Epstein, 1995). There are no "true selves"; however, there exist many "false selves" or images of self which distort perception and generate suffering (Brazier, 1995).

Our attachment to the idea of self is said to be inevitable, a by-product of our psychological and emotional development (Epstein, 1995). However, because the attachment to a concept of self is at the source of many distortions and anxiety (Safran, 2003), it is the self, that is, our stories about ourselves and our self-concept, rather than the ego (in the Freudian sense) which is targeted by Buddhism. Realizing the absence of the metaphysical "I", and accepting that "I" is an unavoidable mind construction without tangible reality, comes with a sense of loss and the need to mourn a fundamental and comforting belief (Safran, 2003).

This important Buddhist distinction, our self-image as different from a core "self", has significant therapeutic implications. As Brazier (1995) notes, the "self" cannot be damaged (through trauma for example); only the perception of a self is said to exist and therefore it is "the damaged picture" rather than "the picture of something damaged" that has reality. The question therefore is to know if the therapist should try to help the client "fix" this picture or to get rid of the picture altogether (Brazier, 1995). The second option is what Buddhism is really about: This self that seems so real to us cannot be broken (by trauma for example); the reason is that this self "is already broken" (Epstein, 1995, p. 81). Although this does not sound like good news at first, the experiential

realization of this Buddhist cornerstone is claimed to have the potential of freeing us from

a multitude of negative emotional experiences. The Eightfold Path, previously

mentioned, represents a dynamic method to gradually de-identify with the images of self

that dominate our lives, freeing us from the suffering that derives from our clinging and

attachment to these deeply ingrained self-concepts (Mruk, 2003).

The Buddhist concept of self has also implications regarding our relationship with

others and the world, and is tightly connected with the concepts of relational ethics and

compassion. Buddhata, our essence which is also the identity of the universe, links us to

everything which exists. From this concept of the universe and all its inhabitants,

creatures, animals and things, as fundamentally one body, emerges a basic concept of

relational ethics: Self-actualization is contingent to our development of harmonious and

respectful relationships with others (Brazier, 1995). Ethics is said to be the natural

expression of an individual having realized his/her unity with everything and a central

aspect of the Eightfold Path, the Buddhist spiritual path (Safran, 2003). When the

distinction me/not me or self/others is understood to be illusory, compassion towards all

emerges naturally. True compassion, one of the six Zen principles (Mruk, 2003) is also

claimed to be the result of the healing of all the internal divisions of our beings, the split-

off parts; alienation from oneself or self-centredness is said to preclude real compassion.

That is also one of the implications of the Wounded-Healer model which makes

self/other healing and true compassion contingents to therapists' successful connection

with their "inner healer" and the unification of all inner separations.

These Buddhist notions imply therefore that it is important to: (a) accept and integrate all the unacknowledged or repressed parts of ourselves, as well as (b) to realize the state of interdependence and interconnection of everyone and everything. Success at these tasks is claimed to powerfully and genuinely release the power of compassion. A closer look at these tasks suggests that they both have to do with integrating, making whole, connecting and reaching unity. In the light of these teachings, it is relevant to wonder if disorders such as CF and VT do not signal a deep feeling of alienation from oneself and others, blocking access to therapists' source of compassion and empathic identification with clients. What leads a therapist to feel self/other alienated in the face of another's narrative and experience of trauma could therefore be the beginning of a useful line of inquiry, from a Buddhist point of view.

Is Self Different from Ego?

The ego is described by Western Buddhist therapists such as Epstein (1995) and Mruk (2003) as a useful mental structure, necessary for good cognitive functioning and adaptation and the basis for rational decision making. The ego is also seen as the natural outcome of each person's development into adulthood. These authors emphasize however that, from the Buddhist point of view, the development of the ego is a mixed blessing: Necessary developmentally, the usual perceptual mechanisms of the ego and its survival strategies tend to trap us into a web of reality distortion and painful clinging.

The Buddhist concept of the Skandhas (translated as "heaps") can be understood as related to the Western concept of ego. This concept of skandhas, or "heaps", points to

the idea that the ego is a kind of aggregate, a cluster of heterogeneous elements, rather than an identifiable, congruent and distinct entity (Brazier, 1995). Sometimes, the Skandhas are also conceptualized as a by-product of ego development, and presented as five steps in the mind processes which are involved in relating to the phenomenal world. The concept of Skandhas represents a theoretical framework that attempts to explain how dualistic (or polarized) consciousness arises and how it is maintained. The Skandhas (understood as processes) operate on the objects of our perception, acknowledging them, labelling the experience, determining feelings and reactions and associating each new experience with past ones or operating classifications. Through these processes we associate valences (positive, neutral or negative) to each object of perception as it relates to our self-concept (the perception that "this concerns me" or that "this is important to me" determines the valence we attach to any experience). Skandhas are said to be "sticky" and to cause many perceptual distortions (Brazier, 1995). This description of the Skandhas should not be interpreted as Buddhism rejection of the ego as unnecessary or undesirable. Buddhism values all potential ego strengths and functions in that they are useful tools to increase self-awareness and attain greater wisdom and compassion. Mindfulness meditation for example, attempts to harness ego functions such as self-control, mastery or adaptation and to channel ego's energy (usually clinging to common human desires and longings) for the benefit of spiritual development (Epstein, 1995). In its attempt to diagnose and treat the causes of universal suffering, Buddhism actually assumes a healthy and well-functioning ego. The ego, in Buddhist teachings, does not need to be transcended but trained; it is the internal experience of "I", the ontological or

metaphysical self, which needs to be acknowledged for what it is (i.e., a self-generated

construction carrying numerous potential problems) and transcended (Safran, 2003). To

assume that the concept of self should be eradicated from a discourse on Buddhist

psychology, however, would be a mistake. It is just the misconceptions or illusions about

it that are targeted by the teachings (Mruk, 2003).

Self, Ego and Mental Conditioning

This section focuses on the notions of self and ego, and specify the ways in which

these concepts contribute to: (a) an understanding of important dynamics related to

mental turmoil, as well as (b) to an appreciation of the Buddhist path to the cessation of

suffering.

When confronted with life's uncertainties and pain, say Buddhist teachings, we

react by building a self, that is, a defensive structure aiming at our emotional and mental

protection, a sort of fortress which in time becomes a prison made of self-protective

habits and patterns of thought and behaviour (Brazier, 2003). The creation and

maintenance of this structure mobilizes a good deal of psychic energy which is not

available for other mental processes.

Our investment in self (the "this concerns me" mental attitude) acts upon our

objects of perception by superimposing personal agendas on what is "out there" and

sorting out events or people into "me/not-me" categories (Brazier, 1995). What we

perceive is then labelled in terms of "pleasurable/not pleasurable", "good/bad",

"scary/not scary", and so on. This mental activity corresponds to step number four in the

Skandhas process, called the Samskaras: attaching feelings, images, memories to what is

being perceived in the present (Brazier, 1995). Identification with the Samskaras is the

beginning of our troubles, according to Buddhism. To de-identify with the Skandhas in

general, that is, to recognize these mental processes as natural while recognizing the fact

that they do not have ultimate reality, is highly recommended if happiness and well-being

are to be experienced. It is a hard task however, because the Skandhas carry with them

what seems most attractive to us, that is, sensual pleasures and a sense of solid identity,

both of which become sources of attachment and clinging (Brazier, 1995).

Buddhism does not necessarily support ideas of self-sacrifice or self-denial,

however, and therefore it is not life enjoyment which is targeted by the teachings, but our

attachment to it; to remain aware of the ephemeral and undependable nature of the

pleasures and displeasures that life entails is key (Epstein, 1995; Brazier, 2003).

Self-concepts and the Skandhas set in motion different kinds of vicious circles

which entrap us in negative and sometimes pathological patterns of thought and enslave

our psychic energy. That is described in much detail in Buddhist teachings under the term

of conditioning (Brazier, 1995; Brazier, 2003). Conditioned existence is also called

Samsara, a term used in contrast to Nirvana (signifying enlightenment and freedom from

the tyranny of mental conditioning). Conditioning exists on a continuum and differs from

individual to individual. The topic of the conditioning of mental states is studied in depth

in the Book of Origination (the seventh book of Abhidharma, the Pattana). Twenty-four

different forms of conditioning are there described (Brazier, 1995). Some of these

theories will be briefly mentioned later in this chapter and the next.

The conditioning of our mental states and its analysis is a cornerstone of Buddhist psychology. Its basic principle is simple: Mental states don't exist in a vacuum; they originate in the existence of conditions outside and inside ourselves. Because of their dependency on these conditions, our mental states fluctuate, change and shift accordingly, from happy moods to distress or discomfort or vice-versa (Brazier, 1995).

Buddhism and its analysis of the nature of ego and self-processes (the Skandhas and the theories of conditioning in particular) offer conceptual tools that are useful to bring reactivity "under the microscope". This analysis has the potential to offer a congruent explanatory framework as to how unpleasant cognitive and emotional symptoms may arise and how to relate to them in order to decrease one's level of reactivity.

The Hurricane Model

Hurricane and tornados are common metaphors for emotional turmoil that spins out of control. In "Zen therapy", Brazier (1995) uses this metaphor in relation to the client's mind in therapy: Often unaware of the real issue at hand, clients' minds, at first, tend to go in circles, apparently out of control. Finding the core issue they need to work on and focusing their energies on it, is for clients, like entering the eye of the hurricane, a space of calm (Brazier, 1995).

In real life, a fully-fledged hurricane is sometimes described like a huge self-sustaining machine made of heat, lightening and rain and fuelled by heat and moisture. When heat and moisture stop fuelling the hurricane, the last progressively fades away

(Lynch, 2002), a good metaphor—I suggest—for the notion of "extinction" of Samsara in Buddhism. Indeed, the Theravada tradition describes the possibility for everyone of a gradual and irreversible "extinction" of all those cognitive and emotional processes through which we generate our own mental suffering; it is possible, says Buddhism, to eradicate all our self-identifications and promote in ourselves states of mind where our pain is contained without reactivity, that is, without avoidance or aversion (Safran, 2003).

The model presented next borrows from the image of the hurricane and the contrast between its violent spiralling energy and the quietness and undisturbed space of the "eye" or centre, a metaphor for equanimity and the extinction of automatic reactivity.

This model has one important characteristic: It encompasses a *structure* combined with a *dynamic* aspect. The structural part of the model is represented by three intersecting axes or dimensions. The dynamic aspect of the model is provided by the concentric spirals spreading around the three axes, whirling around an "eye" or centre, like a hurricane (the spirals represent the movement of a mind "going in circles"). The three dimensions are ones that appear to be regularly targeted by Buddhist teachings (see Figure 5). Each dimension is here conceived as a continuum where an optimal balanced mid-point is surrounded by contrasting and sometimes extremes and more rigid patterns of thought, feelings or relating. Each dimension also reveals distinct sources of self-generated suffering. These dimensions are:

- The mental space: Cognitive and emotional processes involved in our relation to the phenomenal world, that is, perception processes and the thoughts and feelings that derive from these perceptions.

- The mental time: Cognitive and emotional processes which follow patterns of orientation towards the past, present or future.

- The relationships domain: Relationship self (narcissism)/others and self/world.

Figure 5:   The Hurricane Model
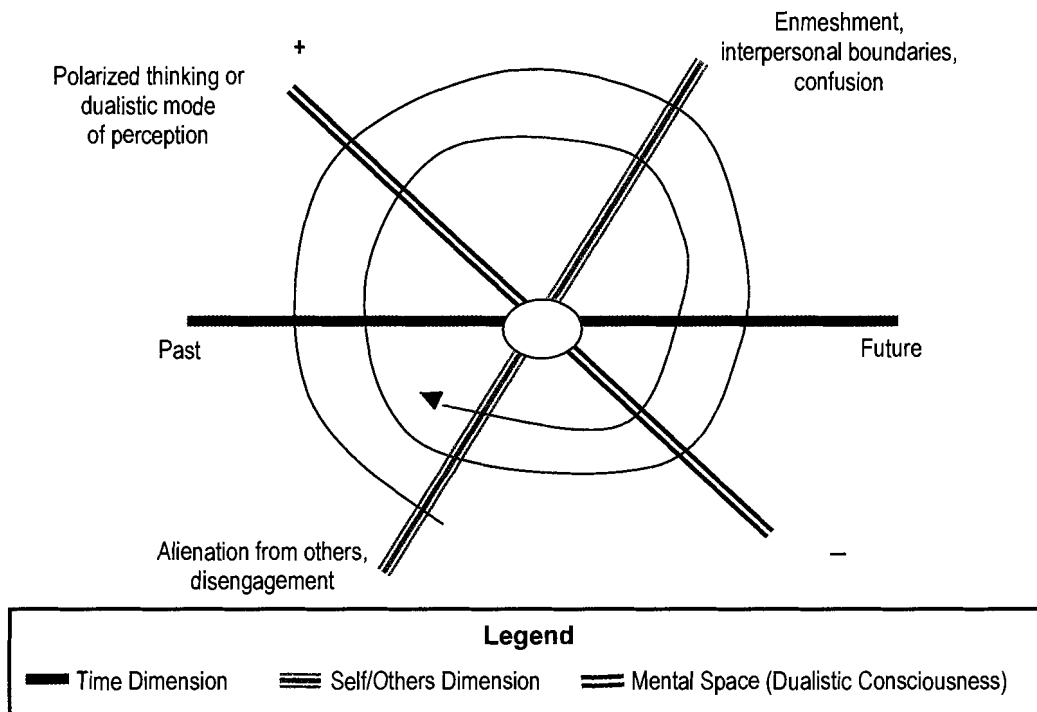
This conceptualization of Buddhist teachings on the mind is suggested as a visual

representation of the way mental turmoil arises and the direction it takes (key aspects of

this turmoil are indicated by those dimensions that become activated at some point); this

model is also a visual tool to picture how turmoil gains momentum or becomes gradually

extinguished.

I found useful to picture mental processes in a way that visually describes the mind as a "weather system", with its fluctuations, amplifications and constant change. That is also a system in which, like the weather, every change or fluctuation is brought about (or conditioned) by the diversity of influences arising from an internal ecology. At any time, especially under pressure, emotional and cognitive turmoil may affect any dimension and spread to the other dimensions. When amplification of these processes occur, the mind goes "in circles", fuelled by the forces of conditioning.

The "eye" of the hurricane represents this ideal balanced point, where an individual's alignment on all three dimensions is optimal and where equanimity develops. Individual positioning on these dimensions appears important: The further from the optimal point (the intersection), the greater the vulnerability to "emotional storms".

As a metaphor for equanimity, the hurricane "eye" appears to be most appropriate. Despite the violence of the spiralling winds, a real hurricane "eye" is a space where a plane could safely be landed as well as a space where animals may find safety from the violence of the winds (Lynch, 2002).

Next, I will present what each dimension (the mental space, time and relationship) is about and relate it to Buddhist teachings about the mind. Later, I will explore the CF/VT symptomatology with the help of this model and suggest some possible ways of understanding these symptoms from the Buddhist point of view.

Dimensions of Suffering

Mental Space or First Dimension

This dimension is about the contents and processes of the mind as well as patterns of polarized thinking under the influence of the Skandhas (ego processes). Examples of workings of the mind targeted for mindfulness training (McClain & Adamson, 2004), and belonging to this dimension are, thoughts, feelings, opinions, expectations, the need for control, desires, categorizing, labelling, prejudices, assumptions, identifications, the "shoulds", "can'ts", and so on. Zen warns us against the power of thoughts and feelings to overwhelm and overpower us. Like wild animals that need taming, our thoughts race (Brazier, 1995), often preventing us from being really attentive and concentrated in the present. This characteristic of our minds is often referred to as "the monkey mind" in Zen literature (McClain & Adamson, 2004). Zen teachings emphasize acknowledging and giving our thoughts and feelings a voice, but avoiding identifying with them; that is, we "have" thoughts and feelings and need to own them but, paradoxically perhaps, "are" not them. Feelings, in this context, do not exist independently, that is, they arise from our processes of perception and the interpretation of what we perceive. Perception and feelings follow a parallel line; to change our feelings, we need to change the way we relate to the reality around us. In other words, the way we choose to make meaning of what we observe or experience will condition our minds in ways that influence our feelings. These in turn will condition future experiences or observations, and so on (Brazier, 1995).

Time or Second Dimension

This dimension is related to the concept of impermanence; in other words, our reality is constantly changing or, as Heraclitus, the Greek philosopher said once, "you can't step into the same river twice" (Gach, 2004). "Going with the flow" rather than fighting this inescapable reality, clinging to the past or living in the future, is greatly recommended in Zen Buddhism if we want to avoid additional mental pain. Zen emphasizes the power of the present as the ultimate reality on which we have some control. Here again, acknowledging the influence of the past or planning for the future are congruent with the Buddhist Middle Path; clinging or attaching to them, however is, according to the teachings, to surrender our power and allow ourselves to become overpowered by anxiety or depression (Epstein, 1995; Gach, 2004; McClain & Adamson, 2004). Impermanence, although a tough reality, is also a source of hope, since everything passes, the good and the bad; pain does not last forever (Gach, 2004; Mruk, 1995).

The Middle Path, where equanimity can be found, corresponds to the "eye" of the hurricane model. That is where the "power of now" is maximized and where temporal split-offs are avoided. Mindfulness practitioners (Zazen meditators for example) stress the importance of experiencing oneself in the present, moment by moment. This practice aims to direct the individual's focus to the body experience as it unfolds. In so doing, the self experiences a shift from a spatial dimension (where the self is viewed as a "core" somewhere "inside" of us and the mind is thought of as something that can be explored) to a temporal dimension (a moment-to-moment experience of self), bridging the mental

and bodily experiences, preventing and healing a mind/body split off, a situation claimed

to be at the origin of mental suffering and trouble (Epstein, 1995).

In Zen, the "now" encompasses all other dimensions of time (Gach, 2004;

Kapleau, 1980). Past and future are unreal, only the present is said to exist. Zen teachings

emphasize that the enlightened individual who understands time experientially is able to

embrace all the dimensions of time and space in him/herself. Among the most difficult

concepts to grasp in Buddhism, the concept of "being-time" (one of 13th Century Zen

master's Dogen teachings) describes our complex relationship to time (as a subjective

experience):

> Every living thing is the whole, even though it itself does not realize it. As
> there is no other time than this, every being-time is the whole of time: one
> blade of grass, every object is time. Each point of time includes every
> being and every world....When I climbed the mountain and crossed the
> river, I was [time]. Time must needs be with me. I have always been; time
> cannot leave me...since being is time, I am my being-time. (Kapleau,
> 1980, p. 310-311)

Time does not simply go away; this would mean that time and things are separate;

"every being in the entire world is a separate time in one continuum" (Kapleau, 1980, p.

311). These teachings about time are intriguing and complex notions. Further exploration

of these ideas is beyond the scope of this chapter, however; it is useful to add

nevertheless that the "eye" in the "hurricane model" is where the "now" is represented. In

this "eye", the "now", all dimensions of time are encompassed.

Relationship Self/Others/World: The Third Dimension

The topic of the attachment to an idea of self-as-a-substance in relation to self-generated suffering has already been explored. I also mentioned that, according to Buddhism, the distinctions me/not me are in essence, illusory and reflect dualistic or conditioned thinking. A concept reflecting the interconnectedness of everything is "codependent arising" or "interbeing" (in Vietnamese Buddhist teacher Thich Nhat Hanh's terms), a notion tied to the belief that nothing has a durable or permanent identity (impermanence) (Gach, 2004). Interbeing is like a "web" linking every being and every thing in the universe. Regarding "interbeing", Martin Luther King is quoted having said, "We are all caught up in an inescapable network of mutuality" (cited in Gach, 2004). To realize the underlying harmony between me and the other is to understand our real nature or "Buddhata" (Brazier, 1995; Gach, 2004; Mruk, 2003). From the experiential understanding of what "interbeing" represents, deep and genuine compassion (as well as a sense of responsibility) for self and others is claimed to arise (Brazier, 1995; Kapleau, 1980).

Symptoms and Buddhist Psychology

What is meant by "symptoms" can be different according to one's theoretical framework. The literature on CF, as mentioned previously, suggests that symptoms can `be signifiers of an underlying psychiatric disorder (STSD), an understanding in agreement with the medical model where sometimes, as in the case of PTSD and STSD, symptoms are organized in syndromes.

The literature on VT appears to use a biological sciences model. VT research

suggests that symptoms are adaptations and that symptoms have a function, that is, to

regain balance and counteract the impact of the traumatic event. Symptoms have

therefore a positive function although the individual's coping mechanisms may be

maladaptive (A. L. Pearlman, personal communication, June 21st, 2004).

In Zen Buddhism, emotions or cognitive disturbance are part of what we are and

should not be considered as alien, undesirable manifestations which need to be

eradicated, despite their unpleasantness (Reynolds, 1980). Psychological symptoms of

distress reflect, in Buddhism, unhealthy thought/feeling processes, that is, a mind which

is misfocused and mispaced. All manifestations of the mind need to be owned; symptoms

are part of what we are at some point in time, and not isolated, extraneous problems.

Buddhism strongly stresses the need to learn to live with our problems and relate to them

differently by learning to observe them, de-identify and detach from them (Reynolds,

1980).

The mental processes and the dynamics illustrated in the "hurricane model"

reflect the Buddhist belief that the forces of conditioning operating on mental activity and

their outcomes are universal processes, common to all human beings. They are a matter

of degree and intensity and vary individually and from moment to moment in the same

individual (Brazier, 1995). Where mental health is concerned, symptoms represent an

imbalance or excess in these processes. The "hurricane model" attempts to show how

symptoms actually reflect an amplification of mind processes that are shared by all of us:

These mind processes (e.g., negative labelling, dualistic thinking, over identification with

one's feelings and thoughts, avoidance of pain, and so on) may tend to become more rigid and to spiral negatively under environmental pressure due to individuals' unawareness of the nature of their own mind processes and/or inability to handle their own reactivity.

Based on Buddhist teachings, this model suggests therefore that: (1) CF and VT symptomatology belong to the domain of stress reactivity, and that (b) individuals' perception of the stressor and their appraisal of it is paramount in the development of this type of symptoms.

CF/VT Symptomatology and the Hurricane Model

The literature on CF suggests up to 76 different symptoms related to seven distinct categories: Cognitive (9), emotional (14), behavioural (12), spiritual (8), personal relations (9), somatic (9) and work performance (15) (Figley, 2002). I suggest that these symptoms can be mapped into the three dimensions of the "hurricane model" as follows:

- Mental Space: In this category, we find symptoms that denote cognitive self-deception, confusion, rigidity, high levels of negative feelings (anxiety, fear), dualistic thinking (as expressed in polarized judgments) and more.

- Mental Time: Symptoms involving a preoccupation with the future (expectations or fear that a traumatic event repeats itself), an obsession about the past (survivor's guilt, intrusive imagery of trauma, impossibility to find closure), and so on.

- Self/Others: Decreased self-esteem, self-doubt or blame, withdrawal, mistrust, decreased interest in intimacy or sex, loneliness, feelings of disconnection and alienation, and more.

Additionally, it is also possible to relate CF/VT symptomatology to the Buddhist

concept of "Kleshas", not yet introduced in this chapter: An important Buddhist theory of

mental conditioning, the "theory of root relations", states that all psychological suffering

is tied to three "bitter roots", while healthy mental states are rooted in three "sweet

roots", the opposite of the "bitter roots" (Brazier, 1995). The Kleshas, or "bitter roots" are

described as "mental contaminants, obscurations or obstacles" that cause mental turmoil

(Brazier, 1995, p. 87). The Sanskrit terms for each bitter root are roughly translated as

'greed', 'hate' (or 'aversion') and 'delusion'. In turn, these three are said to be the roots

of thousands of different kleshas or "poisons" of the mind, causing preconceptions, faulty

perceptions and mental disorder.

States where 'greed' predominates are said to cause us to cling, be attached or

"hooked" to and experience distress about detaching. 'Greed' may include the fact that

we do not succeed in making room in our lives for what is different, or that no space is

given for another person to be who she/he is, and so on.

States where 'hate' predominates may cause us to feel overly detached, alienated

and isolated; "hate" or "aversion" may also be at the source of difficulties to connect, to

be close, to empathize.

States where 'delusion' predominates are, according to Buddhism, characterized

by obsessions, fixed ideas, confusion, incongruence, irrationality and prejudice.

These states of mind are referred to as "closed minds", states where clear

consciousness is obscured, in the way the water is clouded after the mud has been stirred

(Brazier, 1995). Mental illness is sometimes claimed to be traceable to an excess or

imbalance in the experience of one of these 'bitter roots' (Brazier, 1995). 'Greed', for example, is said to be expressed in compulsive eating and neurosis; 'hate' is said to be expressed in anorexia and hysteria, while 'delusion' would characterize bulimia and psychosis (Brazier, 1995). The "antidotes" prescribed by Buddhism for these unwholesome states correspond to the "sweet roots"; these are: Love (for 'greed'), compassion (for 'hate') and wisdom (for 'delusion'). Buddhism recommends that we transform the 'bitter roots' into 'sweet ones': that individuals work at developing a deep and experiential understanding and practice of these 'sweet roots'.

It is also claimed that conditions involving 'hate' are likely to be related to trauma (Brazier, 1995). Relevant to this chapter, Buddhist recommendation for the alleviation or transformation of compassion fatigue and its painful symptoms would appear to be the development of...compassion and empathy. In other words, if trauma and 'hate' (or 'aversion') are related and if the "antidote" for 'hate' conditions is the development of compassion, Buddhist teachings could be pointing to the need to fight self/other alienation (typical to 'hate' conditions) with the development of self/other compassion and empathy. This brings us back to the issue of psychological wholeness and the importance to increase self-awareness and self-acceptance to avoid the repression or denial that lead to split-off parts in our psyche. It appears that both the Wounded-Healer model and Buddhist teachings emphasize the importance of psychological wholeness to awaken our potential for self/other compassion, a vital ingredient in danger of depletion in CF and VT.

CF and VT symptomatology, as said previously, could be mapped to fit the three
dimensions of the "hurricane model". It is actually possible to map CF and VT symptoms
into two combined frameworks: the three dimensions on one hand, and the three "bitter
roots" on the other. Examples of this categorization can be found in Table 2.

Table 2:   Combination of Kleshas and the Three Dimensions of the Hurricane Model

	Mental Space	Time Dimension	Self/Other Dimension
Greed	Clinging to concepts of self or reality that are unrealistic, non-adaptive or negative Overly preoccupied with obtaining comfort or security Imposing one's opinions or beliefs on the client, fighting his fights Appetite changes	Survivor's guilt Other forms of guilt Overly invested in outcome Desire to "fix" problems or overly preoccupied trying to anticipate or avoid problems Rescue fantasies	Regressive attitudes Difficulty with interpersonal boundaries Over-protection, over-identification or over-involvement with the victim Perfectionism
Hate	Avoidance, numbing Fear, suspicion Anger, rejection Depression Intolerance	Constant preoccupation about the client's trauma. Nightmares Anxiety Obsessiveness Intrusive images Frightening or sad fantasies	Withdrawal Decreased interest in sex or intimacy Decreased self-esteem, self-hate or blame Cynicism Disgust and negative appraisal of the client Mistrust Isolation
Delusion	Dissociation Lowered concentration Confusion Disorientation Prejudices Obsession about details	Time disorientation Memory disruptions	Feelings of alienation, isolation, disconnection with others and self Internalization (incorporation) of client's trauma issues

From a Buddhist point of view, these combined frameworks have therapeutic

implications for the counselling of individuals suffering from CF or VT. Although

suggestions for treatment are not part of the present thesis, it can be useful to sketch

general outlines as to the issues which therapeutic work could simultaneously address,

based on this chapter's model: (a) individual symptoms expressed on each dimension, as

well as (b) individual expression of "mental contaminants" (Kleshas) which distort

perception and interpretation (of self, others, events, relationships and time) and give rise

to emotional turmoil or confusion. That is:

1. Individual expression of symptoms in each dimension:

   - Identity and relationship issues (dimension self/others).

   - Perception and meaning-making processes or symbolization of experience (mental dimension).

   - Repair the time-collapse typical to traumatic states (Varvin & Rosenbaum, 2003) through therapeutic work in the "here and now" (time dimension).

2. Individual expression of "mental contaminants" or Kleshas:

   - Individual tendencies to excessive attachment or clinging, difficulties to let go, emotional "hunger", and so on (the 'greed' conditions).

   - Individual tendencies to react with aversion, detachment, withdrawal, mistrust, projection of anger, difficulties to empathize, and so on (the 'hate' conditions).

   - Mental confusion, dissociation, poor concentration, disorientation, delusion, and so on ('delusion' conditions).

Specific combinations corresponding to individual cases could be expected, as in

each case, each individual will present a different situation. I believe it could be useful to

determine, for each individual case, if specific patterns emerge (symptoms which, more

than once, borrow from specific combinations such as, for example, "greed and mental dimension" or "delusion and time dimension").

Clinical Implications

Symptoms of CF/VT: How to Understand Them?

In the light of Buddhist teachings on the nature of emotional symptoms, what genuine compassion represents and the way compassion emerges in an individual, I propose that:

1. CF/VT symptoms could be understood as reflecting the "closing up" of a mind which, unaware of its own workings, is focused on defending the integrity of self from the perceived threats evoked by direct exposure to a client's trauma imagery and story details.

2. CF/VT symptoms reflect therefore a preoccupation with self that closes the door, so to speak, to genuine compassion (requiring de-centring and selflessness). In this sense, CF and VT could be said to be more about: (a) failure to extend genuine compassion (rather than fatigue for having extended too much compassion), and (b) mental exhaustion brought about by unsuccessful attempts to ward off the fear, to avoid facing one's own sense of "going to pieces" and to try to protect the belief in a unified, coherent and solid self.

Are Therapists Being Victimized?

From the Buddhist point of view, and in accordance with the CF/VT and WH model, there is no "victimization" possible through counselling activities, contrary to the opinion expressed in the literature (Arvay, 2001; Figley, 1995; Brady et al., 1999; McCann & Pearlman, 1990; Pearlman & Maclan, 1995). Indeed, psychological suffering in these circumstances can be claimed to be mediated through individual perception and stressor appraisal and to be therefore self-generated. As the literature shows (Brady et al., 1999), CF and VT are possible (rather than predictable) outcomes of counselling the traumatized. In most cases, therapists do fine. The expression "natural by-product" as applied to CF and VT in the literature appears therefore to be a possible exaggeration since not every trauma therapist becomes impaired. Neither compassion fatigue nor vicarious trauma appear to be unavoidable outcomes of therapy with the traumatized, according to the empirical evidence available (Brady et al., 1999; Stamm, 2002).

The "victimization" terminology would probably be rejected in the Buddhist framework as mistaken because it seems to rob us of the margin of freedom we all have in the way we understand and react to the events in our lives. This type of vocabulary seems unfortunate because it may block avenues for individuals to "own" and take responsibility for their thought processes and perceptual habits. By reminding us of our ability to choose and our freedom to transcend our limitations, Buddhism challenges us to look inside ourselves where much of our reality is often created.

Japanese Quiet Therapies

Many of the Buddhist concepts reviewed in this chapter have been traditionally introduced in several forms of modern therapy in Japan. Although the Japanese cultural context is very different from the North American or European one, I found useful to mention the existence of these modern therapeutic practices, as a point of reference representing specific applications of the concepts I elaborated on in this chapter. These Japanese therapies, called the "quiet therapies", approach stress and anxiety disorders in quite different ways from the Western model.

The "quiet therapies" are called Shadan, Naikan, Morita, Seiza and Zen therapy. Contrary to Western forms of psychotherapy, they discourage verbal elaboration of the individual's thoughts or feelings (Reynolds, 1980). Instead, these therapies combine long periods of silence, isolation and meditative exercises with gradually increasing periods of physical work and social integration.

The therapeutic focus in the "quiet therapies" is on regulating the flow of consciousness or awareness. This flow is slowed down (through mandatory isolation, bed rest and/or meditation), refocused (in Shadan and Morita) and directed inward (e.g., focus on breathing in Zen) (Reynolds, 1980). The goal in these forms of therapy is to teach clients to accept, incorporate and transcend their symptoms. The body and mind connection is acknowledged in a holistic perspective which holds that psychological progress is reflected in the body (Reynolds, 1980).

A key characteristic of these therapies is the conceptualization of neurosis as the result of a distorted view of reality; the promoters of these therapies stress that this type

of mental distress can be alleviated through educational training. The alleviation of symptoms however, is subordinated to the necessity for clients to learn to live with their symptoms and to accept their inner distress as part of what they are at some point in time. In this sense, a "cure", as understood in the Western framework, does not represent the ultimate goal of these therapies. Rather, individuals are expected to reconsider the way they evaluate their personal circumstances, relationships and thought patterns and to be able to successfully reintegrate their social roles in constructive ways.

Apparently efficient in their cultural context (according to the available literature to date), the adequacy of these therapies to the Western context still has to be evaluated empirically and poses many challenges in regards to the transposition of Eastern values and belief systems to the Western context (Reynolds, 1980).

Summary

The "Hurricane" model presented a visual model of the way emotional and thought processes may lead to emotional "storms". It also included the notion of a balanced point (the "eye") where reactivity is lessened and equanimity can be developed. This balanced point is acquired, according to Buddhism, through a change in perception, the avoidance of denial and repression on our mental processes and the observation and acceptance of our distress as part of what we are.

Free will and responsibility for our own mental processes appear incompatible with a description of CF and VT as the result of "victimization" (due to therapeutic work with the traumatized). Moreover, these disorders can be understood, according to

Buddhist theory, as reflecting states where the klesha of "hate" (or aversion) predominates, requiring the development of true compassion, as an antidote. True compassion, the result of total self-acceptance and being "whole", with no mental split-off, appears indeed incompatible with states such as CF and VT, where a preoccupation with self and the warding off of fear predominate.

What's Next?

In the next chapter, I chose to explore the issue of "contagion" or "transmission" of symptoms between therapist and client. To examine that issue, I analyzed concepts derived from Buddhist thought such as mindfulness and connected them with Tart's (1986) concept of "consensus trance" as well as with research in the domain of suggestibility and hypnosis. Possible promising lines of inquiry for empirical research will be suggested that could contribute to the understanding of the "transmission" of symptoms of trauma, a mysterious and still virgin field of investigation.

CHAPTER 5:
THE CONTAGION PHENOMENON

My main goal in the previous chapter was to examine CF and VT symptoms in the light of Buddhist teachings. In the present chapter, I wish to explore the issue of "contagion" or "transmission" of symptoms between traumatized clients and their therapists.

When tackling the therapist/client's relationship, Brazier (1995) mentions the "stickiness" of the skandhas and the fact that the therapeutic space can become "contaminated" by specific attitudes in the therapist. The skandhas, as previously mentioned, can be understood as five cognitive steps in the process of relating to the phenomenological world [i.e., (a) perception, (b) acknowledgment of what is perceived, (c) labelling, (d) experiencing feelings and reactions, and (e) associating the new experience with past ones and classifying the experience]. As mentioned before, dualistic (or polarized) consciousness is claimed to be the usual outcome of our perceptions because of the strong hold of conditioning on our minds (Brazier, 1995).

Attending to the client's emotional wounds can be understood as opening up to the client's kleshas. For reminder, Buddhism considers kleshas to be the "poisons" of the mind, that is, mental factors at the roots of emotional and cognitive turmoil. "Greed", "hate" and "delusion" are the basic kleshas said to give rise to a multitude of different

kleshas whose common characteristic is to prevent us to think clearly or behave

rationally. Kleshas are said to be "sticky" (Brazier, 1995). "Stickiness" means, according

to Buddhism, that kleshas have the power to greatly distort our perceptions in the absence

of self-awareness about our mind processes. Because kleshas are said to be like toxic

waste, to attend to the client's kleshas is said to be somewhat risky: Therapists may, if

they are not mindful, become "contaminated" by them. It is not clear, however, how

Brazier (1995) conceptualizes this "contamination". His mention of three main

contaminating factors (judgmental attitudes, focus on self and concern with own issues)

does not provide a direct link as to how clients' kleshas activate therapists' kleshas. I

suggest that it probably makes sense to understand this link as some kind of counter-

transference in which therapists' emotions and thoughts are being triggered by clients'

narrative or behaviour. If therapists do not "clean the therapeutic space", i.e., if they

neglect meditative training, in Brazier's terms, they could set themselves and the

therapeutic relationship up to become "infected". The therapist "needs to create the same

kind of inner space which the client is trying to find. Therapist and client are on the same

path" (Brazier, 1995, p. 30).

Although meaningful, Brazier's contribution does not appear sufficient to address

the issue of "contagion" in CF and VT. Additional concepts seem to be needed to make

better sense of this phenomenon. As already mentioned, "contagion", "virus" and

"transmission" are metaphors used in the literature to attempt to explain mechanisms

which are not clearly understood yet (Figley, 1995, 2002). They are also strange concepts

when applied to stress disorders. Admitting that we considered "contagion" a proper

metaphor to refer to therapists' symptoms of CF and VT, we would still need to explain

through which medium, symptoms of trauma could be "communicated" between two

people in a close relationship. Next, I hope to offer some ideas on how this could happen.

States of Consciousness

The Buddhist concept of mindfulness may be captured by the terms being "fully

awake" or "fully conscious". This concept raises interesting questions about the nature

and diversity of human states of mind or consciousness. Psychological literature

distinguishes between "altered" and "normal" states of consciousness, implying that there

is a "normal" state which, under certain conditions, could be changed or disturbed. An

altered stated of consciousness, on the other hand has been defined as a radical variation

from the individual's general and normal pattern of subjective experiences as well as

altered cognitive processes (such as attention and memory), observable behaviour and

physiological responses. Sleep and dreaming, meditative states as well as hypnosis are

described by some authors as "altered states of consciousness" (Farthing, 1992). An

examination of what the literature says about the difference between normal and "altered"

states of consciousness, and how trauma might be linked to states of suggestibility in the

helper follows.

Normal States and Consensus Trance

What we consider "normal consciousness" is sometimes claimed to be an

unrecognized and convenient fiction, a form of social and cultural hypnosis, also

described as a form of "consensus trance", in Tart's (1986) terms. The term "hypnosis" is

used by Tart in connection to "consensus trance" to describe important and non-

conscious mechanisms of social persuasion; he points to these mechanisms as being at

the source of a powerful and continuous mental conditioning which, from childhood,

shapes our perception of reality. In Rheingold's (1992) terms: "Human groups agree on

which of their perceptions should be admitted to awareness [hence consensus], then they

train each other to see the world in that way and only in that way [hence trance]" (p. 1).

Consensus trance shapes our "waking consciousness", (our perceptions and worldview)

and also translates into specific attitudes and emotional responses (derived from our

collective perception of reality). It makes sense to think about consensus trance as

existing on a continuum of increasing openness to social forms of influence. Most social

interactions are claimed to reinforce this state of consensus trance. The reason for this

seems to be that sharing into a general consensus about the nature of reality makes us feel

safe (Tart, 1986). Consensus trance is described as a fragile illusion, a waking dream

state, which robs us of a life lived mindfully, attentive to the here and now. Mindfulness

training, that is, exercises aiming at increasing our level of general awareness, is then a

valid method to break through the state of "consensus trance" (Tart, 1990).

"Consensus trance", in its more extreme forms, would appear to be located at the

fringes of what we call "normal" states of consciousness, or, I would propose, at the

junction between "normal" and "altered" states". Additionally, Rheingold's (1992)

description of consensus trance strongly evokes the idea of collective skandha processes

where perception is (non-consciously) manipulated, that is, collectively distorted, in order

for the group to share and maintain general agreement on the nature of reality.

Trauma and Altered States

The significant shift in perception, meaning-making process and emotions that are

characteristic of CF/VT appear compatible with the description of a state of

consciousness that is outside the range of what can be called "normal" subjective

experience. Trauma shakes the foundation of our beliefs about self, others and the world;

it also seems to freeze or destroy our capacity for symbolization (Bonomi, 2003), to

fragment the lived experience of time, to blur chronological distinctions and to freeze our

mental capacities, among other disturbances (Varvin & Rosembaum, 2003). Moreover,

the impaired therapist presents patterns of perception which seem aligned with, parallel

to, or as "in consensus" with the client's traumatic experience.

Additionally, a link exists in the literature between trauma and hypnotic

susceptibility (Stutman & Bliss, 1985). Combat veterans, highly impaired with PTSD,

appear to show two related characteristics: High hypnotic susceptibility as well as strong

ability for mental visualization of images. I believe these attributes are significant and

argue that a better understanding of phenomena related to suggestibility might hold the

promise to explain the "contagion" phenomenon in CF and VT. Because the terms

"hypnosis" and "suggestion" are often mentioned in this chapter, it is useful to offer

definitions of these terms with which most readers may agree. The following definition

by Orne (1977) of hypnosis, which I will use in this chapter, seems to be as theoretically

neutral as possible. Orne describes hypnosis as a "state or condition in which subjects are

able to respond to appropriate suggestions with distortions of perception or memory" (p.

19). In Farthing's (1992) terms, suggestion is "a communication from one person to

another that induces the second person to change his/her behavior or beliefs, without any

argument or coercion being involved" (p. 211). Suggestibility—the ability to be subjected

to suggestion—is described as a normal psychological process (Farthing, 1992). In this

chapter, I decided to refer to hypnosis and suggestion following the above Orne and

Farthing's definitions of these terms.

There appear to exist individual limits to suggestion. In hypnosis, for example, it

is accepted that participants cannot be forced to comply with the hypnotist (they can even

resist the hypnotist's instructions). Participants' cooperation is therefore needed and the

literature suggests that these individuals use cognitive strategies through which they

allow themselves to comply with the hypnotist's instructions in order to make their

responses happen. These responses feel involuntary to the participants however, or are

being interpreted as such (Farthing, 1992).

Given the previous definitions, I suggest the following continuum of increasingly

suggestible states: (a) mindfulness, (b) consensus trance, and (c) high levels of

suggestibility (such as those described as "hypnosis"). On this continuum, consensus

trance represents a weaker form of more extreme forms of suggestibility, such as those

involved in the development of "altered states of consciousness" where a radical variation

from the individual's general and normal pattern of subjective experiences is usually

reported, according to Farthing's (1992) definition of "altered state".

Given the premises argued above, two questions are posed: Can strong suggestion processes affect the trauma therapist in some circumstances? And, are CF and VT phenomena somewhere in between an extreme form of "consensus trance" and states of deep suggestibility?

Hypnotic Susceptibility and Its Links to CF and VT

The ability for vivid mental imagery in traumatized combat veterans has been claimed to relate to hypnotic susceptibility, also called hypnotic responsiveness (Sheehan, cited in Farthing, 1992). High hypnotic susceptibility appears to be a relatively lasting individual characteristic (Farthing, 1992), although some researchers wonder if this ability could be improved by training. It has also been found that hypnotic susceptibility is positively correlated with the Absorption Scale. The authors of this empirical study define absorption as a "cognitive-motivational trait" involving the capacity for total attentional involvement" (Tellegen & Atkinson, 1974, p. 275). These findings seem to indicate that trauma (and therefore CF/VT) and the ability for absorption could be correlated, although the available literature connects them indirectly (through hypnotic susceptibility and vivid imagery ability).

Finally, absorption and vivid imagery abilities have been found to correlate with each other, with absorption claimed to be a better predictor of hypnotic susceptibility (Crawford, 1982). Figure 6 illustrates how these constructs are positively linked to each other in the literature.

Figure 6:   Correlates of Hypnotic Susceptibility

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┌─────────────────────────────┐                    ┌─────────────────────────────┐
│   Hypnotic Susceptibility   │◄──────────────────►│         Absorption          │
└─────────────────────────────┘                    └─────────────────────────────┘
            ▲                                                     ▲
            │                                                     │
            │                                                     │
            ▼                                                     ▼
┌─────────────────────────────┐                    ┌─────────────────────────────┐
│          Trauma             │◄──────────────────►│     Vivid Imagery Ability   │
└─────────────────────────────┘                    └─────────────────────────────┘
```
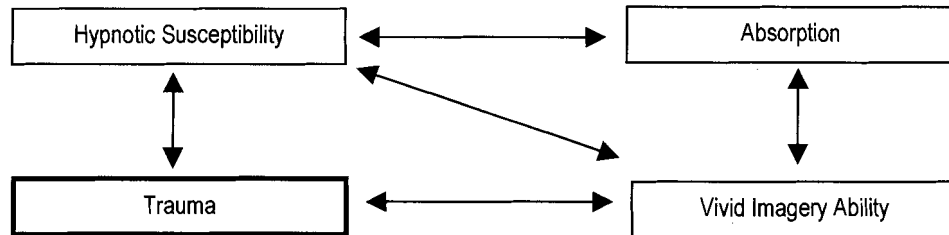
Persons with high imagery ability seem to be especially vulnerable to trauma and its after effects, leading to obsessive recollections and nightmares, for example. This applies to both the direct victims of trauma as well as to the therapists who try to help them and begin to experience similar symptoms such as nightmares, intrusive memories and frightening flashbacks (Cerney, 1995). Imagery and visualization exercises are often used with the victims of trauma in an attempt to divest these mental images from their power and desensitize the victims' memory about the traumatic events.

Given the importance of imagery in trauma, the use of hypnosis is said to be a potentially efficient treatment for both the victims of trauma and their vicariously traumatized therapists (Cerney, 1995). Despite the apparent usefulness of hypnosis to treat therapists affected with CF or VT, no research to date appears to point to links between CF/ VT and the possibility that therapists affected by vicarious trauma might also share a high degree of suggestibility.

Three Tentative Propositions

The positive correlations found among the variables in Figure 6 may be of interest

in exploring the etiology of CF and VT. There are three propositions which would be

worth exploring empirically:

1. Are traumatized therapists highly responsive to suggestion and do they

demonstrate high capacity for absorption and imagery ability?

2. Does high ability for absorption and imagery coupled to high suggestibility in

the helper operate as the "front door" for unconscious exchange of information between

client and therapist, impacting helpers' subjective experience of self? What would such

process look like? First of all, the client's narrative (graphic details and strong negative

affect being expressed) which the therapist is actively focused on and likely visualizing

during the therapy session, may operate as a form of guided imagery, possibly reinforced

by the ritualized procedures of trauma re-enactments. I propose that this active focusing,

in a person with high ability for absorption, may have secondary effects: The authors of

the Tellegen Absorption Scale (Tellegen & Atkinson, 1974) argue that absorption is

incompatible with the ability to, in the same time, entertain metacognitions about the

object of a person's focus. Additionally, it has been argued that the ability to respond to

suggestions could be related to the ability to suspend judgment and reality testing and

also to dissociate (Crawford, 1982). High ability for absorption coupled to high

suggestibility in the helper could therefore operate to facilitate the unexamined,

unconscious exchange of information between client and therapist. This exchange might,

under some circumstances, alter the helper's concept of self. This last idea is supported

by authors who argue that "objects of absorbed attention acquire an importance and

intimacy that are normally reserved for the self and may, therefore, acquire a temporary

self-like quality", and also that " absorbed attention can also result in an altered self when

the attentional object is someone else" (Tellegen & Atkinson, 1974, p. 275).

3. The unconscious exchange of traumatic material (thoughts, feelings, imagery),

from client to therapist, might lead to this material being absorbed and incorporated by

the helper. Once the traumatic material internalized, the therapist could be at greater risk

to develop CF or VT. The "absorption" or "incorporation" of the traumatic material could

explain what has been called the "contagion" of symptoms from client to therapist.

Two issues may be useful to consider:

- In regard to proposition 1: Hypnotic susceptibility appears to be a
  characteristic that varies among people (Farthing, 1992). If we consider
  that hypnotic susceptibility, absorption and ability for vivid mental
  imagery exist on a continuum, I propose that those therapists most
  vulnerable to CF and VT might be found at the end of the distribution for
  these characteristics.

- In regard to proposition 3: The ability to enter a level of trance by the
  combined effect of absorption (on the client's narrative) and imagery
  involvement could facilitate a process of self-suggestion and thus a shift
  in the perception of the therapist's reality (self/others/world). Self-
  suggestion (and the processes which could lead to the incorporation or
  internalization by the therapist of the client's traumatic material and
  graphic memories) could happen without the therapist being aware of the
  process taking place. However, because we know that participants'
  cooperation is needed for hypnosis, it makes sense to add that both
  acceptance and resistance to incorporate this material are possible
  outcomes in those states of suggestibility closer to the normal range of
  consciousness states, as in the therapeutic situation.

The issue of participants' cooperation is linked to the question explored next, that is, individuals' margin of freedom to accept or resist incorporating another's traumatic material. In this next section, I have tried to combine some Buddhist teachings about the mind with what research says about suggestibility. By combining these two theoretical frameworks, I attempted to gather support for the three propositions presented above and to present a more detailed explanatory framework for the way the "contagion" of symptoms might operate between clients and therapists.

The Therapist:
A Willing Participant in a Process of Self-Suggestion?

It is useful at this point to review Buddhist's teachings on mental states. According to these, neither mental states nor feelings have independent existence, that is, they depend on phenomena which allow their arising and determine their course. This is called the "teaching on dependent origination" or theories of conditioning (Brazier, 1995). These theories do not imply determinism however: individuals have free will. Yet, it is claimed, free will is difficult to exercise without a significant degree of mindfulness. The paradox of the Buddhist position points to the notion that most of us are vulnerable to fall prey to our own mental automatisms while having the potential to set ourselves free. The key to our freedom from self-generated suffering appears to be found in understanding our own mental conditioning experientially. According to Buddhist theory, we maintain our conditioning by feeding it (theory of food relation). In the way a fire is fed by twigs and wind, we feed the kleshas of greed, delusion and hate, but do not

recognize it. In the end, claims Buddhism, the problem appears to be our ignorance about these processes (Brazier, 1995).

I believe that there are links between these Buddhist ideas and the material on suggestibility. Individual responses to suggestion do not, as previously argued, happen against an individual's will (although they may "feel" involuntary to the participant). These states of consciousness can be seen as forms of mental conditioning in the Buddhist sense of the term. Buddhist theories appear compatible with the idea that CF/VT symptoms might depend on mechanisms of self-suggestion, with full (although non-conscious) participation of the therapist. Several Buddhist theories seem to give support to this hypothesis.

Buddhism and Mental Conditioning

Two Buddhist ideas are particularly relevant to the present topic: The theory of object relations and the theory of association. The theory of object relations states, that "all mental states are conditioned by the objects, real or unreal, which hold their attention. Mind is that which cognizes objects. As the object is, so will be the mind which clings to it" (Brazier, 1995, p. 95).

The theory of association, on the other hand, states that "each mental impulse is conditioned by those which immediately precede it" and also, that "when we experience a sequence of impulses repeatedly, a track gets worn in our mind, like a path across a field... Association theory studies how each impulse stimulates something related to itself in the next thought moment" (Brazier, 1995, p. 112).

The Buddhist theory of object relations suggests that, through focused attention and absorption, the client's worldview, emotions, and traumatic imagery might be internalized by the therapist and consequently "shape" the helper's own inner emotional and cognitive space. This idea is very close to the concept of absorption as developed by Tellegen and Atkinson (1974). It seems to me likely that, in the process of being incorporated and "owned", the client's traumatic material acquires greater power, and that its momentum becomes self-sustaining. This can in turn be understood through the Buddhist theory of association: In the process of incorporation of the elements of trauma, clients' traumatic material goes first through the therapist personal "filters" (the Buddhist skandhas or ego aggregates). What is originally foreign to therapists (clients' traumatic experiences) may then become associated with whatever similar or related thought or feeling is already there (e.g., a therapists' previous traumatic experience, specific fears or judgments about violent offenders). One connection leading to another, therapists' inner space may feel increasingly constricted. Their inner spaciousness, necessary to attend to the clients and make room for their concerns, becomes crowded.

This inner space could metaphorically be compared to the Indian mythological "Indra's net"[3] (Brazier, 1995), a universe of tightly connected knots (thoughts or feelings that arise and become consolidated) where any movement (or activation) at one level affects all others. Unresolved personal experience with trauma probably increases

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[3]   In Indian mythology, Indra is the god creator of the universe. That is also a metaphor for the mind where conditioning gives rise to mental phenomena at the origin of our suffering and our sense of powerlessness (Brazier, 1995).

vulnerability to these mechanisms, as we become easily persuaded by that which fits

what we already take for a blueprint of reality. The theory of association and its concept

of connected impulses and mental tracks suggests indeed that that is a possibility. The

notion of mental tracks (and their possible underlying neurological substratum) appear

relevant to the understanding of the development of CF and VT symptomatology:

Through repetition of the same ritualized therapeutic procedures and repeated encounters

with similarly traumatized clients, several mental tracks could be created and reinforced

in the therapist (as one mental impulse activates and shapes the next one). In the absence

of awareness about these mechanisms, these mental tracks could stabilize the perceptual

shift that leads to dramatic changes in the therapist sense of well-being.

Mutual Hypnosis?

Eleven papers have been published on mutual hypnosis, according to Gleason,

(1992); these articles develop connections between experiments on mutual hypnosis and

empathy, creativity and emotional healing. Mutual guided imagery and simultaneous

inductions are used by the participants to induce altered states of consciousness in both

individuals at the same time. It is interesting to note that high levels of empathy, shared

fantasies and emotions come to characterize the relationship between the "couples"

functioning as partners in the experiments. The author points to possible therapeutic

applications and positive therapeutic results (Gleason, 1992). What seems relevant to the

topic of this chapter is: (a) the concept of a "shared altered state" between two

individuals, focused on each other and sharing images and a narrative as well as the

vividness of the sensory experiences being evoked. Equally meaningful, this study mentions (b) that interpersonal dynamics were strongly affected, as the participants rapidly developed an intimacy and guarded their world against the involvement of the researcher and another friend who was present. A degree of empathy developed in which experiences were shared with hardly a word said (Gleason, 1992, p.2).

The results of studies on mutual hypnosis could inform research on therapist suggestibility by exploring how the intimate context of therapy coupled with exposure to and shared vivid imagery could lead to phenomena such CF and VT which have been said to be close to what is known as "folie a deux", "couvade" or "copathy" (Figley, 1995).

Finally, if it was confirmed that high suggestibility in trauma therapists presenting CF/VT was indeed a vulnerability factor, the use of hypnosis or guided imagery could probably be thought of as an useful method to "undo" the processes leading to trauma through the manipulation of the same kind of processes which led to trauma in the first place. It seems clear however that in view of Buddhist theory, this would merely mean to exchange one type of conditioning by another. Although these techniques could be a source of relief, it does not necessarily teach individuals to observe their own conditioning processes, to stand back from them and learn to identify them. In the long term, the literature on Buddhism suggests that mindfulness training—as a preventive therapy—could sustain greater resiliency as well as deeper and more permanent states of equanimity in the face of stress. Perhaps a combination of hypnosis, mindfulness training and any other appropriate therapeutic treatment would together hold the promise to

empower the individuals to get back the control on their own mind processes and emotions robbed by disorders such as CF and VT.

As a conclusion, it is useful to indicate some possible limitations to the research and ideas presented in this chapter. The material on hypnosis offers interesting insights and seems helpful to better understand the process of "contagion". It is however difficult to offer a simple definition of what hypnosis constitutes. Hypnosis is defined differently according to the theoretical view of the writer. The nature of hypnosis, its mechanisms and whether hypnosis even exists are therefore the objects of ongoing controversy. For these reasons, I chose to de-emphasize the topic of hypnosis and hypnotic susceptibility, in favor of using the concept of suggestibility which appears to offer more flexibility and also seemed useful in the context of the present discussion. It is worth noting that suggestion was, for Bernheim, a sufficient explanation for the effects of hypnosis and he regarded suggestion as the main mechanism at the basis of hypnosis (Orne, 1977). This way of understanding hypnosis is in agreement with part of the contemporary literature on the topic (Farthing, 1992).

Summary

In light of Buddhist teachings as well as the literature on hypnosis and suggestibility, I attempted to offer three propositions which could represent the beginning of an explanation of the "contagion" phenomenon. First, I suggested that traumatized therapists might be among those who are highly responsive to suggestion and demonstrate high capacity for absorption and imagery ability. Second, high ability for

absorption and imagery combined to high suggestibility in the helper could represent an

"entrance point" for unconscious exchange of information between client and therapist;

this might impact the helper's subjective sense of self (the helper's self "feels" altered).

Third, the unconscious exchange of traumatic material and its incorporation by the helper

might be related to helper's greater vulnerability to CF or VT and explain what has been

called the "contagion" of the symptoms of trauma in the literature. These propositions are

conceptually derived and in need of empirical research. Until then, they represent a

possible theoretical framework to understand an intriguing and yet little explored

phenomenon in the traumatology field.

CHAPTER 6:
CONCLUSION

The principal issues examined in this thesis could be summarized as follows: First, how can we make sense of the symptoms of CF and VT? And second, what is the phenomenon of "contagion" of trauma symptoms about? A more basic issue underlies these two questions: what is the art of healing about and what does it mean for the therapist (personally and professionally) to mediate healing?

In Chapter 2, several psychodynamic concepts are proposed in order to better understand the healing function. Specific therapist/client dynamics are mentioned which could account for the deterioration of the therapeutic relationship (and therapists' eventual impairment).

Chapters 2 to 5 emphasize very different theoretical concepts; each chapter contributes specifically to the understanding of CF and VT and provides tentative answers to the questions mentioned above. The approach in Chapter 3 was very specific, that is, CF and VT were studied from the point of view of Contextual Therapy. In Chapter 4, Buddhist psychology and its teachings about cognition and the nature of emotions offer general conceptual tools to understand the nature of some of the mental processes possibly at the basis of CF and VT. In Chapter 5, the issue of "contagion" of symptoms is analyzed in greater detail and connected to the notion of suggestibility.

The specific contributions of each chapter have been highlighted previously and

comparisons between concepts belonging to different chapters have been offered. The

main goal of this thesis was to explore different approaches and to compare them to some

extent, rather than to try to integrate them. Yet, at this point, I found useful to attempt

some form of integration of the three conceptual frameworks presented previously. This

integration is meant to remain tentative however, open to further analysis in a future

study.

Non-Conscious Mental Processes

The models proposed in Chapters 2, 3 and 4 account for intrapersonal as well as

interpersonal (or systemic) processes. Among these processes, several are thought to be

unconscious or not totally conscious, that is, rooted in individuals' unawareness of their

own motivations, or incomplete understanding of their own mental mechanisms. I also

argued that the notion of non-conscious mental processes was not necessarily

incompatible with the notion of free will and personal responsibility. I therefore rejected

the notion of "victimization" through counselling activities as inadequate and improper to

assist therapists to gain deeper insight into the workings of their own minds and how

these impact their personal lives and counselling practice.

Other/Self Directed Motivations: A Conflict

In the models proposed in Chapters 2 and 3, exposure to clients' narratives of

trauma, imagery and/or re-enactments of traumatic events, leads helpers to experience an

intrapsychic conflict: Therapists' desire to extend empathy and relieve clients' pain (an "other-directed" motivation) coexists, at some point, with therapists' activation of their own unresolved emotional wounding or the fear of not measuring up to the task at hand (achieve successful clients' therapy). These contradictory and difficult feelings may tend to distract therapists' attention from clients' needs and lead helpers to focus on protecting the self against what is perceived as a threat (elements in clients' narratives that trigger unresolved inner trauma or conflict). I propose to describe this tendency as a "self-directed" motivation (the focus is on self).

Therapists' Struggle

What is perceived by therapists as a "threat" to their well-being or feelings of competence is described differently in the models proposed in Chapters 2 and 3. The nature of therapists' inner struggle however is similar: That which threatens helpers' peace of mind or reawakens unresolved pain represents material which is difficult to acknowledge, accept and integrate. The negative perceptions of self, others, the world or the reawakening of an old history of trauma are difficult to handle in therapeutic ways and may overpower the helper. When this happens, the denied or repressed vulnerable aspects of self can be projected onto the client (a destructive "other-directed" impulse) or turned against the self as in the case of the helper adopting the "martyr's role" (a destructive "self-directed" impulse). In both cases, helpers' focus turns inwards to try to maintain a sense of balance and protect a positive self-concept which does not include a history of personal trauma, old fears or feelings of incompetence and disloyalty.

Therapists' Challenge

Trauma therapists who are aware of the risk of compromising clients' therapy outcome and to suffer personal and professional impairment are faced with some important tasks. These could be summarized as developing higher levels of mindedness (if we choose to use Buddhist vocabulary). In other terms, it seems important that helpers become impartial, non-judgmental and compassionate self-observers. It seems also essential that they gather enough courage to face whatever feelings or thoughts they find in themselves, to tolerate, get acquainted with and integrate those aspects which cause pain, discomfort or shame. It is also useful that they develop compassion towards these aspects in themselves they would prefer to ignore, strengthen their potential for self-healing and resiliency, that they "own" these shadowy aspects of themselves (in Jungian terms) and give them "a voice" without identifying with them. A good comprehension of how systems dynamics may impact the professional is an important adjunct, raising the level of awareness from the level of self to the level of collective functioning and group dynamics.

The Real Threat?

In each model proposed, including the "Suffering Servant", therapists' perception of self and therapeutic use of self are very important. I argue that a self in need of protection, partly split-off, cannot be a useful therapeutic tool. Preoccupation with self in response to environmental pressure coupled with lack of self-awareness (and the reactivity these may involve) seem to open the possibility that the dynamics at play in the

dual relationship (therapist/client) or in the counselling system, lead helpers to unproductive and distorted perceptions and interactions. These obstacles also appear to make it difficult to mediate self/others healing and to block the ability to extend genuine compassion to clients. Impartial self-appraisal, compassionate self—acceptance and healing appear to be a priority for helpers who want to avoid compassion depletion, a possible result of helpers gradually greater focus on their wounded selves and their desperate attempts to cover or deny it. Real compassion (for self and others) and relational ethics seem to develop naturally from helpers' efforts to develop wholeness and greater honesty and intimacy with themselves.

Contagion of Symptoms?

The issue of "transmission" or "contagion" of symptoms in Chapters 3 and 5 was discussed in very different ways. In both chapters however, that same topic is addressed by considering the effect of interactions between personal characteristics and situational and interpersonal (or systemic) factors. In Chapter 3, for example, it is proposed that a therapist might adopt the "martyr's role" and attempt to repair a wounded vision of self as a disloyal, incompetent helper, by developing symptoms similar to his or her clients'. Through their suffering, helpers' feelings of guilt could find a measure of relief and their need to appear loyal to the counselling system be thereby indirectly satisfied.

In Chapter 5, "contagion" of symptoms is explained through concepts such as hypnotic susceptibility, ability for absorption and vivid imagery. It is also proposed that trauma therapists who demonstrate these attributes might, through the sharing of intimate

vivid imagery and emotions in therapy, incorporate elements of clients' traumatic

material in non-conscious ways. This incorporation might lead to the helper's sense of an

"altered" self. A key concept in Chapter 5 is suggestion or, more specifically, self-

suggestion; when combined to the Buddhist concept of the skandhas, self-suggestion

appears to be a useful concept adding tools to the understanding of possible mechanisms

at the basis of what has been called "contagion" of symptoms in CF and VT. From a

Buddhist point of view, the "contagion" of symptoms could be categorized as located on

the "self/other" dimension (confusion of boundaries), under the influence of the bitter

root of "delusion" (see table 2).

Although the explanations for "contagion" seem very different in Chapters 3 and

5, common ground can be found in the way the helper's sense of self and its familiar

boundaries appear to dissolve under stress and to allow the incorporation of elements that

are aliens to the helper's own experience (the client's traumatic stress and his/her

perceptual shifts about self, others and the world). Over-identification with clients'

profound changes at the cognitive and emotional levels seems to coexist in these

disorders with deep feelings of disconnection, isolation and increasing inability to extend

compassion to the client. This can be seen as extreme moves on a same dimension where

the boundaries between self and others are alternatively dissolved and rigidified.

In summary, what is perceived as a threat, as previously noted, may gradually

tend to increase helpers' focus on self, in order to regain the lost familiar sense of balance

and inner comfort in the role of healer and fulfill healers' own expectations about

themselves. This reactive preoccupation with self precludes neutral, non-judgmental

observation of the processes at play and increases the levels of stress. At some point, the exacerbation of this painful focus on self appears to lead to patterns of partial dissolution and/or rigidification of the self boundaries, allowing what looks as a "contagion" taking place between therapist and client.

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APPENDIX:
THE SUFFERING SERVANT

The "Suffering Servant" is the name given to a passage from the Hebrew Prophets (Isaiah 53) written over 700 years before Jesus was born. It describes the sufferings of a humble man stricken by God in order to redeem humanity's transgressions and to save and heal humankind. The prophetic text adds that the Suffering Servant has accepted this role and will consequently be greatly rewarded. Christianity understands this text as referring prophetically to Jesus' mission of salvation. Many modern rabbis understand this text as referring to the Messiah to come and his sufferings.

The description of the Suffering Servant provided by Isaiah strikingly fits the wounded-healer metaphor; it also evokes the suffering of therapists affected by CF or VT who readily put themselves in harm's way in order to bring compassion and healing to their traumatized clients. The "martyr's role" or "willing victimization" concepts, as understood in Contextual Therapy, resonate with this prophetic text as well: Like the Suffering Servant, individuals playing the "martyr's role" acquire merit through their suffering, and "rebalance" the accounts of justice in the system by "taking on" the suffering of another.

For these reasons, the "Suffering Servant" seemed to be an adequate metaphor applicable, in the context of the proposed model (Chapter 3), to the therapist who has developed CF or VT. Part of the "Suffering Servant" translation can be found next (*The World English Bible*, the Hebrew Names version).

The Suffering Servant: Isaiah 53

53:3   He was despised, and rejected by men; a man of suffering, and acquainted with disease. He was despised as one from whom men hide their face; and we didn't respect him.

53:4   Surely he has borne our sickness, and carried our suffering; yet we considered him plagued, struck by God, and afflicted.

53:5   But he was pierced for our transgressions. He was crushed for our iniquities. The punishment that brought our peace was on him; and by his wounds we are healed.

53:6   All we like sheep have gone astray. Everyone has turned to his own way; and the LORD has laid on him the iniquity of us all.

53:7   He was oppressed, yet when he was afflicted he didn't open his mouth. As a lamb that is led to the slaughter, and as a sheep that before its shearers is mute, so he didn't open his mouth.

53:8   He was taken away by oppression and judgment; and as for his generation, who considered that he was cut off out of the land of the living and stricken for the disobedience of my people?

53:9   They made his grave with the wicked, and with a rich man in his death; although he had done no violence, neither was any deceit in his mouth.

53:10   Yet it pleased the LORD to bruise him. He has caused him to suffer. When you make his soul an offering for sin, he shall see his seed. He shall prolong his days, and the pleasure of the LORD shall prosper in his hand.

53:11   After the suffering of his soul, he will see the light and be satisfied. My righteous servant will justify many by the knowledge of himself; and he will bear their iniquities.

53:12   Therefore will I divide him a portion with the great, and he shall divide the spoil with the strong; because he poured out his soul to death, and was numbered with the transgressors; yet he bore the sin of many, and made intercession for the transgressors.