TENDER IN THE FIELD: A HERMENEUTIC INQUIRY OF PSYCHODYNAMICS WITHIN COMPASSION FATIGUE

A dissertation submitted

by

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to

PACIFICA GRADUATE INSTITUTE

in partial fulfillment of
the requirements for the
degree of

DOCTOR OF PHILOSOPHY

in

CLINICAL PSYCHOLOGY

with emphasis in

DEPTH PSYCHOLOGY

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MARCH 11, 2015

Abstract

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The purpose of this inquiry was to develop an understanding of psychodynamic perspectives, which would serve as a lens for the conceptualization of clinician compassion fatigue. A Gadamerian hermeneutic methodology provided the process, which also paralleled a psychoanalytic psychological stance. A theoretical description of the psychodynamic nature of the experience of the clinician in terms of self and other in the clinical moment emerged through several themes, which referenced the expanded understanding of compassion fatigue. The results offer a new view of psychodynamic psychology with application to the phenomenon of compassion fatigue.

The intersubjective field was investigated through select depth psychological, nursing, medical, and philosophical textual analyses, which revealed implications of the therapist's subjectivity, empathy, the therapeutic relationship and presence, compassion, countertransference phenomena, and the analytic field. The hermeneutic nature of this qualitative study concurrently brought the lived experience into the process, which both enriched the process itself and ultimately the findings. The rationale for the inquiry included contributing to the development of psychological theory on the psychodynamic nature of compassion fatigue, in particular with clinical relevance to those treating the

traumatized or otherwise suffering, and supporting the development and sustainability of a cadre of clinical providers in the field individually, in the nation, or globally.

Implications of conceptual understanding of psychodynamic processes were illustrated in clinical practice and organizational systems. Suggestions for systems policy development extended the findings to the organizational field. Recommendations for areas of further research including methodological considerations were delineated.

Key words: analytic field, compassion, compassion fatigue, countertransference, empathy, intersubjective, embodied presence, psychodynamic, vicarious traumatization

Dedication

To my Beloved Community

who through their generous, loving, and spirited intentions,

have summoned me to this work.

I honor your voices and hold deep gratitude for the emergent beauty of compassion

forever imprinted in my heart.

My husband Jim and children Tai and Caleb

Family past present near and far

Friends, especially Dr. Lauren Barrett, Dr. Linda O'Dell, and Stephanie Bath,

The *Geist* of the Three Graces of Beverly Green Drive

Pacifica faculty, staff, and cohort "O"

The Wright Institute: faculty, clinical supervisors, interns, & fellows

Patients who have courageously shared their life stories

and colleagues who walk the talk of thoughtful caring

The many authors who communed with me along the hermeneutic way

~

My Chair, Dr. Yakushko, for supporting my process toward an authentic scholarly voice,

for her steady encouragement, and her presence in socially attuned research that matters

My reader, Dr. Lewis, for her deep understanding of psychodynamic thought, inspiring

writing, and abiding support

My external reader, Dr. M. Watson, for holding a sacred and loving space for this work

and developing theory and practice of human caring across the globe

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The style used throughout the dissertation is in accordance with the *Publication manual of the American Psychological Association* (6th Edition, 2009), and *Pacifica Graduate Institute's Dissertation Handbook* (2014-2015).

Chapter 1
Introduction

Purpose Statement

The past few decades have witnessed a plethora of efforts to understand the etiology, experience, and treatment of the phenomena of trauma and the suffering of humankind. Although there has been a profusion of research focused on treating patients, including those traumatized, relatively less attention has been given to the experience of clinicians who tend to the traumatized and others who are suffering from complex psychological concerns.

Tyler (2012) suggested that a slowly growing body of scholarly literature on traumatic stress has begun to emerge. The phenomenon known as compassion fatigue, also known as secondary traumatic stress, vicarious traumatization, burnout, and empathy fatigue, has been studied primarily in terms of symptoms and their amelioration. Despite acknowledgement of the phenomenon, vulnerability persists. The potential implications of compassion fatigue for the inner lives of clinicians well beyond what transpires in the interaction with the individual could provide a fertile focus of attention for prevention of compassion fatigue. Although the focus of the scholarly literature has been primarily on the aforementioned alleviation of symptoms, there are important aspects of the phenomenon that can be conceptualized in terms of what transpires in the relationship between self (i.e., clinician) and other (i.e., patient), within the clinician's inner world, and in the field in between the two. The vast body of psychoanalytic depth psychological scholarly literature has been notably absent or deficient in the literature on compassion fatigue and can best serve the inquiry in conceptualization of the phenomenon. This inquiry proposed that the interface of psychodynamic literature with the field of

compassion fatigue would provide multiple theoretical lenses and rich depth of psychological detail about the phenomenon to better serve subsequent understanding.

This interpretive inquiry proposed that theoretical development of compassion fatigue has potential implications for clinician's endurance in clinical work, and offers a greater ability to understand one's inner life in response to other. The hope of the research was that gaining greater access to what transpires between self and other will impact well beyond what transpires in the interaction, extending into the skills and inner life of the clinician, into the improvement of patient care, and ripple into the work environment to contribute to the sustained viability of a skilled workforce to meet the needs of the traumatized and suffering. Given the critical need for clinicians who are trained and available to meet the needs of a plethora of psychological conditions, including trauma, Figley and colleagues (1995b, 2002a) and McCann and Pearlman (1990) have recommended exploration of the concept of compassion fatigue.

Although compassion is recognized as essential to mature human interaction, both clinician compassion and especially compassion fatigue have not been extensively studied. The purpose of this interpretive inquiry was to inform an understanding of compassion fatigue through psychodynamic psychological perspectives. Particular interests of this study included an analysis of what transpires within the interaction of self and other in the clinical situation, and an interpretation of the interface between psychoanalytic thought and clinician compassion fatigue. The intention was to extend psychological theoretical knowledge through a hermeneutic process of inquiry and draw from the legacy of psychoanalytic scholarly work in the conceptualization of compassion

fatigue. It was anticipated that this would serve the critical need for clinicians' awareness and skills that may avert symptoms of compassion fatigue for those who provide care for the traumatized or otherwise suffering.

Statement of the Problem

Compassion fatigue has been considered by Figley (2002b) as a natural consequence of the helping of individuals who are suffering. The clinician's level of empathic engagement has been suggested as a vulnerable pathway toward vulnerability for compassion fatigue (Decety & Jackson, 2004; Figley, 2002b; Rothschild, 2006). Despite this assumption, there have been few studies supporting the linkage between empathy and secondary trauma (Badger, Royse, & Craig, 2008).

Over the last three decades clinicians and researchers (Figley, 1995a; Raphael, Singh, Bradbury, & Lambert, 1983) have provided important contributions to highlighting the impact of traumatic stress on individuals, including patients. Whereas prior studies focused on variables that influence stress, less attention has been given to impact on clinicians who bear witness to trauma or tend to deeply troubled or otherwise suffering individuals. Despite the widespread need for conceptualizing such impact, the emphasis on clinicians had barely begun by the start of the 21st century, according to Fox (2003), nor had researchers focused extensively on the influence of workplace environment on those working with the traumatized (Harrison & Westwood, 2009).

Though early studies (e.g., Dunning & Silva, 1980; Everstine & Everstine, 1993) began to explore clinicians' vulnerability upon exposure to complex,

difficult, or traumatized patients, later, Steed and Bicknell (2001) emphasized a new shift in recognition of a ripple effect of trauma. Subsequently, terror attacks, particularly those of September 11th, increased attention to the deleterious and contagious effects of trauma and in particular trauma on caregivers (Eidelson, D'Alessio, & Eidelson, 2003). Clinical and theoretical studies suggested that health care providers, particularly those who provide care in mental health and disaster relief (Adams, Boscarino, & Figley, 2006), are among those most vulnerable to what Ohaeri (2003) identified as the "caregiver burden" (p. 457). Additional studies have been directed to the emotional impact on caregivers, such as child-protection workers, nurses, firefighters, and physicians (Figley, 1995a, 1995b).

Further research (Sabin-Farrell & Turpin, 2003) suggested that direct patient care, particularly in psychotherapy with complexly traumatized patients, impacts the clinician with resulting compassion fatigue. Clinicians of all approaches are exposed to those traumatized, but psychotherapists in particular may be repeatedly subjected to descriptions of traumatic experiences by patients who otherwise would not express the details of their stories. The vicarious impact of such exposure has only recently begun to be investigated (Stamm, 2009).

Interest in compassion fatigue has been heightened in during the past several decades, with the advent of globalization through the media, which provides instantaneous pictures of and commentary on a myriad of tragic events, such as natural disasters, wars, assaults, and global terroristic activities. As previously addressed, whereas the research identifies caregiver burden and

compassion fatigue with those proximal to tending to the traumatized, the burden is likely extended to the general population due to vulnerability to impressions from the media.

The importance of a viable workforce in health care, disaster relief, mental health care, and with the military and veteran population, has been delineated by a number of national level expert reports. Increased exposure to a population that has been traumatized has implications for the critical needs of the workforce as suggested by reports as follows. According to the Department of Defense Task Force on Mental Health (2007), there has been an increase in the suicide rate by 26% of 18-29 year old returnees in the years of 2005-2007. Tanielian and Jacox (2008), in a 500-page report, highlighted the complexities of the multiple psychopathologies in military combat veterans, such as the 300,000 or 20% of returnees from Iraq or Afghanistan who suffer from posttraumatic stress disorder, depression, and substance use disorder. The Department of Defense (2007) further indicated that at least 22 percent of veterans seek care outside system, often due to inaccessibility to VA care, and that there is no provision to assure appropriate skills or support for the community providers.

The compassion-fatigued clinician may be preoccupied with such individual and collective traumas of patients (Figley, 1995a, 1995b). The prevalence of individuals who have been diagnosed with posttraumatic stress disorder has been reported to be from 1-2% to upwards of 30% (Breslau, Davis, Andreski, & Peterson, 1991; Briere & Elliot, 2000; Duckworth, 1986), and suggests the extent of exposure of clinicians to vicarious trauma exposure.

Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) provided data through the National Comorbidity Survey, in which 51.2% of women and 60.7 % of men in the general population experienced at least one from a wide range of traumatic events in their lifespan. These events included experiences that were life threatening, including natural disasters, accidents, childhood abuse, and combat trauma. The clinician who daily bears witness to those suffering or otherwise traumatized, and given the increased numbers of traumatized individuals, along with global traumatic events may permeate the clinicians everyday practice.

The result can be increased vulnerability to vicarious traumatization and compassion fatigue with troves of expert clinicians leaving the profession due to professional burnout (Rothschild, 2006). Given that repeated exposure of the media to global trauma is common, it can be argued that there will be an increase in the prevalence of trauma and hence exposure to clinicians to more of the traumatized. According to Stamm (1995, 2009), the clinicians may experience compassion fatigue that mimics symptoms of those they care for, including emotional numbing, anhedonia, and pervasive anxiety. This experience can further diminish competency and self-perspective both professionally and personally.

Compassion fatigue and caregiver burnout have been correlated with clinician recruitment and retention, patient safety, and patient satisfaction (Halbesleben, Wakefield, Wakefield, & Cooper, 2008). These trends were exemplified in Halbesleben and colleagues' study of 800 nurses and 600 patients, which found that units in which the patients were cared for by exhausted nurses

who wanted to resign experienced less satisfaction with the care provided. Friese (2005) studied oncology nurses in a Magnet hospital who, although they worked in highly stressed units in oncology, had less emotional exhaustion. Friese surmised that this was due to the highly reputable hospital, which prided itself on strongly supportive work environments for nurses. Studies such as these (Friese, 2005; Halbesleben et al., 2008) suggest that although the work of caring for complex and traumatized individuals is stressful, the work environment may be in a position to lessen that stress through a supportive systems perspective.

Organizational culture and conditions have also been implicated in impairing clinicians relative to stress in studies of other nurses (Carson, Leary, DeVilliers, Fagin, & Radmall, 1995; Fagin, Brown, Bartlett, Leary, & Carson, 1995; Onyett, Pillinger, & Muijen, 1997). Kurtz (2005), in a review of clinical work with patients with severe characterological disorders, argued for the importance of maintaining an experienced, stable, and viable clinical workforce in the design of fully functioning psychiatric wards. Davis (1991) suggested that an environment of care in which there is a sense of safety helps to foster quality of care. Adshead (2002) posited that a health care environment that promotes safety and security can emulate attachment theory's secure base, from which both clinicians and patients can proceed with minimized stress reactions.

The research of Cunningham (2003), Dunkley and Whelan (2006), Figley (1995a), and Osborn (2004) suggested particular risk factors for secondary traumatic stress, such as large caseload and personal history of trauma as well as mitigating factors such as clinical supervision and support. However, the literature on compassion fatigue

had not focused on what transpires in the therapeutic interaction and relationship that may fuel or mitigate compassion fatigue. The rise in the numbers of individuals, both civilian and military, who are traumatized and who suffer complex multiple difficult problems, contributes to the heightened risk involved in due to the expansion of complex caseloads. Therefore the factors for compassion fatigue will likely rise, while the workforce remains ignorant of the psychodynamic perspectives that could mitigate the risk factors, which is an inherent purpose of this study.

Relevance to Clinical Psychology

Concentration camp survivor and psychoanalytically trained psychiatrist Frankl (1984) emphasized the importance of attention to and understanding of what transpires within clinicians who treat the traumatized in order to sustain their important work. This study proposed attention to depth and psychodynamic phenomena, such as transference, the intersubjective field, therapeutic presence, intersubjectivity and the analytic third, may not only reduce the risk of compassion fatigue but also enhance a sense of what Csikszentimihalyi (1990) identified as flow in the clinical situation.

Psychological theory developed from a focus on the intrapsychic toward a more relational or intersubjective interest. In the beginnings of exploration of the analytic field between the clinician and patient, the discourse on possible influences of the interactive transferential field emerged (Ferro & Basile, 2009a, 2009b; Freud, 1912/1945; Langs, 1979; Sullivan 1953; Winnicott, 1986). This transformational space has been referred to by the social anthropologist Turner (1987) as a transitional liminal "betwixt and between" (p. 1) space, and by Ferro and Basile (2009a), Neri (2009), and Vermote (2009) as the

analytic field, or by Ogden (2009) as the analytic third. This hermeneutic inquiry proposed that accessibility to this analytic space can provide the clinician and researcher enriched ways to consider the development of compassion fatigue.

Psychoanalyst Greenson (1967) posited that the healthy psychotherapist balances clinical work through being an "involved empathizer, the detached sorter and understander of data, and the restrained but compassionate transmitter of insight and interpretations" (p. 280). Self-psychologist Kohut (1984) described the process of empathy as the facility "to think and feel oneself into the inner life of another person" (p. 2). When encountering compassion fatigue, there may be great difficulty with maintaining therapeutic presence due to the stress reaction that parallels symptoms in the patient such as blunting of emotions, anxiety, hypervigilance, depression, and intrusive thoughts that may occur as a consequence of working closely and bearing witness to patients who have troubling traumatic stress or other difficult experiences. Furthermore, unique demands of the profession, as exemplified through Buechler's (2012) discussion on the inability to process loss due to professional requirements of confidentiality, may establish fertile ground for the development of compassion fatigue.

Few researchers or clinicians have examined the legacy of scholarly psychoanalytic literature in relationship to compassion fatigue. Rothschild (2006) particularly identified the "emotional reverberations" (p. 15) that impinge on clinicians and foster vicarious experience of trauma. Ragen (2009), in her book, *The Consulting Room And Beyond: Psychoanalytic Work And Its Reverberations In The Analyst's Life*, thoughtfully explored the nature of therapeutic work that bears on the subjective experiences of the clinician. Freud (1922/1949) called this contagion, and stated:

> Something exists in us which, when we become aware of signs of an emotion in someone else, tends to make us fall into the same emotion; but how often do we not successfully oppose it, resist the emotion, and react in quite an opposite way? Why, therefore, do we invariably give way to this contagion? (p. 35)

Emotional contagion was later described more extensively by Hatfield, Cacioppo, and Rapson (1994) and by Diamond (1996) as psychological infestation. Several researchers have explored the implications of emotional contagion through the construct of countertransference, and through psychoanalytic perspectives in vicarious traumatization (Pearlman & Saakvitne, 1995a, 1995b; Rothschild, 2006). Theorists such as Figley and colleagues (1995a, 2002b) have tied psychoanalytic perspectives such as transference to their perspectives on compassion fatigue; however, they drew from secondary sources and provided incomplete conceptualization of phenomena such as countertransference.

In this dissertation I hope to develop a conceptual understanding of compassion and its fatigue, with a focus on trauma through interpretive inquiry. The dissertation explored the psychodynamic dimensions of compassion fatigue that can contribute to an in-depth understanding of the concept. The preliminary findings from the literature review identified an inherent impulse from the psyche that is activated during the process of the intersubjective work of the clinician, which calls forth compassion. Further, the intersubjective field, including holding the place for compassion and healing presence, operates to inform clinician consciousness, at times through discomfort.

The critical need for this research is considered to be relevant to clinicians of all theoretical orientations, including psychotherapists, to understand that

working with trauma is a part of the human condition—a part that, despite its negative experiences, can also serve a deeply psychological transformation. The research approach is hermeneutic, characterized by a philosophical perspective of the holistic nature of the human condition. The dissertation developed a psychological theory that was informed by general psychological and psychoanalytic constructs on compassion fatigue, compassion, empathy, and relationship, with an exploration of emergent associations that support understanding of compassion fatigue as a uniquely individualized response to what transpires between self and other. I hope that that this further conceptualization of compassion fatigue can open the possibility of not only informing to mitigate the problem and symptoms, but to harness new energy for the clinical work through transformation of the approach of clinicians. This contribution can serve as a means for generating the momentum for renewed joy in the work, which further supports ongoing compassion rather than compassion fatigue.

Researcher's Interest in the Topic

Psychoanalyst Buechler (2012) discussed the personal impact of being involved in the clinical practice over a long period of time. The effects of a sense of loss with clients because of attrition or more troubling circumstances, and bearing witness closely to patients' suffering, including traumatic narratives, may contribute to such a personal experience. As Aronson (2009) discussed, therapists may lose a bit of themselves when they lose a patient by whatever means. The switching of gears with patients, from the most recalcitrant to the most aggressive

or hostile and demanding, can also lead to disequilibrium in the work. Furthermore, the ethical responsibility to maintain confidentiality, although vital to the professional work, limits the ways the clinician can manage the emotional consequences of such work, the exception being in one's own psychotherapy or analysis and clinical supervision.

The belief appears to persist that to maintain boundaries, the clinician must maintain neutrality, which Buechler (2004, 2008) suggested is impossible. What is required and helpful is to be "aware of how my psyche functions. I have to face my psychological limitations for the sake of my work, not just for the sake of m own personal growth" (Buechler, 2012, p. xiii). Buechler asked about the meaning and the effect on clinicians who are emotionally and psychically available to the distress and suffering of others. She also highlighted the impact on clinicians who lease out their psyche daily, including the impact of having to defer in considering their own needs repetitively so as to be available to others. Buechler addressed ways to manage these challenges, through listening with deep concentration both within and hearing the patient, considering the experience wholistically, clinical supervision, psychotherapy, and appropriate training.

As Figley (2002b) stated, compassion and empathy in a caring relationship is costly, as the therapist or clinician seeks to ascertain the world of the sufferer. Compassion fatigue is the apt term to connote a reduction in capacity to care and to bear witness of suffering. Learning about this process, I became interested in the conceptualization of compassion fatigue: What if there was an integrated understanding of compassion fatigue from an informed psychoanalytic perspective? And what if in vivo

the clinician can hold and carry the patient through a situating oneself with other, perhaps through deep analytic listening, within the transferential field?

Echoing Buechler's (2012) description of her long-term practice, I too began to formulate questions long ago when first exposed to the traumatized in Kenya while serving in the Peace Corps. It was then that I conducted assessments of women and children during a severe drought, when guilt and shame dominated the families' culture to the extent that people hid children who were starving due to a belief in an evil spirit overtaking them. I saw cattle strewn across either sides of the dirt roads and quickly learned of the severe trauma that grasped on the tenuous strands of life. Thereafter I bore witness to multiple traumas replicated across the country as a result of political unrest at the borders and Idi Amin's torturous activities on the border of Uganda. Simultaneously, I experienced the juxtaposition of the strength of a people who survived due to their spiritual connection with one another in the austere poverty and environment and incessant trauma.

Further experiences included work with intergenerational trauma with the Navajo in Arizona, and work with veterans and active duty military personnel who were severely traumatized through combat, and other experiences. My work with those who have killed or perpetrated other acts of violence in combat was initially the most troublesome, until I found that their experience of trauma was similar to the experiences of those who were the recipients of trauma, and most severe in terms of their loss of meaning. Bing and Snyders (2012) characterized such work as "entering the abyss" (p. 282), an abyss where they considered the importance of their own countertransference as researchers in work with torturers.

As part of my process in doctoral training, I attended a psychoanalytically informed institute for my internship. It was there that I began to process my work with those traumatized and otherwise suffering in a way that was deeply informed through analytic process and personal transformation. I found both the theoretical constructs and the inner work within the institute provided a context and theoretical basis through which clinicians could access compassion and multilayered understanding of the human condition. This transformative experience was naturally mirrored in the subsequent clinical work in accessing a depth inquiry into my own inner process in concert with the clinical experience with other, and the intersubjective or analytic space. The discovery of an analytic context informed my way of thinking about the context and systems of care, which provided support and a holding place for the clinician to sustain the intensity of the work, and to engage in and sustain compassionate care. As Yalom (1989) stated, "we are, all of us, in this together" (p. 14).

Statement of the Research Questions

As a qualitative inquiry, this research sought to achieve understanding through interpretation of textual material on the psychodynamics of compassion fatigue. The research explored depth psychological perspectives relevant to compassion fatigue, such as transference, projective identification, and therapeutic relationship as they impact on the clinician, through a hermeneutic interpretive methodology. The hermeneutic stance provided a means to dialogue between the scholarly literature related to psychoanalytic psychology and compassion fatigue.

Therefore this interpretive study explored compassion fatigue in terms of the clinician intrapsychically and intersubjectively and offered alternative perspectives on

compassion fatigue, and ways to hold or process difficult and challenging trauma and complex suffering of other. The legacy of psychoanalytic theory provided an array of theoretical perspectives that have just begun to be explored for their relevance to conceptualization of compassion fatigue. Therefore, a hermeneutic interpretive process was the methodology, as it would provide a means of dialogue between the psychoanalytic thought and compassion fatigue.

The intention of this study was to generate rich data to gain new understanding of compassion fatigue through a hermeneutic dialogue between psychoanalytic psychological perspectives of the inner and intersubjective life of the clinician. The hope of this inquiry was to bring a deeper understanding of compassion fatigue, which can inform psychotherapeutic and clinical theory, practice, and training. The research involved the interpretation of textual material on compassion fatigue, burnout, or vicarious traumatization and psychoanalytically informed psychology, with specific psychodynamic thought on transference, projective identification, therapist relationship, and the analytic third as guided through the hermeneutic interpretive process. Further attention to streams of data was incorporated as they emerged in the hermeneutic process.

The inquiry excavated a deeper conceptualization of compassion fatigue, one that addressed what transpires between self and other in the therapeutic relationship and the emergent constellation of the experience of compassion fatigue. The interpretive inquiry engaged an understanding of compassion and its fatigue from a depth psychoanalytic perspective on what occurs in the analytic field, and explored options for reconsidering deep ways of listening within and holding the patient and experience. The purpose of this study was to fill the gap in the extant literature on compassion fatigue, and offered a way

to consider how the clinician could manage what Slochower (2014) characterized as the "timeless quality" (p. 13) of the therapeutic encounter and relationship. Compassion fatigue and its related concepts need considerable attention today. However, what has been missing is a conceptualization of what the clinician can do to prevent compassion fatigue in the ways in which he or she is engaged in and approaches the work.

The guiding focus questions included:

- What is the nature of compassion fatigue as it is informed by psychodynamic understanding of empathy and transference-countertransference in the therapeutic relationship?
- What is the nature of the analytic field, and how might this be engaged in the clinician's work to foster ways to hold or process difficult and challenging trauma and complex suffering of other? How might what transpires in the field between self and other influence compassion fatigue?

This interpretive study concluded with a discussion of the relevance of depth psychological approaches to the construction of theory on compassion fatigue. The study took a depth psychological interpretative stance to integrate the implicit unconscious, which has been overlooked in examining this topic. The implications for an integrative depth psychological interpretation of compassion fatigue were summarized relative to training, clinical practice, and systems perspectives.

Chapter 2
Literature Review

The literature review was a systematic overview of compassion fatigue and select perspectives from a psychoanalytic/psychodynamic perspective that contribute to a depth psychological hermeneutic inquiry. The complexity of the theoretical foundations of the focus of inquiry stimulated a substantial range of scholarly literature. This chapter consisted of a peripatetic survey of the literature, which laid the foundation for an exploratory interpretive dialogue between compassion fatigue with its various constellations, and the rich inheritance of depth psychological theory. The literature review arose out of the exploration of the conceptual development of compassion fatigue of clinicians and psychotherapists, in concert with pertinent constructs from psychodynamic/psychoanalytic literature. Whereas this chapter did not provide an exhaustive review of the literature, it was meant to provide a preliminary basis from which to explore the missing hermeneutic conversation between the concept of compassion fatigue, and applicable depth psychological perspectives.

The literature review was delineated into two sections. The first section reviewed compassion fatigue in regard to a number of its defining variations, such as burnout, vicarious traumatization, secondary traumatic stress, and compassion fatigue. An overview of compassion and its differentiation from empathy was elaborated as a means to contextualize the attention to the concept. The second section concerned theoretical foundations of depth psychology, which contributed to further understanding of compassion fatigue, and which have also had not been included in formulations of compassion fatigue. Depth psychological foundations, which consist of psychodynamic

and psychoanalytic perspectives, were explored in terms of their contributions to what transpires between the self/clinician and the other/patient in the analytic space. The overarching intention was to engage in discourse in terms of the psychodynamic implications for the inner world of the clinician which influences compassion fatigue. I had chosen to begin the second section of this chapter with a focus on literature from a psychoanalytic view, with an emphasis on those traditions that inform depth psychological perspectives on transference and countertransference, empathy, and therapeutic relationship/presence in the intersubjective or analytic space.

Further contributions from scholarly works were included in subsequent chapters, thus providing a means to adhere to the hermeneutic methodology of inquiry.
The two literature sections were then followed by a summary of the emergent key themes, which would then serve in the subsequent hermeneutic discourse as guided by the research questions. The intention of the literature review chapter summary was to refer to psychodynamic lenses, which were subsequently elaborated to provide a means of seeing anew compassion fatigue in this hermeneutic inquiry.

Introduction

Although psychology and health care practice in general clearly constitute a relational experience, the emphasis in clinical and psychological research has been focused on the recipients rather than providers of care. The concentration camp survivor and psychoanalytically trained clinician Victor Frankl (1984) emphasized the importance of examining the toll on caregivers tending closely to those in psychic pain, as those who "give light must endure burning" (pp. 67-68). Although the concerns for the toll of care giving has been explored for some time, only recently has there been substantial

emphasis on study in the field of traumatology, regarding the impact of this particular work has on the caregiver. Specifically, only recently there has been a development of an interest in the impact of challenging therapeutic processes on the therapist. Furthermore, this literature review suggested that the consequences of trauma work hold implications for general clinical work, which likewise has impact on clinicians from diverse fields.

Early study by Dunning and Silva (1980) in the long history of trauma inquiry suggested that there was an inherent predisposition to vulnerability to trauma symptoms after traumatic exposure constellation. Later, Everstine and Everstine (1993) argued that normal human beings are vulnerable to traumatic symptoms given exposure to trauma. Historically, minimal attention was provided to the caregivers of the traumatized (Figley, 1995a; Raphael et al., 1983). Steed and Bicknell (2001) highlighted the shift in emphasis in conceptualization from an exclusive patient concern to a phase that involved examining the ripple affect of vicarious traumatization on others, including family members, caregivers, and helping professionals. Morrissette (2004) similarly described the "notion of an emotional membrane believed to shield and protect helping professionals and significant others from the emotional effect of a traumatic event was challenged" (p. 7).

Increased attention to the contagious effects of trauma was particularly noted after the traumatic experiences of September 11th during assessment of emergency personnel by research conducted by Eidelson et al. (2003). The researchers suggested that there was a notable sense of helplessness or inadequacy amidst the overwhelming enormity of suffering witnessed and experienced.

Traumatology was defined as the social and psychobiological effects of

natural and human-made traumatic experiences, and the preventative or interventive mechanisms that emerge from trauma study (Donovan, 1991, p. 434). A number of constructs of traumatology were separated into secondary traumatic stress or compassion fatigue, vicarious traumatization, acute stress disorder, and critical incident stress (Donovan, 1991; Figley, 1995a). The psychological impact of trauma has been known by various names, including combat fatigue, shell-shock, combat neurosis, and soldier's heart, and by 1980 was formally recognized as a posttraumatic stress disorder (Shalev, Bonne, & Eth, 1996).

The contributions of Figley (1995a, 1995b), as well as Berah, Jones, and Valent (1984) energized interest in recognizing the distress found in others who are in close proximity to those traumatized and suffering. Adams, Boscarino, and Figley (2006) remarked that though trauma had been studied rigorously for several decades, few studies had targeted the population of the caring professions, a high-risk group, as empathy is a primary therapeutic emphasis. Terminology used for such distress abounds and includes traumatic countertransference (Herman, 1992), compassion fatigue/secondary stress (Figley, 1995a), vicarious traumatization (McCann & Pearlman, 1990; Baird & Kracen, 2006), workplace burnout (Maslach, 2003; Maslach & Jackson, 1982; Maslach & Schaufeh, 1993; Maslach, Schaufeh, & Leiter, 2001), and *empathy fatigue* (Stebnicki, 2008). Wilson and Thomas (2004) conceptualized compassion fatigue, secondary stress syndrome, and vicarious traumatization as "traumatoid states" (p. 143) in the context of occupational stress. The terms noted above have both similarities and differences, and the following provides additional clarification.

Compassion Fatigue

The emergent concept of compassion fatigue originated in a descriptive journal article (Joinson, 1992) on surgical nurses when Doris Chase, a veteran crisis counselor, proposed the term as a unique form of burnout within caregiving professions. She noticed that though the competent nurses had grieved loss and suffering of others under their charge, they despaired, detached, and lost an "ability to nurture" (p. 119). Although compassion fatigue appeared to be related to traumatic stress and considered a natural consequence to repeated exposure to the extreme stress and pain of others, Joinson suggested that the caregiver who empathizes and bonds with the patient is better equipped to sustain compassion. Figley (1995b) posited that listening to and imaging of traumatic material contributed to the burden on the care provider, and eventually led to compassion fatigue. Compassion fatigue was found to be associated with a deep desire to alleviate suffering, and worsened under conditions in which the clinician felt a diminished sense of control.

During the past several decades Figley and colleagues (2002b) have provided a focus on the often-neglected topic of what can occur in the caring for others, including compassion fatigue and secondary traumatization. From compassion fatigue to secondary traumatic stress and vicarious traumatization and burnout, the phenomenon has been variously termed. Stamm (1995) reviewed nearly 200 scholarly articles across various search engines and found that there was no routine term utilized. The following is an elaboration on the development of the terms, which thereby provides a direction for the utilization of specific terms for the inquiry.

Coetzee and Klopper (2010), in a theoretical study of South African nursing, posited compassion fatigue as the eminent result of unrelieved discomfort caused by an accumulative process of exposure to stress. Compassion fatigue has been defined from a composite of perspectives (Adams, Boscarino, & Figley, 2006; Coetzee & Klopper, 2010; Figley, 1995a), as a constellation of emotions and behaviors, including a diminished capacity for empathy, which results from secondary traumatic stress and occurs in relationship to engaging in helping the traumatized or those suffering. This operational definition required an understanding of implications of secondary stress and empathy. Although empathy is discussed at length in the latter section of this literature review, the following addresses a preliminary conceptualization of empathy. The noted humanistic psychologist Rogers (1980) defined empathy as the capability to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto, as if one were the person, but without ever losing the "as if" condition (pp. 140-141). Kohut (1984), a psychoanalyst who led a prominent school of analytic thought, self-psychology, described empathy as the ability "to think and feel oneself into the inner life of another person" (p. 2).

Pearlman and Caringi (2009) suggested that therapists' empathic engagement was linked to the development of vicarious traumatization. The nature of therapy as a confidential enterprise, bearing witness to intense of the traumatic narratives, and the limits of support, further accentuated vulnerability. The burdens imposed on the clinician may lead to the major signs of vicarious traumatization, namely dysregulated affective reactions, somatization, mood and anxiety disorders, altered personal life view, and dissociative or numbing

symptoms. Pearlman and Caringi suggested that awareness on behalf of the therapist is one way to prevent vicarious traumatization, though this was not elaborated.

Secondary Traumatic Stress

The term *secondary traumatic stress* (Figley, 1995a) is often interchanged with what Figley (1995a) considered the more positive term: compassion fatigue. Secondary traumatic stress refers to the feeling of being overwhelmed by disturbing intrusive thoughts and images, and attempts to avoid re-exposure to the traumatic material. Secondary traumatic stress emerged in the response of providers to the direct interactions with those traumatized, and specifically to the intersubjective demanding experience with patients, as detailed by Figley (1995a) and Kadambi and Ennis (2004). Figley noted that unlike the development of burnout, which is insidious, secondary traumatic stress and compassion fatigue could be sudden.

A review of the literature on secondary traumatic stress identified risk factors for its development (Cunningham, 2003; Osborn, 2004), including repeated direct treatment to those traumatized, excessive numbers in the caseload, female gender, and personal history of trauma (Dunkley & Whelan, 2006). Experience and support, including clinical supervision and peer/collegial support, appear to mitigate its development. Figley (1995a) suggested, though, that secondary traumatic stress is an inherent part of clinician's empathy, and thus the vulnerability to unmitigated symptoms can propel otherwise well qualified and empathic providers from the field.

Vicarious Traumatization

The term *vicarious traumatization* was found in the early work of McCann and Pearlman (1990) as well as Pearlman and Saakvitne (1995a, 1995b). Vicarious traumatization refers to "the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material" (Pearlman & Saakvitne, 1995a, p. 31). McCann and Pearlman (1990) posited that vicarious traumatization is a specific type of burnout, which impacts on therapeutic work as well as the intrapsychic life of the clinician through the affecting cognitive schemas of safety, trust, esteem, meaning and capacities to toward efficacy and intersubjective connectedness.

Saakvitne and Pearlman (1995) suggested that vicarious traumatization can manifest within the intrapsychic world of the therapist and therapeutic relationship because of the potential of shifts in personal identity, view of the world, sense of hope, ability to respond emotionally, and altered core values and beliefs. Rasmussen (2005), considered the relevance of consequential intrapsychic changes such as progressively distorted views of self and others, a diminished ability to respond in relationship, a sense of depersonalization, and heightened stress reactions, to the sustained viability of clinicians.

Pearlman and Caringi (2009) defined vicarious traumatization, based on McCann and Pearlman's (1990) work on complex trauma, as "the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma

material, combined with a commitment or responsibility to help them…hallmark is disrupted spirituality" (pp. 202-203). M. A. Stebnicki (personal communication, June 2, 2014) also emphasized spirituality in the conceptualization of empathy fatigue. Stebnicki (2008) proposed that empathy fatigue was a syndrome incurred by professional counselors who provided person-centric empathic care and was a direct result of the necessary empathic skill utilized in the work.

Pearlman and Saakvitne (1995a) suggested that the development of vicarious trauma and compassion fatigue is attributed to numbers and types of patients seen, the occupational support or its absence, the volume of exposure to trauma narratives, and empathic exposure. In the process of empathizing into the world of other, the individual accesses the distressing experience, which in turn influences empathic response, compassion, and also adverse reactions such as a re-experiencing of trauma. Figley (2002a) posited that the "act of being compassionate and empathic extracts a cost under most circumstances" (p. 1434). These points lead me to explore compassion, empathy, and the relevance to compassion fatigue.

Compassion

Interest in compassion has been heightened in general during the past decade, which is arguably related to an increase in interest in Eastern philosophy among Western individuals as well as globalization (Dalai Lama & Cutler, 2009; Davidson, 2006; Davidson & Harrington, 2002). The literature on compassion fatigue provides rare reference to the development of compassion.

The 4th century (BC) Confucian philosopher, Mencius, stated that there is a common feeling in humanity of not being able to "bear to see others suffer…. This

feeling of distress is the first sign of humanity" (trans. 1963, p. 132). The New Oxford American Dictionary (2010) identifies the etymology of the word *compassion* as related to the old French and ecclesiastical Latin, *compati*, which referred to the emotional feeling of being moved by another's distress or suffering. Schopenhauer (1840/2005) considered compassion to be equivalent to the German *Mitleid*, meaning to suffer with other. Hosking (2007) viewed compassion as a conscious reflection on the emotional feeling evoked in witnessing distressing experiences of another with a desire to provide relief. At least two central components to compassion have been emphasized, including an identification with and feeling into the experience of the other, and a desire to alleviate suffering through an active response. Hosking suggested that the two components require a balance between feeling the distress enough to understand, and using discernment in action rather than over reacting to mitigate the pain of other. This aspect of the impulse to alleviate suffering and potential for vicarious traumatization or compassion fatigue will be addressed at length in a separate chapter in this study.

Cassell (2005) proposed that compassion appears to be an emotion through which individuals fulfill a basic need for care and connection or succorance. Further, compassion is thought to be evoked by the suffering of others, and as Cassell outlined, it is considered a "unilateral emotion…most commonly brought forth in settings in which the sufferer(s) have no awareness of the feelings they are evoking in others" (p. 435), and is paradoxically both a subjective and social experience.

Compassion as a process appears to be related to understanding others through the inescapable fundamental sociality of being human. The experience of compassion has been explored through the intersubjective perspectives of early human development,

psychoneurology and social psychology (Bråten, 1998; Mead, 1934; Meltzoff, 1985; Stern, 2000). The evidence that has accumulated during the past several decades suggests an early capacity of intersubjective engagement, which was conceptualized by Bråten (1998) as "altercentric participation" (p. 105), a complementary dance to the mother's bodily and facial movements. Bråten explained that this participatory process is evoked through proprioception as if looking in a mirror image. The perspective of the intersubjective and altercentric participation offered an expanded view of the implications of compassion, and the embodied human response to the suffering other. As Bråten summarized, the infant-mother relational findings "indicate that our nervous system has been constructed in such a way that it enables us to capture others' living experiences just by watching them" (p. 73). Further studies have investigated the visuo-motor neurons, known as mirror neurons, which appear to discharge even with observation of others (Rizzolatti & Craighero, 2004; Rizzolatti, Fogassi, & Gallese, 2001;Rizzolatti, Fadiga, Gallese, Fogassi, 1996). The evidence in support of mirror neurons suggests implications for compassion and also compassion fatigue, and is commensurate with the emergence of interest in intersubjectivity (Atwood & Stolorow, 1984; Stolorow, Atwood, & Brandchaft, 1994; Stolorow, Brandchaft, & Atwood, 1987).

Compassion and related terms such as *love* are explored in Eastern religious traditions. The Dalai Lama (Dali Lama & Cutler, 1997) described compassion as an unconstrained mental attitude and commitment toward freedom from suffering, while deeply respecting the experience of others. Hillman (1983), a contemporary post-Jungian analyst, suggested that such attitudes and feelings are equated with "an explosion of the imagination, an extraordinarily powerful way the psyche produces its images" (p. 178).

Through history, in both Western and Eastern civilizations, the concept of compassion has been found in sacred and philosophical traditions. A belief that can be traced back to Socrates existed regarding people who were compassionate; they were considered protected from harm (Vlastos, 1991). In terms of Western tradition, Aristotle (trans. 1984) was one of the first to address compassion in some depth, although Plato briefly mentioned it. As described by Cassell (2005), Aristotle interchanged *compassion* with the term *pity*, which referred to "a feeling of pain at an apparent evil, destructive or painful, which befalls one who doesn't deserve it" (Aristotle, trans. 1984, p. 113) and thus which can occur to anyone. Based in Aristotle's discourse, Cassell (2005) and Nussbaum (2001) were directed toward several requirements to experience compassion: that suffering is important, that the sufferer is not responsible and does not deserve to suffer, and that the one feeling compassion is able to empathize through imaging himself or herself or those close to him or her in a similar situation. Contemporary conceptualization of compassion includes the "emotional and transcendent components" (Underwood, 2002, p. 78) inherent to a feeling and expression of love. This process has been exemplified through Sprecher and Feher's (2005) development of a *Compassionate Love Scale*, which is concerned with the parameters of the behavioral, emotional, and cognitive attitude of caring for the suffering of others.

Nussbaum (2001) in her compelling work, *Upheavals of Thought: The Intelligence of Emotions*, argued for emotions to be considered as judgments of value, and specified compassion as a painful emotion, which focuses on the suffering of others. Compassion involves a valuing of other beyond one's own immediate and usual circle of concern, and is connected with benevolent action. As elaborated by Vanden-Eynde

(2004), Nussbaum suggested that compassion might be traced along an evolutionary history, whereby humans attempt to respond to the overall situations impacting the entire group. The valuing of other extends the concern of self toward other as is experienced in the work of clinicians, as illustrated by Harvey (2000), in his introductory material on Buddhist ethics. Harvey offered a view of the non-separateness of "your" and "my" suffering. He argued that suffering should be considered as a common human experience which we are not "in control of our own minds as we would like to think" as separate and permanent beings (p. 36).

The philosopher Nussbaum (2001) encapsulated her perspective on compassion as being "motivated or supported by the imaginative exercise of putting oneself in that person's place…the compassioned person will acquire motivations to help the person for whom she has compassion" (p. 342). Van der Cingel (2009) reiterated this perspective in the identification of the preliminary conditions of compassion to include being able to identify with other, empathy, and imagination. The use of imagination in particular holds relevance to the work between therapist and patient, whereby the work entails engagement in the intersubjective, analytic space between self and other. Schopenhauer (1840/2005) spoke to the imaginative through his consideration of compassion as a means of "feeling with" the other metaphysically (p. 133). Albert Einstein (1950/2005), in a letter of condolence, addressed this connection in the analytic space as follows:

> A human being is a part of the whole, called by us "Universe," a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest—a kind of optical delusion of his consciousness. The striving to free oneself from this delusion is the one issue of true religion. Not to

> nourish the delusion but to try to overcome it is the way to reach the attainable measure of peace of mind. (p. 206)

The literature on compassion had received limited focus of attention in general psychology (Gilbert, 2005; Glaser, 2005; Kristeller & Johnson, 2005), though there are researchers more recently who have been interested in this phenomenon (Neff, 2003). Neff proposed that compassion refers to having access and an openness to the suffering of others. Neff considered that it is in the experience of being touched by the suffering of others that a person is able to engage feelings of kindness and the yearning to alleviate suffering. Lewin (1996), in his monograph on compassion as an animating core value of psychotherapy, considered compassion an unbridled process of caring which engages the therapist's personal ethics both in and outside the "highly permeable membrane" (p. 27) of the consulting room. Lewin suggested that the capacity for compassion is decisive in sustaining the arduous work of psychotherapists, a point taken up further by other researchers, including Davidson (2006) in a neuropsychological study of compassion meditation in Buddhist monks. Preliminary findings exist to support the belief that those who act with compassion receive benefits (Goleman, 2003). This finding may suggest that those therapists and other clinicians, who cannot act on compassionate feelings, may be averted from experiencing the benefits of compassion, which may propel compassion fatigue.

The noted physicist Zajonc (2006) considered the words of Goethe who claimed that: "In all things we learn only from those we love" (p. 1). Zajonc implied that there is an important relationship between understanding and love, whereby acts that lead to understanding and knowledge of other carry the possibility of affectional ties. This

perspective suggests a tendency of the compassionate caregiver to dwell in the words of those tended. Further, Gilbert (2005) denoted that compassion emerges from the process of care giving that engages such motivation for caring, emotional concerns, and cognitive processes through ascertaining the needs of other.

Gilbert (2005) considered compassion as a part of Buddhist loving-kindness, which impels a process of understanding suffering through a "combination of motives, emotions, thoughts and behaviors" (p. 1). Similarly, Zajonc (2006) remarked that since he was a scientist, he considered attempts to

> relate knowledge to love feels like an enormous breach of etiquette; it is very bad form, especially so in a public setting such as this. But I have come to conclude that the fear I have felt when broaching this topic was based on particular institutional forms and forces that have ultimately worked against our fundamental human interests. (p. 1)

Zajonc's statement highlights the conspicuous absence of compassion in science. In this study, what is also noted is that the concept of compassion is notably absent from the discourse in psychoanalytic and psychological literature. Furthermore, the literature that explicates compassion fatigue, also notably lacks elaboration of compassion.

Depth Psychodynamic Considerations

Coppin and Nelson (2005), in their scholarly work on qualitative research, advised researchers to engage in depth psychological approaches that draw the researcher "beneath the surfaces" (p. 42), to access what is not immediately evident. Furthermore, Coppin and Nelson considered that paying "attention to something requires turning towards it…[which] necessarily means turning away from something else" (p. 39). The

vast breadth of psychoanalytic and psychodynamic theory naturally precludes a review of the literature on its totality, and therefore I turn toward certain aspects while seemingly avoiding others. Over the past century, psychoanalytic theories appear to have developed from the classical perspective of seeing the individual through an evolving exploration of the relational. This literature review traced a preliminary focus on psychoanalytic psychology from classical intrapsychic through relational psychoanalytic thought to provide lenses for the subsequent examination of the implications for compassion fatigue in relation to transference, empathy, and the intersubjective space. However, due to the nature of this theoretical study, the remainder of the inquiry elaborated on the most salient literature.

Psychodynamic theorists from Freud (1933/1964) to contemporary theorists such as Hillman (1983) have explored symptoms as manifestations that call for attention, as a means of understanding the conditions of mind and the unconscious. As Freud (1933/1964) stated in a public lecture, "Symptoms are derived from the repressed, they are…its representatives before the ego–the internal foreign territory–just as reality…is external foreign territory" (p. 71). Hillman (1997) similarly remarked in *The Thought of the Heart and the Soul of the World*:

> The world, because of its breakdown, is entering a new moment of consciousness: by drawing attention to itself by means of its symptoms, it is becoming aware of itself as a psychic reality. The world is now the subject of immense suffering, exhibiting acute and crass symptoms by means of which it defends itself against collapse. (p. 97)

Compassion fatigue may be considered such a symptom. As symptom, compassion fatigue may be likened to Freud's repressed or to Hillman's psychic reality that is calling for attention. The following consisted of a review of relevant psychoanalytic theoretical bases that will provide a means of developing further understanding for the conceptualization of compassion fatigue.

Classic psychoanalysis provided for Freud's (1915/1957) attention to the unconscious laid the groundwork for subsequent intrapsychic and arguably intersubjective experiences of phenomena. Freud's emphasis on the unconscious was particularly instructive, as he stated in his paper on the disposition to obsessional neurosis that he "had good reason for asserting that everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people" (p. 320). Further, Freud noted the distinctive influence of the unconscious, which remained unconscious. He encouraged further investigation of what he considered "a very remarkable thing that the Ucs [unconscious] of one human being can react upon that of another, without passing through the Cs [consciousness]" (1915/1957, p. 194).

Freud (1922/1949) linked the nature of empathy to the earliest expressions of emotional ties to others. Empathy was considered the first relational connection, which facilitated an understanding of what was different in others as compared with our own ego. Freud (1922/1949) posited the function of identification and imitation as the ability to position oneself toward the mental state of another and ascertain commonalities. This turning toward the other enhances new emotional ties, which serve healthy ego functioning.

Classical psychoanalytic theory has been cautious about bringing an empathetic attitude into the session because of the preference toward the therapist's "evenly suspended attention" (Freud, 1912/1945, p. 111), which provided the therapist with spaciousness to attend to countertransference. The psychoanalyst Bernstein (2001), in a paper entitled *The Fear of Compassion*, however, drew attention to the misreading of Freud's perspectives on such neutrality and fears of countertransference (p. 210). Freud (1910/1924) made a single reference to countertransference as a problem to be overcome as it was an influence on the therapist's unconscious and encouraged the therapist to undergo self-analysis to broaden and deepen understanding of complexes, in service to better understanding and provision for patients. According to Bernstein (2001), it is the resistance of the therapist to examine his or her own feelings that is the "countertransference problem" (p. 211), and posited that the misreading of Freud conspired "to deprive psychoanalysts of the privilege of enjoying their feelings, especially the feeling of compassion, and of the option of behaving compassionately with respect to their patients" (p. 210). Freud (1912/1945) may have experienced vulnerability to the patients, and set up his work to avert this influence. Freud's stated that the use of the recumbent position on the couch, for example, was for the enhancement of free association and because he had difficulty tolerating "being stared at by other people" (p. 134) in the context of the volume of patients in his practice. Furthermore, Thompson (1994) outlined that while other psychoanalysts such as Karen Horney, Sullivan, and R. D. Laing did not use the couch; they did situate the chairs to minimize eye contact.

Initially Western psychoanalytic thought had been construed from the internal and individualistic models of mind (Freud, 1913/1958; 1922/1949). Ellenberger (1970) and

Gottlieb (2012) have suggested that from the beginnings of Western depth psychological thought, a developmental process has occurred in the conceptualization of clinical approach and the nature of the mind. Orange (2008) further described a trend toward context of the individual developmental history, and the relational. One of the first transitions to an interpersonal model was in the 1920s with the American psychiatrist H. S. Sullivan (1953, 1964). Sullivan emphasized interpersonal processes, which evolved from his work with patients with severe schizophrenia who he found exquisitely sensitive to the interpersonal environment.

Self psychology has provided important considerations for the empathic response of the clinician. Kohut (1981), the imminent lead in the tradition of self-psychology, maintained an emphasis on being responsive and empathic, in service toward making accurate interpretation during the analytic process. According to Mitchell (1988), the self-psychology tradition has considered a classical view of the therapist's subjectivity as irrelevant to the therapeutic process. This point was further elaborated by Goldberg (1986), who identified that self–psychology "struggles hard not to be an interpersonal psychology…because it wishes to minimize the input of the analyst into the mix" (p. 387) thus rendering the theory and practice as a one-person rather than interrelational psychology. Though influenced by Kohut, the psychoanalyst Schwaber (1995), argued for participation with the patient's intrapsychic world in a process of discovery. Schwaber emphasized interaction with the patient with a focus on the use of the therapist's subjectivity in service of locating the subjectivity of other. She wrote that despite the "co-participatory elements" (p. 558), psychoanalysis remained a one-person endeavor, the patient's psychology. Later work by Bollas (1989) also suggested the

utilization of self only to provide a potential space for examining the patient. Mitchell (1988) considered Stolorow as a self psychologist most aligned with a relational perspective in his intersubjective psychotherapy. Stolorow (1995) considered Kohut's work a relic of the past due to his rigid adherence to the isolated mind.

The commitment to transition to a "two-person psychology" (Aron, 1996) has varied, and this was true with the British object relations school. The expected roles and responses of the analyst are revealing, as illustrated by Winnicott's (1986) *good enough mother* and *holding* and Bion's (1959) *container* and *metabolizer*. In the object relations perspective, the clinician is simultaneously denied of a subjective experience and yet required to be open to receive, as pointed out by Mitchell (1988). This denial of subjective experience was emphasized in a parallel way through a feminist lens by Chodorow (1989), who admonished theorists about their focus on the mother as a fulfiller of baby's needs rather than taking the mother's subjectivity seriously.

A feminist critique on psychoanalysis as outlined by Benjamin (1988) further accentuated the need to rework the development of the child as a relational being, who in his or her developmental process arrives at a view of mother not only as a separate object, but a subject unto her own. The resulting intersubjectivity, according to Benjamin (1992), applies to an experience in which "the other is not merely the object of the ego's need/drive or cognition/perception, but has a separate and equivalent center of self" (p. 45). According to Mitchell (1988), Benjamin followed Winnicott in emphasizing the importance of maintaining a dual awareness of both the intrapsychic object orientation and the position toward others as subjects who are separate. Winnicott (1986)

emphasized attention to the interaction between the internal world and the surrounding external environment.

Similarly, the construct of compassion has evolved toward understanding compassion in the life of the patient, and has turned toward interest in what transpires between people rather than isolated individuals (Stolorow & Atwood, 1992). The term *empathy* is used in psychoanalytic literature to connote access to other, as focused on by the two prominent psychoanalysts, Kohut (1981, 1984) and Winnicott (1949). Whereas empathy connotes accessing understanding of the experience of other, Nussbaum (2001) suggested that compassion involves an affective experience, which propels the individual to act to ameliorate suffering.

Though classical psychoanalytic theory focused on instinctual intrapsychic tension and discharge, theory has been redefined "to transactional patterns and internal structures derived from an interactive, interpersonal field" (Mitchell, 1988, p. 17). Mitchell (1988) determined that the emergence of contemporary psychoanalytic theory hailed a transition to what he termed a relational model, which embraces the British school of object relations, interpersonal psychoanalysis, and self psychology, and later to intersubjectivity. Mitchell argued that a relational model provided a means to integrate the nature vs. nurture dimensions in an understanding that the human being "did not evolve and then enter into social and cultural interactions; the human mind is, in its very origins and a nature, a social product" (p. 18). According to Mitchell, central theorists for a relational model, such as Sullivan and Fairbairn, argued for the human mind as an "interactional interpersonal field or a relational matrix" (p. 19). Furthermore, the individual may only be understood through this field. Other theorists support relational

theory, as exemplified by Mahler, Pine, and Bergman (2000), who posited that the development of the infant's ego is found within a psychic merger with mother, or Bion (1967b), who characterized the mother as container for the child within the relational process.

Cooper (1998), in a review of relational theory, further accentuated the utility of British and American object relationists who promulgated containing and processing affect or expressiveness and participation. The concept of the social mind was supported through the psychiatrist, psychoanalyst, and infant development expert Stern (2000), who considered consciousness as "socially negotiated states" in which the reality of the infant is pervasively "self-with-other" (p. 104). According to Mitchell and Black (1995), Edith Jacobson, a Berlin psychoanalyst who escaped Germany after having been imprisoned, sought to reconcile the mutual influence of what is constitutional with what is environmental. In her work *The Self and the Object World*, Jacobson (1964) proposed that development constitutes a process of both simultaneously, in a mutual influence of environment on the individual innate potentialities.

According to Frie (1997), the French psychoanalyst Lacan provided for the initial development of the utility of intersubjectivity in psychoanalytic thoughts, through his emphasis on the social aspects of development, such as culture and language, in shaping experience. Psychoanalysts Stolorow and Atwood (1984) introduced the concept of intersubjectivity to American psychoanalysts. as a psychological dynamic process of "forming at the interface of reciprocally interacting worlds of experience" (p. 1). Stolorow and Atwood (1992) emphasized that the focus on the term intersubjective refers "to any psychological field formed by interacting worlds of experience, at whatever

developmental level these worlds may be organized" (p. 3).

Research has suggested that the determinants of success in psychotherapy are multifactorial, including the therapist, patient, context, treatment method, and the therapeutic relationship (see Norcross, 2011, for review). A meta-analysis of over two hundred peer-reviewed articles from the period of 1973-2000 found positive correlations between the quality of the therapeutic alliance and treatment outcomes for a variety of psychotherapies. Therapeutic relationship was found to be the most important factor in psychotherapy outcome (Ablon & Jones, 1999; Blatt, Quinlan, Pilkonis, & Shea, 1995; Fairbairn, 1953; Mitchell, 2000; Safran & Muran, 2000; Stern, 2000; Stolorow & Atwood 1992).

Diener, Hilsenroth, and Weinberger (2007) reviewed 500 articles and investigated in a meta-analysis the relationship between the psychodynamic therapist's facilitation of the emotional expression of the patient and identified outcome. The study suggested that emotional affective experience facilitated through the therapeutic relationship in brief psychodynamic therapy promoted change. Change emerged through the interaction between the analyst and patient, which was also asserted by Stern et al. (1998) as an "implicit relational knowing" (p. 903) in enactments with the therapist. This relational quality therefore connotes the relevance of both the patient and the clinician, which has been explored through constructs of intersubjectivity (Atwood & Stolorow, 2014; Stolorow & Atwood, 1992).

Psychoanalytic theory of intersubjectivity has been expanded to explore the nature of what transpires between self and other in therapeutic work (Atwood & Stolorow, 2014; Stolorow, 2011a, 2011b; Stolorow, Brandchaft, & Atwood, 1987). Karamanolaki (2008)

described the inner life of the therapist, from the first encounter, as inherently an intersubjective experience. Similarly, Ogden (1994) considered the *analytic third*, which may be related to Kohut's (1971) *selfobject*. Stolorow and Atwood (1984) articulated the work of trauma within a relational context, through intersubjectivity theory, which provided support for exploring the roles of affect, empathy, construction of meaning, and the relevance of countertransference. Such conceptualization of the intersubjective in psychotherapeutic relationship has closely attended to the dynamic living presence in the space between the therapist and patient. Rasmussen (2005) pointed to the likelihood of the therapist mirroring the experience of the client. They understood vicarious traumatization as a transformation due to this empathic engagement.

The connectedness in relationship, as Stolorow (2007) argued, counters Descartes' profoundly isolative existence, a "disembodied, unembedded, and decontextualized cogito" (p. 5). Was then perhaps vicarious traumatization and compassion fatigue a result of disengagement and dissociation, rather than connection in relationship? Did the work of psychotherapy demand a flexible living process of the aforementioned Jungian view of delving into the living image, the fantasy, rather than dissociating, splitting, into inner states that are unfamiliar? According to Wilson and Lindy (1994), countertransference and associated episodes of patient as well as clinician dissociation are important to track during psychotherapy, though neither phenomenon is easily perceived. Further, as Pearlman and Saakvitne (1995a) described, with an understanding of the dissociative mechanisms inherent to the traumatized patient, the therapist can more readily interpret the client's pauses, empty responses, seeming lapses in memory, and the nuances of generally unusual presentations and interactions in the

therapy. In the process, the therapist delves into the narrative of the trauma and can experience what Wilson and Lindy (1994) termed "trauma-specific transference" (p. 9), the unmetabolized fragments of the trauma experience.

As Karamanolaki (2008) stated, the inner life of the therapist from the first encounter on, inherently belongs to the intersubjective experience, which is similar to what Ogden (1994) considered the *analytic third*. It is in this space that the therapist traverses the vast territory of psyche with the patient. Bromberg (1991) described the aesthetic process of gaining access to knowing a patient from the inside through this intersubjective field of the therapeutic relationship. The unconscious communication occurs through transference in an enactment of experience, which is unsymbolized. Bromberg described the therapeutic relationship as a means of "bridging dissociated aspects of self through the creation of a dyadic experiential field that is both 'inside' and 'outside'" (p. 399). Therefore, the intersubjective field was the locus of attention for this inquiry. As Rasmussen (2005) noted, the emphasis on intersubjectivity in the study of vicarious trauma and compassion fatigue provides an extended perspective into the impact on the clinician and clinical process.

Empathy

Stueber (2014) described the introduction of the term *empathy* by the psychologist Titchener in the early 20th century, and his translation of the term from German term *Einfuhlung*, or "feeling in," and the ancient Greek *empatheia* (*New Oxford*, 2010). In the late 19th century, according to Stueber, the term *empathy* was introduced by Vischer, used among German philosophers, and understood in its reference to the aesthetic sensibility of human projection onto natural objects.

Freud (1915/1957) considered both the conscious and unconscious processes of empathy by which the individual gains a sense for experiences of others. He commented that the process is vital to understanding other and for establishing a positive transference in the therapeutic relationship. Campbell (2004), in his introductory notes to Bolognini's (2004) work on psychoanalytic empathy, suggested that empathy is a process of tapping into "the recesses of our experience to find within ourselves an approximation of what we think" (p. 9).

The term *empathy* has had a relatively recent intellectual history, but has been notably referred to as the central way in which knowledge of others' minds can be attained. Stueber (2014) outlined the contribution of Lipps, a Munich professor and philosopher, who provided a more thorough analysis and conceived of a psychological perspective on empathy. According to Stueber, Lipps attributed the intuitive quality of empathy as a means to gain access to the inner subjective experience of another, and emphasized it as a philosophical concept in the human science tradition. Lipps considered empathy as a phenomenon that occurs in resonance with the inner processes of another, and toward which individuals attribute negative or positive experience. Empathy played a role in aesthetics, and importantly in the means of appreciation of one another as creatures with minds. The concept of empathy was revived in 1960 after Greenson studied its meaning (Widlöcher, 2005), and noted the influence of countertransference from the works of Racker and Heimann. Further, empathy was assigned a role in the unconscious and the part played by the therapeutic effect of the psychoanalyst by Kohut.

Nussbaum (2001) defined empathy as the capability to imagine the experience of another, through a process of entering into the other's realm while maintaining a

distinction of self from other. Further, empathy is distinguished from compassion, since, as Nussbaum commented, "a sadist may have considerable empathy with the situation of another person, and use it to harm that person" (p. 209). Kohut further accentuated this idea in his last lecture, when he described Hitler's empathy for those who were destroyed by his bombs and the fact that he purposely added sound to them to heighten the fear of those who were about to die. Nussbaum (2001) suggested that there is something valuable morally with empathy, including the fact that it enables a person to give recognition that there is another who shares one's own central experience. She stated that individuals may find that the "empathetic torturer is very bad, but perhaps there is something worse still in the utter failure to recognize humanity" through the lack of compassion (p. 333). As stated by Kohut (1981):

> Empathy serves also, and this is now the most difficult part—namely, that despite all…empathy, per se, is a therapeutic action in the broadest sense, a beneficial action…. The dreadful experiences of prolonged stays in concentration camps during the Nazi era in Germany were just that. It was not cruelty on the whole…. They totally disregarded the humanity of the victims. They were not human…. That was the worst. (p. 530)

Fliess (1942) proposed that the therapist or analyst who ventures into and briefly identifies with the patient's emotional experience is able to gain an experience of and understanding of the person's state. According to Fleiss, the analyst is admonished to keep the access to the state brief, as otherwise he or she could dangerously succumb to vulnerability a "damming up" (p. 685) of instinctual energy, which is toxic and could potentially lead to neurotic symptom formation.

Rogers (1961/1995) considered empathy a process whereby a person can enter into the isolated private world of another, temporarily inhabiting another's life. Kohut (1984) considered empathy "vicarious introspection," whereby the therapist can "think and feel into the inner life of another person" (p. 82). Such empathic engagement, particularly with the traumatic material of patients, has been considered instrumental in the transformation of the internal experiences of the therapist, as described by McCann and Pearlman (1990).

Bohart and Greenberg (1997) provided a description of empathy from both analytic and humanistic perspectives. Empathy from a humanistic stance is considered a way to create an experience in which the client can make a variety of choices in living. A client-centered approach would include a therapist's unconditional positive regard and valuing of the client. According to Bohart and Greenberg, from an analytic perspective, empathy was construed as a means by which the therapist feels *with* rather than feels *for*, as the latter connotes sympathy, and infers judgment. Empathy in this sense imbues a certain quality of appreciation for the person as central, regardless of the person's state.

Mayeroff (1990) stressed the importance of maintaining compassion and an attitude of caring, because, as he explained, "few things are more encouraging to another than to realize that his growth evokes admiration, a spontaneous delight or joy, in the one who cares" (p. 56). Skovholt (2010) emphasized caring as an essential quality in clinical providers, due to their primary emphasis on human connection in a therapeutic relationship. Furthermore, Skovholt suggested, the inability to care signals a process of clinician burnout and becoming incompetent. Skovholt further suggested that the work of therapists includes development of skills to process a repetitive "Cycle of Caring" (p.

153), which includes phases of attaching, engaging, separating, grieving, and resolving/recreating, similar to what Bowlby (1973) described in his work on attachment theory. Skovholt (2010) also addressed the "curse of ambiguity" (p. 37) and the isolated experiences of the work of psychotherapy, which likely influence the development of a professional identity and potential adverse impact.

The cost of caring has been noted in early references. Jung's (1907/1960) description of countertransference in the *Psychology of Dementia Praecox* particularly noted the potential impact of close therapeutic encounters. He recommended for the benefit particularly of psychotic patients to participate with the patient in their delusionary material. According to Sedgwick (2001), Jung advised, however, that such participation in shadow material could impact the therapist in a deleterious manner.

As Kanter (2007) emphasized, the historical aspects of psychoanalytic perspectives, such as the potential contributions from the well conceptualized countertransference, are neglected, outdated, or limited. Figley (2002b) further exemplified this limitation in his description of a case in which he confused compassion fatigue with countertransference, and excluded the plethora of psychoanalytic thought in contemporary object relations, attachment, and intersubjective/interpersonal perspectives.

Winnicott (1949) explored the countertransference phenomena in a classic paper, *Hate in the Countertransference*, in which he described the effect of the therapeutic interaction on the therapist. Fauth (2006) explained that although there are a number of definitions of the concept of countertransference, there is no consensus regarding the concept. Though the concept emerged and developed in classical and neoclassical psychoanalytic literature, this phenomenon was not addressed by Fauth. Pearlman and

Saakvitne (1995a), however, had suggested that countertransference includes a number of conscious and unconscious reactions by the clinician toward the patient that likely influence the development of vicarious traumatization and compassion fatigue.

Transference-Countertransference

In a review of the literature, the term *countertransference* was often misconstrued from the original or developing intention, and as Berzoff and Kita (2010) suggested, is "confounded, collapsed and presented as one and the same" (p. 341). Early classical psychoanalytic thought considered countertransference as the unconscious sexual and aggressive impulses, which were evoked in the clinician through interactions with the patient (Freud, 1912/1945). Countertransference was thus initially viewed as an error that must be avoided. This perspective though gave way to understanding that countertransference is an inevitable result of the psychodynamic process, and is both essential and inherent to the therapeutic process.

By 1950, through the seminal work of Heimann, there was a fundamental shift in the perspective of countertransference from the negative and undesired responses to being central to all the responses, and central to psychoanalytic work. Racker (2007) then delineated concordant identification, which was a direct empathic countertransference in response to homologous experience. Racker differentiated complementary identification as the clinician psychodynamic response to assuming the role of the patient's internal objects. Therefore, the categorization of concordant and complementary countertransference further defined, the ways that the clinician can respond empathically with the patient, either directly or in the role of the externalized. Therefore, concordant countertransference represents the direct empathic response to the patient.

Complementary countertransference represents empathic response such as reenactment to the externalized object.

Psychoanalysts such as Fromm-Reichman (1950) and Racker (1968/1988) considered countertransference as a useful skill for the analytic process. Ogden (1994) supported the concept that the feelings, thoughts, and imaginings that occur in the clinician are a result of the meld of patient fantasy in the midst of clinician reverie, and which according to Bollas (1989), may not otherwise be known.

According to Figley (1995b), although there is no conclusive evidence of the means of transference of traumatic stress to another, the role of empathy may be considered in the process of transference. Bowlby (1973) highlighted

> the concept of transference implies, first, that the analyst in his caretaking relationship with to the patient is being assimilated to some pre-existing (and perhaps unconscious) model that the patient has of how any caretaker might be expected to relate to him, and…that the patient's pre-existing model of caretakers has not yet been accommodated–namely, is not yet modified–to take account of how the analyst has actually behaved and still is behaving in relation to him. (p. 206)

Klein (1975) originally considered projective identification, which was then further developed. In addition, findings in affective neuroscience and infant research supported the understanding that the matching of emotional states between patient and psychotherapist occurs via a system of mirror neurons (Ferrari & Gallese, 2007; Greatrex, 2002; Rizzolatti & Craighero, 2004; Rizzolatti, Fadiga, Gallese, Fogassi, 1996; Rizzolatti, Fogassi, & Gallese, 2001). According to Ferrari and Gallese (2007), mirror

neurons appear to allow for spontaneous engagement in bodily sensations, intentions, and emotions of others' experiences, a process suggesting support for the notion of the embodied experience of countertransference.

Jaffe (1986) discussed the reliance that therapists have on subjective processes as a means of accessing the psyche and helping patients. Freud (1912/1945) fundamentally recommended the ways of listening to gain access to the unconscious, including uncensored communication by the patient and an attitude of "evenly-suspended attention" (p. 111), which enhances access to unconscious of self and other. Freud suggested that the unconscious of the patient transmits itself to the receptivity of the unconscious of the therapist.

Jung's (1907/1960) discussion of countertransference, defined as the psychotherapist's conscious and unconscious reactions, encouraged the psychotherapist to explore and seek direct experience with the patient's unresolved and disturbing fantasies and images. Sandner and Wong (1997) described this process in relationship to its similarities to shamanism. Jung (1907/1960) also warned that engagement in the material, which would include the interplay of complexes (i.e., emotionally based constellations tied into certain images that structure and circulate around a personality), could take the form of a two-person madness—a "folie-à-deux" (Sedgwick, 2001, p. 46).

Jung (1946/1983) was concerned with the potential for experiencing "mental contagion" in the alchemical process of the therapeutic relationship (p. 176). He stated that the caregiver, "by voluntarily and consciously taking over the psychic sufferings of the patient, exposes himself to the overpowering contents of the unconscious and hence also to their inductive action" (Jung, 1946/1983, p. 176). The transference, in his view,

activates a constellation of unconscious ties and projections, within which both the psychotherapist and patient contract an *unconscious infection* (p. 176). Jung's concept of the *psychological contagion* (Sedgwick, 2001, p. 46) may be similar to the experience of a shaman who is possessed, as described by Sandner and Wong (1997), and it appears to support the contemporary view of vicarious traumatization and compassion fatigue.

The tending to the seemingly invisible human wounds appears to call for a certain stance on the part of the psychotherapist to buffer potential adverse effects. Stolorow and Atwood (1992) recognized that the "essence of trauma lies in the experience of unbearable affect" (p. 52), to which the clinician is repeatedly exposed. Reik (1948/1983) emphasized that the therapist utilizes his or her emotions and reactions to further understanding the patient emphasized this stance in his quote of Nietzsche: "The psychoanalyst has to learn how one mind speaks to another beyond words and in silence. He must learn to listen "with the third ear" (p. 144). Therefore, the engagement with other intersubjectively in the therapeutic relationship constitutes one of those ways of listening with the third ear.

Embodiment

The consideration of embodied presence brings a particular view on psychotherapeutic presence in the intersubjective. This perspective is informed by a tapestry of luminaries in addition to Jung, in the feminist literature (Woodman & Dickson, 1997), the phenomenology of the lived body (Merleau-Ponty, 1945/1962, 1969; Romanyshyn, 2002, 2007), and conceptualization of focusing (Gendlin, 2007). Embodiment has particular relevance in terms of trauma work, as the psychotherapist experiences other through both psyche and soma via the transferential space third, while

bearing witness through deep listening to the nuances of the experiences of the traumatized.

Merleau-Ponty (1969) highlighted a two-fold view of embodiment as encompassing both the phenomenological lived experience and the context, similar to contemporary understanding of the complexities of neuroscience previously briefly discussed. Gendlin (2007), in his work on *focusing*, has been concerned with therapist's conscious presence in working "at the edge" (p. 69) of the unconscious, a place of a *felt sense*. This therapeutic space was further described in Romanyshyn's (2002) work on grief, wherein he considered the neglected deep visceral experience of "ghosts and the gestures of compassion" (p. 54). This haunting in a gestural field of psychotherapy touches on impressions in which *the other* lingers as an "absent-presence, soliciting the gesture without confirming it" (p. 55). Similar to the ache of a phantom limb, this gestural field is a space in which the heartache of compassion fatigue may reside. As Romanyshyn (2002) suggested, it is the imaginal field where provision is made to release that which haunts "the symptomatic body and its gestural field" (p. 58).

Alternatively, Woodman and Dickson (1997) offered the importance of embodying of living images as they emerge, rather than reducing, concretizing, and killing them in the psychotherapeutic process. In a book entitled *Dancing in the Flames*, they described traumatic experience as a means of firing up and animating the imagination in order to transform the masculine and feminine energies in the individuating patient, and vicariously in the psychotherapist.

Summary

The review of scholarly literature has revealed that over the past three decades, clinicians and researchers have discussed the multifaceted roles that stress exposure plays in the lives of individuals. Figley (1995a) and Raphael et al. (1983) emphasized that historically studies have considered patient outcomes, and that minimal attention has been given to the impact of such work on clinicians' experiences. In spite of widespread understanding of the significance of bearing witness to stress and trauma, only recently have researchers begun to explore the impact on clinicians (Fox, 2003). Psychoanalytically informed psychiatrist Frankl (1984) emphasized the importance of considering what transpires within the clinician in response to clinical experiences in order to sustain the intensity work. Pearlman and Saakvitne (1995b) suggested that vicarious traumatization could manifest both within the intrapsychic world of the therapist and therapeutic relationship, because of what such close work with difficult traumatic experiences entailed.

A review of early studies (Dunning & Silva, 1980; Everstine & Everstine, 1993) began to explore clinicians' vulnerability to traumatized patients to whom they are exposed. Steed and Bicknell (2001) emphasized a new shift in recognition of a ripple effect of trauma vicariously to those surrounding the traumatized, including helping professionals, which was further echoed by Morrissette's (2004) description of the clinician as unshielded from the emotional effects of such work. The results of various terroristic attacks, particularly those

of September 11th, increased attention to the deleterious and contagious effects of trauma (Eidelson et al. 2003). A plethora of literature on trauma emerged, and interest in traumatology ensued, along with an expanded emphasis on the results of exposure to traumatic experiences both directly and vicariously (Berah et al., 1984; Donovan, 1991; Figley, 1995a, 1995b; Shaley, Bonne, & Eth, 1996). Terminology evolved to capture the distress incurred by others, including clinicians (Figley, 1995a; Herman, 1992; Maslach et al., 2001; McCann & Pearlman, 1990; Stebnicki, 2008; Wilson & Thomas, 2004).

An array of scholarly work on compassion fatigue revealed an emphasis on the symptomatic results and recommendations for unburdening the caregiver through enhancing personal well-being. A brief history of the term emphasized the potential for cumulative clinician symptoms reflective of exposure to stressful experiences (Joinson, 1992; Coetzee & Klopper, 2010). Pearlman and Caringi (2009) posited that such exposure is related to empathy, which was further elaborated by humanistic psychologist Rogers (1961/1995), traumatologists Pearlman and Caringi (2009), and the psychoanalyst Kohut (1984). Compassion fatigue was also conceptualized as secondary traumatic stress (Figley, 1995a), which evolved from the intersubjective empathetic experience (Kadambi & Ennis, 2004). The research of Figley (1995a), Cunningham (2003), Dunkley and Whelan (2006), and Osborn (2004) posited risk factors for secondary traumatic stress, such as large caseload and personal history of trauma and mitigating factors such as clinical supervision and support. However, the compassion fatigue literature did not expound on the actual interaction within the clinical experience, which likely impacts on the experience of compassion fatigue, other than Pearlman and Saakvitne's (1995b)

review of trauma care for early sexually abuse and Rothschild's (2006) review of ways to help the helper.

The literature on compassion fatigue was found deficient on conceptualization of compassion, as illustrated by Figley (2002c), considered an expert on compassion fatigue, who referenced the term through a Webster's definition and in only two sentences of the 227-page book on the treatment of compassion fatigue. Figley (2002a) stated that "being compassionate and empathic extracts a cost under most circumstances" (p. 1434). These limitations led me to explore emergent themes on compassion in the endeavor to gain further understanding for conceptualization and analysis of compassion fatigue, which was situated in clinicians who manage care for complex patients who are traumatized or otherwise suffering.

For further illumination, I turned to the literature on compassion and the psychoanalytic literature, both of which revealed several ways that in which the engagement with patients, particularly those who are complexly traumatized or otherwise suffering, potentially impacts on the inner world of the clinician. The literature on compassion in general psychology scholarly works was limited (Gilbert, 2005; Glaser, 2005; Kristeller & Johnson, 2005), though recently there is expanded interest (Neff, 2003). The researchers of the intersubjective perspectives of compassion (Bråten, 1998; Mead, 1934; Meltzoff, 1985; Stern, 2000) did not explicitly connect findings with compassion fatigue. I found that there was an implied connection, which was also mirrored in the work of Rizzolatti and colleagues (2001) in their discourse on the psychoneurology of compassion. Spiritual and transcultural perspectives of compassion accentuated long held beliefs that those who are compassionate are protected from

harmful influences (Vlastos, 1991). The literature on compassion, from Aristotle's discourse (Cassell, 2005; Nussbaum, 2001) to contemporary conceptualizations emphasized the importance of feeling with other (Nussbaum, 2001), and the experience of suffering in a transcendent quality which is equated with love (Sprecher & Fehr, 2005), and valuing the other (Harvey, 2000). These qualities of compassion are deficient in those who have symptoms of compassion fatigue.

The literature has also been limited in terms of its avoidance of the vast psychoanalytic legacy of thought that could inform a more comprehensive and deeper understanding of compassion fatigue. Kanter (2007) noted that a review of Figley's writings suggests his lack of the use of primary resources relative to psychoanalytic thought when he speaks to psychoanalytic constructs. Figley (2002a) exemplified this in a delimited and inaccurate psychoanalytic perspectives of countertransference considered as "an emotional reaction to a client by the therapist-irrespective of empathy, the trauma, or suffering" (p. 1435). Contemporary psychoanalytic literature was not incorporated, though psychoanalytic terms were utilized in the conceptual development of compassion fatigue. The breadth of psychoanalytic and psychodynamic literature in what has become known as depth psychology was examined in this literature review to extract those perspectives relevant to an expanded understanding of compassion fatigue.

The review of depth psychological literature traced the threads for interpretive inquiry on compassion fatigue from classical (Freud, 1933/1964) through contemporary (Hillman, 1960/2001) views of the contributions of the unconscious, psychodynamic forces, and intersubjective or relational perspectives on compassion fatigue. Perspectives on empathy, the therapeutic relationship, concerns of neutrality, clarifications of

transferential relationship, countertransference, and implications of emotional contagion on the therapist were explored. The nature of the mind, from considering it as individually embodied forces (i.e., classical, ego psychology) to a more relational perspective, was also reviewed to identify various contributions to the inquiry. Perspectives on the relational aspects of psychological understanding of compassion included Sullivan's (1953, 1964) interpersonal processes derived from work with patients with schizophrenia to Kohut's (1981) empathic response in service toward appropriate interpretation in psychoanalysis. A trend toward relational psychology was also interlinked with object relations and attachment scholarly materials of Bion (1967a), Mitchell (1988), and Winnicott (1986). Feminist theorists such as Chodorow (1989) emphasized the relevance of exploring the subjective experience, which was relevant for this study overall, as the primary focus was on examining the subjective experience of the clinician.

Empathy from a psychoanalytic perspective was identified in terms of Kohut's (1981, 1984) and Winnicott's (1949) understanding the experience of other. Empathy was differentiated from compassion via Nussbaum's (2001) consideration of the affective experience, which compels one to alleviate suffering of another. It was further posited based on the work of the relational theorists (Mitchell, 1988) that the human mind is within the context of a relational matrix or interactional interpersonal field rather than confined within one or even two individuals, which was further emphasized by Stolorow and Atwood (1992) in their work on intersubjectivity. This focus on the intersubjective worlds of experience was suggested to be inherent to the therapist's experience.

Karamanolaki (2008), in what Ogden (1994, 2004) called the analytic third, and in what is described by Ferro and Basile (2009a, 2009b) was considered as the analytic field.

This inquiry considered what Rasmussen (2005) described as a mirroring experience, which occurs in the clinical situation, and the resulting vicarious traumatization or compassion fatigue that may emerge. The interpretive inquiry engaged in understanding of compassion and its fatigue from a depth psychoanalytic perspective of what occurs in the analytic field, and explored options for reconsidering deep ways of listening within the holding of the patient and experience. The purpose of this study was to meet the need of what was currently missing from the extant literature on compassion fatigue, and offered a way to consider what the clinician might be able to do in-vivo to mitigate otherwise difficult symptoms that mimic those of the patients in order to retain a healthy and skilled workforce. Compassion fatigue and its related concepts need considerable attention today. However, what has been missing is a conceptualization of what the clinician can do to prevent compassion fatigue from the very beginning of training and gaining skills in clinical work. Therefore this study explored compassion fatigue in terms of the clinician intrapsychically and intersubjectively and offered alternative perspectives on compassion, compassion fatigue, and ways to hold or process difficult and challenging trauma and complex suffering of other.

Chapter 3
Methodology

Introduction

The purpose of this chapter was to establish the approach and methodology of the intended inquiry. This introduction to method was meant to explore aspects of classical hermeneutics that would provide the groundwork to inform the processes the processes for this qualitative inquiry. First, a qualitative hermeneutic approach was described in light of the research guiding questions. A brief introduction to the extensive history of the tradition of hermeneutics, with particular attention to applicability to the focus of inquiry and the reflexivity of the researcher, served to outline the complex nature of hermeneutics. Following the explication of philosophical hermeneutics, methodological procedures, including a means of data collection and analyses were presented. The chapter culminated in a description of relevant validity and ethical considerations.

The inquiry proposed a hermeneutic approach, referred to as *the art of interpretation as transformation* (Ferraris, 1996, p. 1), which is a rigorous research approach to human inquiry. As qualitative scholarship, the inquiry sought to achieve understanding through interpretation of textual material on the psychodynamic intersubjective space between self and other and its implications for compassion fatigue. The research explored depth psychological perspectives relevant to compassion fatigue, such as transference, projective identification, and therapeutic relationship as they impact on the therapist. Therefore this study was guided by the following questions:

- What is the nature of compassion fatigue as it is informed by psychodynamic understanding of empathy and transference-countertransference in the therapeutic relationship?
- What is the nature of the analytic field, and how might this be engaged in the clinician's work to foster ways to hold or process difficult and challenging trauma and complex suffering of other? How might what transpires in the field between self and other influence compassion fatigue?

The choice of method was determined through the suitability to the topic as based on the research questions, and the preliminary findings in the literature review. Hermeneutics methodology was selected, as it emphasizes vitality in the pursuit of understanding (Kinsella, 2006), and provides a broad repertoire of processes in its approach to this theoretical qualitative study. Gadamer's (1975/1989) *fusion of horizons* (p. 317), the move toward illumination of multiple voices at times hidden within textual material, the role of history, and the perception of inquiry as a conversation provided a framework for conceptualization of this methodological approach. As researcher, I chose this approach because of the discovery of a notable disconnection between the rich heritage of psychoanalytic thought from conceptualization of the psychodynamics and consequences of clinical work. I found in a preliminary review of the literature, that depth psychological analyses of the phenomenon of compassion fatigue were omitted. Therefore, phenomenological hermeneutics became a distinctly favorable methodology for this qualitative study. As Kinsella (2006) explained, hermeneutics emphasizes understanding and interpretation over explaining and verifying data.

The intention of this study was to dialogue between psychoanalytic psychological perspectives and the inner life of the clinician in terms of compassion fatigue with a focus on the field between, in a "genuine encounter" (Binding & Tapp, 2008, p. 121) that generates rich data from which to gain new understanding. The hope of this inquiry was to bring a deeper understanding of compassion fatigue, by way of interpretive inquiry from a depth psychoanalytic perspective that can inform psychotherapeutic and clinical theory, practice, and training. Through the claim of the textual material on the inquirer and reader, the intention was to engage in a conversation to inform clinical theory, practice, and training.

The research involved the interpretation of textual material on psychoanalytically informed psychology, as exemplified by those related to self-psychology (Kohut, 1984, 1985), the British Middle School (Winnicott, 1971/2005), and relational intersubjectivity (Atwood & Stolorow, 2014; Stolorow, 2011a, 2011b; Stolorow, Brandchaft, & Atwood, 1987). I intended to proceed with textual material as exemplified by following: the analytic field (Ferro & Basile, 2009a), compassion fatigue/burnout/vicarious traumatization (Figley, 1995a, 2002c; Rothschild, 2006; Todaro-Franceschi, 2013), and specific psychodynamic thought on transference, projective identification, and the therapist relationship as guided through the hermeneutic interpretive process. Additional data that illustrated the interpretive process was incorporated, such as field notes and images through artwork or photography. Although there was a need to delimit the sources for the purpose of this dissertation, both expansion into other textual material or delimiting material occurred according to what was prompted for in the hermeneutic circle and interpretive process. Research that engages the implicit, or as Romanyshyn

(2007) stated, keeps *soul in mind* (p. 3), maintains the awareness of the import of the dynamic field between self and other, and the unconscious material. In research, keeping soul in mind occurs through the intersubjective place between researcher and the work, the call to the work, and interest in the value of the inner recesses of psychological life. Through a hermeneutic qualitative research design, influenced by classical philosophers such as Gadamer (1975/1989) with the addition of a postmodern alchemical hermeneutics of Romanyshyn (2007), the aim of the study was, as previously identified, to explore psychodynamic perspectives of compassion fatigue within the clinical and psychological field. In a sense, as researcher, the process mirrored a *fusion of horizons* (Packer & Addison, 1989), which was Gadamer's understanding of emergent meaning, through the interpretive work in the intersubjective space between two worlds, psychodynamic psychology and therapist or clinician compassion fatigue. The study required a hermeneutic approach to open the dialogue between the horizons of clinician compassion fatigue and psychoanalytic thought to enrich understanding and to birth new meaning.

Research Approach

The methodological approach was driven by the work's "internal imperative" (Romanyshyn, 2007, p. 3), as previously addressed, the researcher's own philosophical perspective about the nature of reality (Creswell, 2007), and its suitability for the intended transformative understanding of the focus of attention. According to Gadamer (1975/1989), hermeneutics commences with the inquirer's "bond to the subject matter that comes into language through the…text" (p. 295). As qualitative research, this inquiry is fundamentally a human process similar to Coppin and Nelson's (2005) encouragement of research as an "active, reciprocal relationship with the world" (p. 11). Further, the

approach incorporated a caring science perspective (Lindberg, von Post, & Eriksson (2013) into methodology in relationship to how the topic, the emergent data, and the researcher are held with respect in the process. In consort with this inquiry's intention to address compassion fatigue, and my pre-understandings as a health care practitioner with phenomena of compassion, human suffering and human caring (Watson, 2012), this study endeavored to begin to operationalize caring dynamics in tending to the researcher and research process. This hermeneutic research was approached in a spirit of discovery (Heidegger, 1962/1996; Moustakas, 1990), relationally through textual conversation (Gadamer, 1975/1989), embodied (Schuster, 2013), and meditative (Bentz & Shapiro, 1998). The hermeneutic approach is viewed as a process of *uncovering* (Heidegger, 1962/1996, p. 109) of what has been "concealed by abstraction" (Gadamer, 1975/1989, p. 153) and provides a means of engaging the unconscious guided through Romanyshyn's (2007) alchemical hermeneutics.

Gadamer (1975/1989) noted that hermeneutics is interested in the tension between the "polarity of familiarity and strangeness" (p. 295) of what the text says, the way it is said, and the story that emerges. According to Gadamer, hermeneutics is found in the interplay in the space "in-between" (p. 295) the familiar and what is strange or hidden. The emphasis on the in-between hermeneutic space is integrated in both the process and content of the focus of inquiry, relative to the exploration of the intersubjective field and that between the researcher and the textual material. As researcher, I engaged in this space between in a way similar to Gadamer's description of a *fusion of horizons*, as an "encounter with tradition that takes place within historical consciousness involves the experience of a tension between the text and the present" (p. 305). The fusion of horizons

conveyed a "birth of new understanding" (Stern 2003, p. 844), which arose from many possibilities. Gadamer characterized the task of hermeneutics as consisting of uncovering the tension between horizons by not "attempting a naïve assimilation of the two but in consciously bringing it out" (p. 305). Therefore, the fusion of horizons extended the range of vision of the inquiry (Moules, 2002), and engaged rather than bracketed out personal horizons, which provided a range of vision and enrichment of the lived understanding that Packer and Addison (1989) consider requisite to study.

According to Palmer (1969), hermeneutics employs both the science and art of understanding for the purpose of human science inquiry. Dreyfus and Wakefield (1988) and Palmer (1969) suggested that hermeneutics is the way that human beings naturally engage to learn about and interpret the world. Most importantly, hermeneutics was an intentional interpretive process sculpted in a way that allows for discovery of the implicit, which has been developed further through the work of Romanyshyn (2007) through alchemical hermeneutics, and Anderson (1998) through intuitive inquiry. The design of this qualitative study engaged the implicit as a living process, as Van Manen (1990) suggested, in a transformative experience as outlined by Ferraris (1996), which is influenced by philosophical underpinnings. Kinsella (2006) suggested that although all research is informed by philosophy, generally this is not made explicit. The purpose of the following, therefore, was to explicate several historical philosophical influences on the development of the hermeneutics utilized in this study. Although it was not my intention to provide an exhaustive recount of the history of hermeneutics, I delineated particular historical aspects that were relevant to the particular focus of the inquiry.

Historical Development of Hermeneutics

According to Palmer (1969) *hermeneutics* was derived from the Greek term, *hermeneuein,* meaning to say or to interpret, *hermeneuia,* the resulting interpretive explication, and *hermeios,* the interpreter (pp. 12–13). Hermeneutics conveys the qualities of the "trickster" and "winged-messenger Hermes" (p. 13), who "transmuted what is beyond human understanding into a form that human intelligence can grasp" (p. 13). Known also as Mercury, Hermes was characterized by his fluid and mischievous ways of navigating the space between the gods and humans, and mediating understanding through his translations (Packer & Addison, 1989). Hermes was able to interpret so that mere humans were able to comprehend the messages from the gods. In a circular fashion, on his return (arc) to the gods, Hermes became a conduit for supplying knowledge of the human condition. The similarity of the role of Hermes with the gods to that of researcher with inquiry establishes the hermeneutic process as a central means of interpretive understanding and discovery. As Packer and Addison described, although we no longer necessarily have a godly messenger such as Hermes, it is up to us to provide a means of interpretation.

Palmer (1969) provided a historical review of a hermeneutic approach as follows. Hermeneutics carries an ancient history from the Oracle of Delphi, and was utilized as a means of exegesis of sacred texts. In the 17th century, hermeneutics theories were inspired by both the rational and divine. Scriptural meaning was explored through the illumination of the embedded dialogue between text and reader, and this perspective is also utilized today. According to Palmer, the German philosopher and philologist, Friedrich Ast held the perspective that the spirit behind the text was steeped in

sociocultural and historical context, and hence was the preferred focus of attention rather than mere textual grammatical meaning.

As Palmer (1969) elaborated, hermeneutics was considered a means of "extracting the *geistige* (spiritual) meaning of the text" (p. 76), which would provide access to the spirit of the author. Hermeneutics, Palmer explained, has been elaborated as a process of the clarification of meaning through an iterative relationship among inner parts and to the whole within the context of the "larger spirit of the age" (p. 77). The following describes several of the key contributors to hermeneutics.

Schleiermacher.

In the late 18th century, the German theologian, biblical scholar, and philosopher Schleiermacher was influential in establishing the foundations of philosophical hermeneutics (Bowie, 2013). According to Palmer (1969), Schleiermacher left a legacy of thought on a psychological view of hermeneutics, including as a primary means of interpretation, understanding, and discovery of the author's intention. As Palmer (1969) clarified, Schleiermacher found a discrepancy between the essence of the text and the exigencies of language. Early in his work, Schleiermacher believed that the task of hermeneutics was to transcend language in order to access the inner process of thought, through his rudimentary concept of a circular process, later known as the hermeneutic circle, in which understanding emerged through an iterative process of movement of part to whole and whole to part. Hermeneutics was considered a humanistic science and art, *Geistesweissenschaften* (Palmer, 1969, pp. 40-41), with *Geist* referring to spirit, mind, or essence (Betteridge, 2012, p. 250).

Dilthey.

According to Palmer (1969), Dilthey's perspective on hermeneutics accommodated a relationship between lived experience, *Erlebnis*, and its expression and understanding (pp. 106-117). Dilthey considered understanding, *Verstehen*, as inherently built into lived experience, out of which understanding of the "mind" (Geist) of the other could be grasped *(*Palmer, 1969, p. 115*).* Palmer further explained Dilthey's idea that human understanding and meaning are derived through *historicality* (p. 116), which was found through a long stretch of horizons, and attempted to perfect an epistemology of the human sciences (Tan, Wilson, & Olver, 2009). Ricoeur (1981) addressed Dilthey's beginning transition from a focus on the text's author's intention or pure historicality to its lived meaning, in the interpretive moment. According to Ricoeur, "Dilthey glimpsed a mode of transcending finitude without absolute knowledge, a mode which is properly interpretive" (p. 53). This indicated that discovery occurs through the notion "the text must be unfolded, no longer towards its author, but towards its immanent sense and towards the world which it opens up and discloses" (Ricoeur, 1981, p. 53), and that the work is never finished.

Dilthey (1976) furthered expansion into various textual sources of understanding including written materials, behavior, art, and religion. Vestiges of the hermeneutic circle began when Dilthey explored ways of knowing through understanding text within the frame of historical-cultural context and the perceived author's intention. In reference to this inquiry, Dilthey's perspective on unfolding the lived experience and meaning was exemplified throughout the interpretive process, in the selection of the textual materials,

through their analyses and recommendations toward the implications for application globally.

Heidegger.

Heidegger's legacy (Heidegger, 1962/1996; Hoy, 2006) evolved from his deep analysis of the ontological stance, the essential human being-in-the-world, or *Dasein* (Heidegger, 1962/1996, p. 297). Heidegger argued that knowledge evolves through engagement in the world, and that such engagement informs further understanding. Heidegger radically distinguished be-ing in the world and countered "the traditional model of the subject as the knower standing over against what is to be known, the objective world" (Hoy, 2006, p. 179). Further, he emphasized the historicality inherent to understanding and the influences of preunderstanding upon textual interpretation. The notion of the hermeneutic circle was formed, which incorporated the acts of revealing and unveiling, basic processes of hermeneutic interpretation (Tan et al., 2009). Heidegger's version of a hermeneutic circle confers an enlivened quality of human understanding to the nature of inquiry. Heidegger was credited by Hoy (2006) with countering Cartesian dualism by expansion of the view of the nature of this life or human be-ing as interpretive, embedded, and mediated.

Koch (1995) provided a description of Heidegger's consideration of "pre-understanding" in reference to the apriori cultural world of the researcher which influences perspective in the interpretative act. Heidegger considered the world and person as co-constructed and inseparable. Therefore, every interpretation is replete with the researcher or reader's forestructures of cognition. Interpretation moves within the context of both preunderstandings and that which is about to be interpreted in a type of

dialectic within the hermeneutic circle. Interpretation therefore involves a new appropriation or modification of understanding rather than purely the acquisition of new knowledge.

According to Heidegger (1962/1996), there was essentially no split between inner and outer, or subject and object, human and world, or essence and existence. They were interwoven in a complex fabric of life, which was comprised of individuals embedded contextually. Heidegger argued that knowledge is attained through engagement in everyday life in a world that then informs understanding. Heidegger suggested that such engagement forms a basis for pre-reflection of an external world, which is pre-printed with purpose into a "web of human meaning" (p. 20), termed a "horizon" or "clearing." As Sass (1989) conveyed, the clearing is considered a "primordial region" that is "imbued with a deep and, in a sense, paradoxical quality of obscurity or concealedness" (p. 21). Heidegger had related the interplay of revealing and concealing, a process of truth seeking that Wrathall (2006) stated was through the ancient Greek term for truth, "aletheia" (p. 20). Aletheia connotes "un-forgetfulness" or "un-concealment," according to Guignon (2006, p. xxii). The act of interpretation entails making that which has been veiled explicit, so that there may be understanding. Heidegger's perspective contributed to this research in terms of the focus on the research process as a living mediated process, which recognized the researcher's intention of exploration of aletheia, clearings, and forestructures in the hermeneutic circle.

Gadamer.

Gadamer (1975/1989), in his magnum opus *Truth and Method,* followed Heidegger in the development of a philosophical hermeneutics, which situated

hermeneutic thinking as “historically operative consciousness” (Palmer, 1969, p. 42). Hermeneutic theory by Gadamer appeared by some to be a reconstructionist means of viewing text in a unified way. Gadamer (1975/1989) stressed that the engagement in a hermeneutic project be focused on the clarification of conditions within which understanding occurs, rather than to develop a discrete procedure through which to gain understanding. Gadamer emphasized that hermeneutics refers to what is evident in a dialogue/text, in conjunction with what was silenced, omitted, or forgotten. Gadamer considered the evident text should consistently be thought of in relationship to what is silent (p. 370), and that the inquirer should be attentive to what is omitted in the language, similar to Heidegger’s practice of aletheia previously described. The process of hermeneutics in this study was comprised of attentiveness to the particular, question what has been rote with the intention to see between the lines, and recognize the inquirer’s resonance with what emerges.

Gadamer (1975/1989) also engaged with Heidegger’s analysis of historicality and pre-understanding, and did not believe there was a pure knowledge unrestricted by past influence. As Gadamer understood, according to Ezzy (2002), there is no pure present, and therefore, no interpretation can ever be complete or fully understood. Gadamer considered understanding in reference to a dynamic past, which is both revealed and enlivened in the interpretive process. Gadamer provided the perspective that the relationship between reader or researcher and text is a continual conversation, which results in what he termed a fusion of horizons. The fusion of horizons refers to the perpetual mediation between the interpreter’s forestructure and the present horizon or experience. Tan et al. (2009) described this process by which once a question is posed,

preunderstanding from prior experiences concerning the question are "superseded by the impact of our exposure to the new experience…understanding is continually expanding as we expose it to dialogue with text, be that written or lived experience" (p. 4).

Gadamer's (1975/1989) hermeneutics was incorporated throughout this study from several perspectives: The interaction that I had as researcher with the textual material was a continual discourse, and hence I was embedded with the material in both the rigors of interpretative analysis as well as the illustrative autoethnographic lived experiences in the field. I engaged in the emergent process, in an open way toward the guiding questions, and drew from previous understanding of the question, and awaited emergence of what transpired between the material and myself. The hermeneutic process was designed to provide exposure to new experience through dialogue with textual materials, whether written, drawn, or lived. The hermeneutic circular dynamics encompassed a fusion of horizons, which was a constant mediation between the textual materials as they were in relationship to my present experience as interpreter.

Ricoeur.

Ricoeur, a French philosopher, further developed the focus on textual interpretation of both manifest and "latent or hidden meaning" (Palmer, 1996, p. 43), and extended textual interpretation to other objects such as symbols in dreams, myths, literature, or society in general. Palmer elaborated that such multilayered textual material "may constitute a semantic unity which has a fully coherent surface meaning and at the same time a deeper significance" (p. 43). Ricoeur emphasized that textual material is not fixed, and as Moules (2002) suggested, is subject to moments of disruption. In hermeneutics, the inquirer is most interested in such moments of disruption, as these are

times when there is a greater potential for understanding, which illuminates that which had been hidden or forgotten.

According to Palmer (1996), Ricoeur proposed that in modern times, there are several approaches to hermeneutics, including demythologizing text through treating it "as a window to a sacred reality…in an effort to recover a meaning hidden it" (p. 44). The approach additionally provides a means to position the interpreter into what Spence (1988) termed a "tough and tender-minded hermeneutics" (p. 62), which speaks to the rigor and diligence of the process.

In reviewing a text, Ricoeur (1991) considered both examining the text's internal nature and text contextually. The repeated exposure to the living text would aid in access further unveiling of context, content, and processes of experiences of meaning of the authors. Ricoeur explained that it is impossible to recreate any event in its entirety, and that there is a meaning to be discovered in the text. Ricoeur believed that access to a "depth semantics" invited the interpreter to "follow the path of thought opened up by the text, to place oneself en route toward…the text" (p. 122).

Postmodern hermeneutics.

Postmodern qualitative research methodologies and hermeneutic approaches in particular have allowed researchers to access and understand hidden human phenomena, the role of the researcher, and the integrative aspects of the implicit (Anderson, 2006; Anderson & Braud, 2011; Moustakas, 1990; Romanyshyn, 2007). In particular, Romanyshyn, a depth psychologist, scholar, and poet, has developed "alchemical hermeneutics," which provided a means of accessing the unconscious through an "imaginal approach" (p. 7). Though the hermeneutic conversation is never complete, this

approach provides a means to allow for the emergence of the unresolved or as yet unspoken. The research process engages the imaginal and offers an enriched dialogue between the researcher and author or text in the hermeneutic circle.

Romanyshyn (2007) carefully outlined specific methodological processes to access the dynamic nature of the unconscious through the transferential field between researcher and the work, and to incorporate vocational ties of the researcher. Romanyshyn's perspectives on intention and approach will be incorporated in the phases of this inquiry. The term *transference* was purposely used to connote the researcher's presence and the evocative nature of the research process. In order to delve into the transference field between researcher and this inquiry, I incorporated the hermeneutic phenomenological perspective in conjunction with strategies delineated by Romanyshyn (2007, p. 173), and these methodological processes are outlined in a later section of this chapter.

As Romanyshyn (2007) suggested, the research and the researcher are not severed from life, but rather are immersed in life, or be-ing, which is richly imbued with the unconscious. The unconscious, according to this perspective, is a dynamic presence underlying the entire research process. The dynamic interaction situated between the researcher and the work is engaged through active imagination, which may be represented in artwork, dreams, and other means of access to the imaginal realm.

According to Romanyshyn (2007), alchemical hermeneutics creates a doorway through which the unconscious is welcomed. The researcher's embodied presence in the personal, cultural, or collective levels of human experience provides a means of transformation into what Romanyshyn described as the psychoid nature of archetype. The

psychoid nature, according to Romanyshyn, is a "pivotal reality, the third between the two of matter and mind, or nature and spirit" (p. 262), and whose language consists of intuitions, reverie, symptoms, dreams, and synchronicities. This view on hermeneutics methodology, which Romanyshyn identified as a "science of soul" (p. 260), is aligned with deep subjectivity.

Romanyshyn (2007) admonished the researcher to engage in releasing, both initially as the work commences, and on an ongoing basis through the phases in the hermeneutic circle. Romanyshyn suggested that the alchemical hermeneutic process of reverie provides a means to let go into the work, in a way that simultaneously grants the work itself to speak. As Bachelard (1969) considered, reverie is a means to contain this letting go process and to access the reconstruction of the work in novel ways.

Nonordinary states of consciousness through reverie, awaiting presence, and provisional thinking are several of the ways to maintain a "metaphoric sensibility" (Romanyshyn, 2007, p. 27), which buffers against the temptation to prematurely delimit a particular analysis of the work. In Jung's (1916/1960) description of the transcendent function, a symbol is one of the means that holds the tension between two forces. Romanyshyn (2007) likened this perspective to that of Corbin's ta'wil (p. 266), which is illustrative of the space between that which is readily known or seen, and the unknown or unseen. Romanyshyn (2007) extended further through a depth psychological perspective of engaging the immanent voices found through the unconscious field beneath or behind the text. As Coppin and Nelson (2005) described, depth psychology "draws one beneath the surfaces of thought, word, and action to the inclinations and impulses of the soul they are rooted in" (p. 42).

Romanyshyn (2007) designed what he termed alchemical hermeneutics (pp. 259-271), as a complex, creative, and systematic process that integrates unconscious processes into the research, as means of "service to soul" (p. 259). Romanyshyn argued that alchemical hermeneutics, most often used adjunctively with another method, provides a means to span the abyss between subjective and objective through accessing the depths of unconscious material. Access to the subtle or hidden has been supported by Steele (1979) in his description of critical hermeneutics, whereby the invisible is rendered visible, through a "hermeneutic gaze" (p. 224). He described this gaze as a type of double vision in which the reader has one eye on careful following of the text, while the other eye flexibly accesses various angles outside the text.

Romanyshyn (2007) considered the need for a "metaphoric sensibility" (p. 27) that can avert the tendency to diminish the tension between the unconscious and the conscious. It is this metaphoric sensibility that keeps the eye on the state in-between, the field between self and other, researcher and the research, and conscious and the unconscious. Romanyshyn noted the influence of Jung's association with symbol and a sense for metaphor as a means of mediation between unconscious and conscious, the visible and invisible, and the light and the dark, the researcher, and the "others" (p. 263) of the work. The processes of this research mirrored the research focus, which demonstrated engagement in exploration of the field between clinician and patient. The research process was inevitably contextual as the topic was steeped in the substrate of psychological, social, cultural, individual and natural conditions in what has been termed as the "analytic field" (Ferro & Basile, 2009a, p. 5), a field that carried not only the

nuances of relational and intersubjective worlds (Stolorow & Atwood, 1992, p. 2), but the larger contextual environment.

Research Procedures

The research procedures are grounded in classical hermeneutics (Gadamer, 1975/1989) and informed by Romanyshyn's alchemical hermeneutics (2007) to explore the "symptom" of compassion fatigue through the lenses of psychodynamic psychology. Hermeneutics is a dynamic approach to textual material in a way that invites possibilities of understanding through developing a dialogue with the material (Davey, 2006). The hermeneutic process of accessing textual material offers the researcher and subsequent readers of the research a means of gaining insights, which lead to understanding and transformation. The held perspective was not to elaborate on the vast history of psychoanalytic thought, but to engender a way of approaching the choice of readings and the actual material so that the voice of the "other," in this case the voices of psychodynamic and psychoanalytic psychology, could dialogue with the textual material of compassion fatigue.

The risk of attempting to confine hermeneutics into strategies and procedures, as Moules (2002) contended, was to "come face to face with the trickster, Hermes, pestering us in different directions" (p. 7). The intention of proceeding in this research with hermeneutics as the foundation of inquiry was to make sense and find meaning (Smith, 1991); however, to that end there were certain methodological procedural considerations that helped guide the process.

Palmer (1969) suggested that inquiry is an original condition of being human, as human existence arises together with understanding, and identified the hermeneutic frame

of inquiry as a fundamental genetic "prestructure" (p. 135) of the nature of the human being. According to Bertrando (2007), in both hermeneutics research and in therapeutic relationship, there is a longing to illuminate connections, the emergence of absence and presence, the inner and outer worlds, and the in-between intersubjective meanings. This hermeneutics inquiry mirrored the psychoanalytic process in terms of my interest in exploration of the yet to be revealed, the implicit, the unconscious, and thematic interconnections through deep listening and presence. I intended to engage in the interpretive inquiry through a process of researching between and underneath and below the surface of the evident, as reflected in Clark and Hoggett's (2009) book title, *Researching Beneath the Surface*. The depth perspective incorporated Jervis's (2009) researcher's self as a tool to access and analyze countertransference, embodied/somatic responses, emotional reactions, associations, and synchronicities.

The hermeneutic process brought into the research living presences of other, which Bertrando (2007) named the "presentification of the third party" (pp. 110-111), and Romanyshyn (2007) identified as the others and imaginal realm in alchemical hermeneutics methodology. The access to the third party referred to a process of reflection, which accesses the inner voices in the text. I incorporated an approach in which meditative reflection and reverie provided a means for the textual voices to emerge. Voices included the authors and the confluence of other voices that were historically, contextually, or unconsciously awaiting discovery.

The following were several specific key elements to the hermeneutic approach to inquiry, which were referenced throughout the work: The process in hermeneutics involved the "hermeneutical circle" as described and elaborated by Packer and Addison

(1989), Palmer (1969), and Bontekoe (2000). The hermeneutic circle, as described by Schleiermacher (Palmer, 1969), addressed the essential dialogue between the text which is in its author's voice, the researcher's readings of the text, and the moments of reflection to open to other emergent data. As with other conversations, there was a mutual transformation that occurred through the continuous interpretative process.

The hermeneutic circle has been considered as a circle, a spiral (Romanyshyn, 2007), or a labyrinth (McEntire, 2005). For the purposes of this inquiry, the hermeneutic circle was thought of dynamically, which was reflective of the movement and aliveness of the process, and so a spiral or a mandala was more fitting in terms of this interpretive study. The hermeneutic circle, as Bontekoe (2000) described, is an energetic cycle, fueled by new understanding, which is then integrated in the previous historical groundwork of understanding. The processes of the hermeneutic circle were rhythmic in terms of including periods of activity, which included engaging in acquiring and reading new material, and resting when the emergent material was given the opportunity to settle and the researcher became more receptive to subsequent interpretive moves. According to Ezzy (2002), the circle does not devolve into a vicious cycle if there is ongoing development of the interpretation and transformation of the researcher in the iterations of the cycles. Gadamer (1975/1989, p. 267) noted that understanding a text is a process of projecting, from initial impression of textual meaning, to ever evolving new meanings, which thereby merge into an in-depth penetration of the material (p. 267).

As Anderson described, interpretive inquiry varies the "focal depth" (1998, p. 85) to rhythmically access in to the detail and outward toward the more global aspects of the focus of inquiry. In this inquiry, psychodynamic lenses examined dialectic between

compassion fatigue and psychodynamic views in the forward and return arcs of the hermeneutic circle. In addition, Ricoeur (1991) addressed a kind of reading that extended the interpretation from the individual to the other, into an anthropological global context. Ricoeur considered hermeneutics invites us to the understanding that "the necessary stage between structural explanation and self-understanding is the unfolding of the world of the text; it is the latter that finally forms and transforms the reader's being-a-self in accordance with his or her intention" (p. 95). Schuster (2013) elaborated that understanding from the past and the present is "intertwined, in the light of the common conditions of human life" (p. 203), which assists toward and orientation to the future. It is then that the task of hermeneutics is attained, a changed life.

Hermeneutic processes proceeded in a dynamic rhythm of understanding, through consistent movement from the part to the whole and the whole to the part in a dialogic conversation between parts and whole. This was exemplified through exploration of compassion fatigue in its many forms, as burnout, as vicarious traumatization, to the theory of compassion fatigue and back to examining what is present and what is silent. In addition, the whole to parts was exemplified with the dialogue between depth psychological perspectives and compassion fatigue.

According to Gadamer (1975/1989), the "harmony of all the details with the whole is the criterion of correct understanding" (p. 291). The inquirer used prior knowledge, essentially relinquished constraint, and moved toward relatedness and a metaphorical sensibility into the material to engage into a *conceptual rhythm*, as described by the anthropologist Geertz (1983, p. 69).

The forward arc constituted pre-understandings and the draw toward the textual material, whereas the return arc reflected a transformation of pre-understanding through the interpretive process (Packer & Addison, 1989). In this inquiry, my pre-understandings included the years of work and training in health care, specifically direct clinical and psychotherapeutic care, to a number of individual, families, groups, and community organizations, and more recently textual and clinical material in psychoanalysis. In addition, pre-understanding in terms of compassion fatigue, vicarious traumatization, and therapeutic presence, in what is termed the analytic third (Ogden, 1997), was exemplified through clinical work with the traumatized, including military veterans, seriously mentally ill individuals, and those with multiple and complex psychological conditions. I experienced phases of movement through the cycles, which were counterbalanced by periods of reverie, both of which provided for refinement and amplification of my interpretive experience through a process of uncovering.

As Packer and Addison (1989) suggested, "uncovering" (p. 278), in which truth is revealed, mirrored the return arc of the hermeneutic circle. As the uncovering process occurred, the circle reverberated back into the process of inquiry, enfolded into the next circle, or what may be better symbolized by a spiral or mandala, which then became circles that overlapped revealing common threads of understanding. This new information was then not only incorporated in the object studied, but was utilized as history through interpretive revisions.

Researcher as Interpreter

Jacobs (2008) argued for the importance of the researcher's authentic "voice, experience, creativity, and authority" (p. 1) in inquiry. Coryn (2006) contributed that

research is a distinct activity in which the researcher engages in "truth-seeking activity, which contributes to knowledge" (p. 124). Denzin (2014) argued that high proficiency in the research project is most likely attained through an interpretive approach. Van Manen (1990), in his description of qualitative study, implored the researcher to live the question. As previously described in this study, the lived experience in the field drew me into this research. Although I continued to draw from varying depth psychoanalytical clinical experiences, it was a deeper call, or as Ricoeur (1981) described, a summoning to the design, that fueled my inspiration for the rigorous hermeneutic research process. The reflectivity of the researcher was considered inherent generally in this research (Lincoln & Guba, 1990), though often in research projects this is not explicated. From the outset of this inquiry, through the selection of the topic, the design and guiding questions, the determination of textual materials and analyses, the researcher was involved with defining, determining, and analyzing possibilities.

Hermeneutic inquiry considered the reflexivity of the researcher (Palmer, 1969), which was considered commensurate with the distinguishing characteristics of a heuristic design that explicated the lived experience of the researcher in the process (Moustakas, 1990). The selection of the topic and the crafting of the guiding research question were founded on my analysis of lived experiences. Such qualitative research begins, as Moustakas elaborated, with an internal searching in a quest of discovery. Moustakas passionately encouraged the researcher to consider the inquiry process as one in which "it becomes a kind of song into which the researcher breathes life…because the question itself is infused in the researcher" (p. 43). The illumination of the reflexivity of the researcher in relationship to that which was studied empowered the final phase of the

research, which was marked by a creative synthesis of both the explicit and the implicit data.

This hermeneutic inquiry incorporated the embodied presence of the researcher into the interpretive process. As described by Schuster (2013), hermeneutic inquiry involved considering the textual material, the interpreter, and the interpretive process as a dynamic alive and fully embodied experience. The transcription of textual material into notes, for example, was not entered into in a perfunctory static way, as it included field notes, which added to the feelings, thoughts, rhythm, silences, and pauses that emerged in the process of interpreting texts. Silences, as Van Manen (1990) suggested, emerged in a way of drawing the interpreter intimately into the place where words are born and meaning between the dialectic of words and space emerged.

Schuster (2013) provided support for ways to interpret textual materials. Reading was situated in a dialectical movement back and forth among the various texts. Interpretation consisted of an initial "naïve" (p. 202), reading which was a way in which the reader approached closely to the text without reflection. Simultaneously, the approach included a critical process of distancing, as elaborated by Shuster's review of Ricoeur. Such proximity to the text engaged the reader to enter the text in a way that allowed for the penetration of the unfamiliar and the arousal of feelings. The endeavor of interpreting the text involved the questioning of the familiar and the unfamiliar so as to understand the other, the text, and to understand the self as interpreter. Schuster stated that "reading from distance is a form of textual reading aimed at creating a space between the researcher and the text" which is both analytical and systematic (p. 202). There were progressive turns from the naïve reading to critical reading and toward the researcher as

the interpreter. Questions interpreted in the reading of the texts included, why do I react as I do when confronted by the text? What is the felt sense, the embodied response in these passages? How is this similar or differ from other texts?

Gadamer's (1975/1989) concept of *Bildung* was considered useful for hermeneutic methodology (Turner, 2003), as a term used to describe the researcher's openness to meaning and learning. *Bildung* originated in ancient mystical traditions, when it referred to the cultivation of an image of God within oneself. Currently, *Bildung* refers to a proclivity to an "inner process of formation and cultivation" (Gadamer, 1975/1989, p. 10). The incorporation of the state of *Bildung* was critical for hermeneutic understanding, as it allowed the interpreter to reserve judgment in favor of openness to alternative perspectives. *Bildung* can be likened to a mindfulness approach (Bentz & Shapiro, 1998) in terms of its focus on detachment from personal desire and openness to possibility in a nonattached way.

Gadamer (1975/1989) further elaborated that *Bildung* allowed for the person to "affirm what is different from oneself and to find universal viewpoints from which one can grasp the thing…in its freedom without selfish interest" (p. 13). *Bildung* is a "return to oneself" (p. 14), while also being open to difference. As Gadamer stated, "A person who is trying to understand is exposed to distraction from fore-meanings that are not borne out by the things themselves. Working out appropriate projections…to be confirmed "by the things" themselves, is the constant task of understanding." (p. 280). I anticipated *Bildung* to manifest in the hermeneutic circle, through the phases of the research process of accessing the differences of texts and fore-projections to gain access

to understanding. *Bildung* was integrated in the study through the data collection, analysis, and summary of findings.

Gadamer (1975/1989) identified the exploration of fore-projection, fore-sight, fore-understanding, fore-having, and fore-structure, which was applied to this study relative to understanding the pre-established stories related to the topic. An important distinction of hermeneutic inquiry was that there was a confirmation rather than a bracketing of the preconceptions. The interpreter was prepared for the text to inform her of something, and this is why, as Gadamer determined that "a hermeneutically trained consciousness must be, from the start, sensitive to the text's alterity," aware of one's own biases, so that the "text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 282).

Phases of Research

The research constituted four stages in which focused intention and determination of preliminary texts, data gathering, data analysis, and final recommendations and discussion occurred. The hermeneutic circle was a ritualistic holding place for the activities of the research. The activities were noted in phases, but as the hermeneutic process was a continual one, the task of gathering textual material, pausing in reverie, noting emergent material, and analyses, occurred cyclically throughout the process.

Phase 1. Discovery of intention.

This phase was designated the initial phase in which the focus and methodology of inquiry were identified through reviewing journal writing from the prior 6 months on the topic and self-inquiry. This phase also was one in which I identified and clarified methodology as related to the topical content, process, and inclinations. There also was a

preliminary identification of textual material. During this phase, I begin a dialogue with emergent material, in art form, journal writing, meditations, and conversations with others in the field. An invitation was set for the implicit to immerge and to bear witness to the dialogue.

To identify initial textual materials, and the relevance of the research, I engaged with the guiding questions to access thoughts, impressions, visions, intuitions, conversations, and experiences. This engagement was a dialectic process, which coalesced into promptings to reread texts, and to discover potential leads for additional textual. The determination of the data process replicated the hermeneutic circle, and included a process of refining the materials as relevant to the guiding questions of inquiry to assure that the textual material was fully accessed yet both manageable and promising for the intended impact in the field. Throughout this research, there was an intention to make the hermeneutic processes of engaging with material explicit.

During the literature review, emergent textual patterns and what had been seen as limited material led to the determination of specific textual material to interpret more deeply as the research proceeded. Preparation of a list of preliminary interpretative lenses or materials was accomplished through reflection on texts from extant literature on compassion fatigue and psychoanalytic literature, as previously outlined. In the spirit of Bentz and Shapiro's (1998) focus on a mindful inquiry (p. 39) in scholarly work, and my forestructures of understanding, I incorporated a mindful awareness of self. This allowed a means to thoughtfully sustain both a scholarly and authentic voice amidst the onslaught of data available. An invitation was established to multiple perspectives, including the mysterious, an openness to the implicit, and an intention to contribute to the

understanding of compassion and compassion fatigue in the hope of alleviation of suffering. Additionally, as researcher I alerted to textual data, which emerged through experiences and conversations in the field. The foundations of this phase essentially were completed by the completion of the proposal phase.

Phase 2a. Entering the hermeneutic circle.

As Romanyshyn (2007) relied on Corbin's conception of the mundus imaginalis, this phase was one in which I attended to the process in the space between self and other through a compassionate presence. As researcher, I incorporated an intention to be mindful throughout the process, which was experienced in an embodied way.

The acknowledgement of one's horizons and prejudices, although not bracketed in a hermeneutic study as is done in phenomenological studies (Giorgi, 1970), were relevant to recognize as part of one's unconscious ideology. Gadamer (1975/1989) identified the assumptions and perceptions brought into the field of inquiry as "prejudices" that should be reflected upon and brought into the inquiry, with the intention toward understanding and what Grondin (2002) considered an agreement, over a fusion of horizons. As Anderson (2006) claimed, interpretive inquiry invited the identification of personal lenses and perspectives into the study for their revision and transformation. Several examples of interpretive lenses that I brought into the work included cultural perspectives from engagement in health care, midwifery, integrative holistic nursing practice, a clinical psychology student with emphasis in depth psychology, and clinical training in psychoanalytically informed psychotherapy.

In this phase I engaged in reading, reflection, sustained awareness of lived experiences, beginning interpretation, and recorded field notes. Reading of textual

material progressed in a manner that I had adapted from Romanyshyn's (2007) guidelines, in which he suggested that the complexity of what occurs between the reader and the text is an emulation of what transpires in the complex transferential field between psychotherapist and patient. The reading of text abolished the distance between self (researcher) and other (text), and the texts simultaneously "read us and we are as much infected or interpreted by them as they are by us" (Romanyshyn & Goodchild, 2003, p. 17).

The following guidelines were adapted from Romanyshyn (2007). The guidelines provided a preliminary means to read the material to lay the groundwork for interpretation in a way that respected the unconscious, while a frame was maintained that limited over involvement, which would eclipse the text. The following were key points of the guidelines: (a) A frame for reading was established similar to that used for therapy or ritual. For example, I established a means of access to the material, time, and place. I gathered all the material, through purchasing, library loans, and when available, through electronic form; (b) During the reading process, I attended to moments of hesitancy and to urgings to stop in the text. Through these moments of pausing, I awaited an association, image, and felt sense, made note of that, and then recognized shifts in reengagement with the material; (c) The next aspect of reading was to be aware of a felt sense somatically and within the space between self and other. Again, this provided for associations, images, and thoughts, which expanded the sense for interpretation of the textual material; (d) This step called for diminished effort to delineate the information in the text in favor of being present in a state of even attention, which provided a means to extend and expand rather then prematurely reducing down the textual material, in what

could be described as Keats's negative capability (Bate, 2012). Particular attention was given to awareness of misreading or mistaking phrases and times of dissociation or forgetfulness; (e) Particular passages, which were associated with any of the above, were then spoken. The transition from silently reading to vocally reading, provided for a means of a slower indwelling with the material and an engagement with the embodied process of interpretation.

Throughout the process, field notes were written, including underlining or highlighting with notes written in text. Additionally, journal notes of the textual materials were written in two columns, which included content reflective of thoughts, feelings, or associations to the material, through words, and images in terms of the topical area, as exemplified through readings, synchronicities, dreams, lived experiences, and other material. In addition, the researcher continued to record in daily electronic journal impressions of the topic, photographs, and drawings. These notes were utilized in subsequent phases during rereading of the material, further deepening of the material through engagement of the unconscious, the determination of additional texts, and data analysis.

Phase 2b. Deepening in the hermeneutic circle.

The next part of this phase of the research shifted toward incorporation of select perspectives from the alchemical hermeneutics of Romanyshyn (2007). The processes included an approach to the unconscious material through creative processes which drew from the historicity of the work, including ancient and ancestral history, and recovered what had been hidden or veiled, into an understanding and re-creation of voices left unfinished. The ongoing inquiry was a "creation continua" (p. 271), a work that is never

done, which therefore required that I engage in a caring compassionate partnership in the dynamic hermeneutic circle.

The illumination of material from rereading of textual material occurred within the transferential space between the researcher and the other, and in terms of the guiding questions. The interpretations were consistent with the guiding question, and other emergent questions that evolved in the dynamic process in the hermeneutic circle. My intention was to substantially explore the meaningful interconnections of depth analytic approaches to compassion fatigue, which offered to illuminate understanding and its prevention. This phase enlisted what Love (1994) described as "features of significance" (p. 1 para. 4), which revealed what was omitted or limited from the literature. Textual material was closely examined to identify noticeable repetitions, the evocative nature of the material in terms of a felt sense of the researcher, and unexpected or surprising associations.

During this phase, an adaptation of Romanyshyn's (2007) transference dialogues occurred, which provided for an expanded means of material for interpretive analysis. In a ritualized and meditative way, I established a time and space during this phase to open to the voices of the authors and others to provide me with additional perspectives. As this additional textual material was reviewed, I took notes electronically and highlighted felt sense and feelings, which provided a sense for the significant features and voices within the data. Handwritten notes were written in the margins as indicated during dwelling with the material, and emergent themes were noted or drawn. Further interpretations or ideas were illustrated through the lived experience in the field, which data was kept on a daily basis in a separate journal.

In the imaginative method in alchemical hermeneutics, Romanyshyn (2007) ascribed value to inviting various states of consciousness, including active imagination and meditative awareness of the invisible connections of meaning. The structure of inquiry provided enough flexibility to allow for creativity, which invited the unfolding of the work into evolving possibilities through the hermeneutic circle or spiral. Creativity took the form of words or images that emerged through reverie, the direct interpretive readings, dreams, interactions, meditation, or in the processes of active imagination through transference dialogues. The inquiry remained flexible in terms of allowing for textual material to emerge which included dialogue, journaling, poetry, images through photography, paintings, and drawings such as mandalas (Cornell, 2006).

The documentation of textual material, including transference dialogues, occurred through written field notes as described by Emerson, Fretz, and Shaw (2011), with a separate column included for notes (e.g., thoughts, surprises, associations) when writing and when rereading. Field notes provided a means for systematically processing associations, reverie, meditations, felt sense (Gendlin, 2007) and embodied experience (Schuster, 2013), dreams, and synchronicities. The notes were considered textual material, and were incorporated with other data for subsequent re-view and analyses.

Phase 3. Emergence: Analysis of connections and patterns.

The next phase allowed for the refinement of the initial textual material through the identification of emergent patterns and surprises, augmentation of additional texts, which enhanced deepening of the patterns, and textual analysis. There were two movements in this phase: “Incubating the Data” (Anderson, 1998, p. 91) and data analysis. Incubation connoted a period of rest, when I sequestered away from the

intensity of data collection and concentration on the question, and moved toward a process of opening and settling. The period of retreat was followed by a period of analyses, whereby the data continued to be refined, through a process of *sympathetic resonance* (Anderson, 1998, p. 73).

The data analysis included setting up the materials for analysis: reviewing field notes, which included handwritten and e-journal entries, highlights of textual materials, transcription of electronic notes, and drawing or other artwork. In hermeneutic inquiry, the data analysis was accomplished throughout the research in ever-evolving turns in the hermeneutic circle as necessary as the data emerged. If patterns emerged, I accessed these through insights and syntheses, and provided a descriptive account for the relationship of findings to the guiding questions. This was a phase of discovery in which I examined the implications for my changed view of the focus of inquiry, and integrated illustrative themes through lived narrative, artwork, and other textual data derived from field notes. This phase also constituted a time of further incorporation of feedback from my committee.

Phase 4. Transformation: Extension into the field.

Herda (1999) stated that through the creative act of analysis, the "researcher appropriates a prosed world from the text. When we expose ourselves to a text, we come away from it different than we were before" (p. 98). According to Ricoeur (1981), "the text must be unfolded, no longer towards its author but towards its imminent sense and towards the world which it opens up and discloses" (p. 53).

During this phase, as researcher, I planned to engage the interpretive material in the forward arc of the hermeneutic circle to its application and relevance to the whole,

thus allowing for launching of the data in a new way. The data, as transformed through engagement in prior phases, was integrated in a way that could be utilized for the benefit of psychological knowledge and health care practice. This phase fostered the identification of connections among the dynamic emergent patterns to the guiding questions, and integrated and reorganized the data to provide a means for revisioning the focus of inquiry. As Anderson stated, "the most important feature of interpreting data is intuitive breakthroughs, those illuminating moments when the data begin to shape themselves before the researcher" (2006, p. 28). In this phase, emergent patterns were constellated in a variety of ways, including descriptive narrative, images, and composite clinical illustrations. In this part of the process, I reviewed the data in light of the initial phases, and discussed what the value of the study had been in terms of personal process, contribution to a body of knowledge, clinical implications, global relevance, and suggestions for further research.

Validity in Qualitative Inquiry

A number of researchers have noted the different ways to view validity in qualitative research (Lincoln & Guba, 1990). As Anderson (2006) proposed, being rigorously detailed in subjective truth and in speaking from your own voice while avoiding circularity in seeing data that confirms values and assumptions, allows for the reader to "sympathetic resonance" (p. 38) in the topic. In a qualitative study such as this, the value of the findings was found in the distinct applicability to the intended audience, in this case, other clinicians, including psychologists, medical providers, nursing providers, social workers, and other mental health professionals.

The validity of this inquiry was achieved through appropriate selection of texts, and as Fischer (2006) described, a "scrupulous faithfulness to the data in the analysis and in the representation of the findings" (p. xvii) enhanced validity of the inquiry. Fischer outlined the possibilities of validity (p. xvii), which were relevant for this study, including *touchpoint validity*, which referred to the connection of the findings with theory and other research in a way that provided confirmation or expanded prior understanding. For this interpretive inquiry, touchpoint validity was discovered through access to textual material on hermeneutic methodology, compassion fatigue, and psychoanalytic theories. *Efficiency validity* referred to the usefulness of the findings in terms of their impact on theory or practice. Efficiency validity was elaborated in the last sections of the dissertation related to the relevance of understanding compassion fatigue from the perspective of the psychodynamics of what occurs between self and other in the field between as a means of further understanding primary and secondary prevention, clinician supervision and training, and further research. *Resonance validity* referred to how the data would be commensurate with the experiences of those in the field. Clinical composites illustrated experiences in the field, and the feedback from the scholar-practitioners on the committee were taken into consideration. Further, *revisionary validity*, which compels individuals to affirm or revise prior understanding, through a deeper or changed understanding, was found in the refinement of the data through the analysis and constellation into emergent thematic patterns. The latter section of the dissertation process was devoted to emergent patterns and connections across theoretical orientation of understanding to engage in a deeper and transformative understanding of the data.

As Anderson (2006) suggested, in a hermeneutic research, there is the important efficacy validity, which referred to the reader finding value, meaning, and understanding through the study. To evaluate this latter validity, I considered my transformation in the course of the study, including an increase in depth of understanding of the topic and its applicability and potential impact on engaging others in considering new actions to tend to themselves in their continued clinical care.

Ethical Considerations

There were no animal or human participants in this study. Every effort was made to engage in the approach and process of hermeneutic inquiry through clear respect for the textual authors. Any of the illustrative materials were composites of the researcher's experiences and do not reflect any particular individual, place, or situation. Previously published case examples were duly referenced. Engagement with the phenomena was accomplished through a process that mirrored compassion and human caring, and awareness of self. As emphasized by Romanyshyn (2007), the engagement of the researcher who works on conscious awareness of what she or he brings to the work, demonstrates an ethical obligation to the research method.

Chapter 4
Hermeneutic Turns of Psychodynamics and Compassion Fatigue

> The search for reason ends at the shore of the known; on the immense expanse beyond it only the sense of the ineffable can glide…. We do not leave the shore of the known in search of adventure or suspense or because of the failure of reason to answer our questions. We sail because our mind is like a fantastic seashell, and when applying our ear to its lips we hear a perpetual murmur from the waves beyond the shore…. Citizens of two realms, we all must sustain a dual allegiance: we sense the ineffable in one realm, we name and exploit reality in another. Between the two we set up a system of references, but we can never fill the gap. They are as far and as close to each other as time and calendar, as violin and melody, as life and what lies beyond the last breath.
>
> (Abraham Heschel, 1990, pp. 1-2)

Introduction

In this chapter, the emergent textual data originated from the preceding chapters, and evolved through an empathic examination and interpretation of classical through contemporary psychodynamic thought. The rhythm of the inquiry evolved through a pulsing of leaning in toward the psychodynamics as a meta-language of compassion fatigue, and leaning out in a state of engaging reverie. The hermeneutic turn appeared as a balance point between the backward glance into the textual materials, and within the state of reverie to discover what was hidden between the lines. The foregoing chapters formed a basis which thrust me into the momentum of the spiral of hermeneutic

interpretation of psychodynamic thought relevant to compassion fatigue.

A psychological lens was employed in a way that enabled me to visualize and interpret textual material from the surface in words and thought to the depths of unconscious patterns, dreams, and meaning, which ultimately erupted into emergent streams of thematic material. At this juncture, the process of inquiry has followed the process described by the philosopher, poet, and psychologist Romanyshyn (2007), who dedicated such a study to the emergent voices gleaned from within both the lines of the textual and the lived research interpretive moments.

My engagement with the material started with an embrace of the vast psychoanalytic tradition steeped in the classical through its development into relational and contextual contemporary psychodynamic perspectives. I had chosen the works as they called to me through the textual references, and also through the visions and impressions while working with "other," including patients, other interdisciplinary team perspectives, and environments, including the health care system and the natural environment. The depth psychological perspectives garnered were then brought into conversation with the felt sense of compassion fatigue. An attitude, similar to an analytic attitude, of curious discovery prevailed as I began to envision the mirroring of posttraumatic stress and vicarious reactions such as emotional numbing, avoidance, and hyperarousal with diminished engagement in the world or altered belief in a safe and just relational world. The voices from the textual material interspersed with the lived experience of the interpretive process, and culminated in a crescendo. It was as if the vast horizons of the global transitions of consciousness, reflective of deep change, with both beauty and terror, had conspired to drop into my process of inquiry. The eruptive

process occurred at the deepest levels of psyche, even to the point where Kileauea volcano erupted, and for the first time threated the community on the Big Island on which I have resided for over 30 years.

My work moved into what could be described as a sitting with "other," in the eruptions within the texts of profoundly great writers, being receptive to emergent ideas in the lived experience, and engaging in putting to pen what emerged. I became progressively more curious about how we as clinical providers sit with those who call to the attention of a clinician, whether because of severe trauma, recent and ancient, suffering, or with those who enlist the aide of another to avert the feeling of alienation and move through a process of healing with other. Patients may seek an attachment figure, someone who, in the mode of a recent movie, *Avatar,* "sees them," but does not intrude and usurp whatever vestiges of sense of self and respect is left intact from, for example, severely troubled childhoods. While during the process of this writing, I worked in both a psychoanalytically informed psychotherapy internship and then as a clinical nurse specialist/therapist with the most severely challenged psychologically. These experiences brought a daily momentum to the eruption of connections to the questions posed by this inquiry. The following is a summary of this experience, which coalesced into several emergent themes that are instructive for further research and as applied to clinical training and practice.

The process of this inquiry mirrored that which formed the basis for attention, namely what transpires in between self and other. The clinical setting involves therapist or clinician as self to the patient as other, which was reflected similarly in inquiry as researcher (self) to the textual material (other). The clinical intersubjectivity is in the

clinical moment; the research intersubjectivity was in the hermeneutic interpretation of the data. In the sense of a hermeneutic inquiry, both the intention and stance that I took was one of open discovery, and inviting what psychoanalyst and practicing Buddhist Epstein (1995) termed "thoughts without a thinker" (p. 1) to emerge. A form of reverie took place alongside of engagement with and episodic pauses of interpretation of textual and experiential phenomena. The hermeneutic process paralleled a psychoanalytically informed practice of interpretation guided by a gentle mindful presence within the inner world of the researcher, which allowed for the unconscious to erupt into consciousness.

The process entailed hermeneutic movements, which stimulated a type of sensing of emergent patterns in the conversation between psychodynamic perspectives and compassion fatigue. The steps involved in moving through the textual material were enfolded in an existential experience, and provided a flexible frame, guided by the organicity of the hermeneutic spiral. The space between the inquirer and inquiry emulated the shared analytic field, the relational field between self with other as first illustrated with mother, and echoed in therapeutic relationship. The thematic interpretive process was experienced commensurate to Gendlin's (2007) "deeper bodily felt sense" (p. vii). The process entailed in this felt sense an allowance to dwell in moments of obscurity and to be "open into a whole field of intricate detail from which new steps of thought and action emerge" (Gendlin, 2007, p. viii).

Re-Viewing Compassion Fatigue in the Field

Clinicians, although well intentioned, have lacked the in-depth training involved with understanding the depth psychological perspectives of what transpires between self and other and within the clinician in particular. To further this dilemma, most care

providers work in isolation to some extent, even if they work within a team in which they seek to provide comprehensive care to the patient. It is rare to find such care integrated in a trauma informed and supportive environment for the provider/clinician. As Pearlman and Saakvitne (1995a) described in their thorough exploration of the impact of countertransference and vicarious traumatization on the therapist, the therapist in isolation who lacks a clear conceptual framework readily becomes both overtaxed and at risk for harm of self and harming others. Both Pearlman and Saakvitne have considered the helpful understanding of developmental trauma, therapeutic alliance, transference and countertransference, within a base of psychoanalytic theory as a means to mitigate the deleterious effect of working with both the complex/difficult and numbers of patients managed.

The history of trauma work has gone through periods of amnesia, according to traumatologist Herman (1992). The recall of such work emulates the symptomatology of the traumatized, namely the associated symptoms of dissociation, denial, and repression. The ensuing difficulties for the clinician include engagement in dissociated unconscious reenactments. These experiences of reenactments or even identification, compel therapists to act in ways that are commensurate with those of the patient, which in the case of the traumatized patient, can mean being engaged in a power struggle.

Figley (2002b) and Badger et al. (2008) considered compassion fatigue as an inevitable consequence of empathic tending to those who are suffering. The therapist's empathic engagement has been linked to the development of vicarious traumatization (Pearlman & Caringi, 2009), but it remains unclear in what ways this process might occur. Tansey and Burke (1989) in their compendium of

formulations on empathy suggest that we consider countertransference an aspect of empathic process. For example, early studies on therapists who worked intensely with combat veterans were burdened by symptoms of vicarious traumatization, including emotional dysregulation, anxiety, emotional numbing, aggressive fantasy, judgmental attitudes, grief, horror, anger and rage, and existential angst (Blank, 1985; Haley, 1974; Lindy, Green, Grace, MacLeod, & Spitz, 1988; Scurfield, 1985). Those same symptoms mirrored the posttraumatic stress symptoms of the veterans, which were characterized by Chessick (1978) as a type of sadness of the soul.

Lindy and Wilson (1994) ascribed the evolving patterns of symptoms incurred by the traumatized to the psychodynamic unconscious patterns of tension, which are layered over and over from unresolved earlier events. This kind of layering may permeate and organize today's psychic life in affected individuals. Then when the clinician meets such an individual in a therapeutic alliance, reenactments or repetitions can play out within the context of the therapeutic relationship.

Lindy and Wilson (1994) suggested that the therapist, who thereby establishes certain parameters, is in a position to enable the work to continue. The patient's progress is both disencumbered while the sustained well-being of self of the clinician is sustained. Others have identified these parameters as gaining a working alliance and rapport (Greenson, 1967), a therapeutic frame (Etchegoyen, 1991; Levine, 2009), a neutral yet empathic perspective (Strachey, 1934), and the provision of understanding and interpretation (Gill, 1983; Langs, 1982).

Furthermore, the recognition of transference-countertransference phenomena has been recognized for its significant role in organizing what transpires in the therapist-patient dyad, and understanding what affects the clinician and (Kohut, 1959).

The therapist may be placed in a position of "catching" disaffected shards of traumatic experiences from the patient who has disavowed, dissociated, suppressed or otherwise denied the fragments of experience. The clinician is in a position through the empathic response, self-reflection, and as Kernberg (1965, 1987) suggested, the use of projective identification, to recover those lost parts of experience. As Tansey and Burke (1989) considered, projective identification provides the clinician with a visceral way of accessing a felt sense of other. Through projective identification, the clinician's experience could be considered an extreme empathic response, "as if" she or he were in direct involvement into the dynamic experience of other.

The clinician who works with the patient who has denied or suppressed painful experiences from the past may experience the retrieval and reenactment in some capacity, the original encounter. This process was illustrated in a case outlined by Lindy and Wilson (1994, pp. 72-73), in which a patient who had suffered childhood incest with a stepfather asked the therapist to extend hours into the evening for her appointments. The therapist (reluctantly) changed the hours, though he thought there might be less safety by doing so, yet at the same time he did not want to come across as being harsh. Several months later, the patient asked to have a fee reduction due to financial problems, which had been kept

hidden from the therapist. Therefore, the therapist feared that he would be viewed as sadistic if he did not comply and sacrificed his usual fee to accommodate her. She began to have terrifying dreams and feelings, which were representative of past traumas. These experiences were emulated in the transference. The therapist noticed being drawn to the patient's neediness and yet felt irritable about her not paying the bill. As the therapist followed up in clinical supervision, it was revealed that the uninterpreted internal pressures that the clinician was experiencing then resulted in shifts in boundaries and the analytic frame, and the subsequent countertransference reactions prevented him from clearly identifying the demise of the frame.

The indicators of countertransference may be heightened affect, pressure to manage affects and to quickly respond, shifts in therapeutic frame, derailment from therapeutic empathetic stance, and vestiges of past trauma through feelings of being swept into unusual sensations and feelings reenactment. This clinician sought clinical supervision for this one patient, and he did not technically cross an ethical boundary. The work, however, does not entail one patient, but many, including many who may be survivors of trauma, severe early childhood trauma, and a cycle of what Herman (1992) called a "familial climate of pervasive terror" (p. 98). When this is coupled with the pervasive terrorism in the world, the empathic response to others is affected. Should the clinician manage large numbers of patients who also have severe histories, the building of multiple complementary or mixed types of countertransference suggests a resulting

complex reaction of compassion fatigue and vicarious traumatization in the clinician.

To counter the above, Lindy and Wilson (1995) have suggested that the therapist who actively self monitors for countertransference reactions, and appropriately attributes transferential thoughts, feelings, and shifts in behaviors to countertransference, will be better able to recognize and manage formatively in the developing therapeutic relationship. The contributions of Lindy and Wilson in relationship to what the clinician can do in vivo when managing the clinical care of others who have been traumatized encourages the understanding of countertransference reactions.

Lindy and Wilson's (1995) outline of countertransference reactions can facilitate recognition of signals reflective of the progressive development toward compassion fatigue. Countertransference reactions may manifest as dysphoria or excessive affects that impact internally on the clinician. There can be ensuing defenses set in motion to effectively distance the therapist from other or spur overextension and over involvement. The empathic strain is characterized by over identification or further withdrawal from other, regression, or a sense of disequilibrium. The clinician may experience an eruption of defenses, including, as Lindy and Wilson noted, "symptom formation or ego-alien thoughts or feelings … impairment of at least one component in the therapist's usual, empathic, neutral function, and loss of some aspect of professional boundary or therapeutic frame" (pp. 70-71)**.**

Saakvitne (2002) described psychotherapeutic work as a process, which is "risking connection … in which both patient and therapist must risk deep emotional connection, both intrapsychically, within themselves, and interpersonally, with one another" (p. 446). There is a range of affects that clinician's experience that often parallels those of their patients. Studies done with Holocaust survivors (Danieli, 1984), with combat veterans (Lindy et al., 1988), and with clinicians (Lindy & Wilson, 1994) suggested that there can be excessive affect, which is experienced as subjectively distressing or discharged through actions are either ego-syntonic such as through prosocial action, mindfulness in session, or skillfully authentic empathy. Alternatively, the clinician may have ego-dystonic distress such as unacceptable sado-masochistic thought or fantasy. The clinician may alternatively attempt to manage the intensity of affect by withdrawal, through dissociation, intellectualizing, premature interpretation, distraction, feelings of boredom, considering the trauma stories witnessed as fabricated, or constricted affect. Countering the avoidance, the therapist may be overly responsive, as exemplified by the clinician above who provided excessive and repeated accommodation to the patient's requests in terms of shifting the frame. Furthermore, the clinician may opt to see a patient more frequently, though frightened by the patient. The affects and actions of the clinician provide clues that he or she may be undergoing a countertransference response, thereby alerting to the need to process the raw psychic material evoked in the process of working closely with others.

Unaddressed countertransference becomes a problem when the therapist fails to act within a therapeutic frame or there is interference with the provision of functional care. The eruptive symptoms of the therapist may parallel those of the patient, and vary with the therapist's personality, style, and history. Lindy and Wilson (1994) exemplified this with a case in which the psychologist reacted to a graphic traumatic narrative of carnage in which he had somatic symptoms of adrenergic response and had to distance from the setting to regain composure. Further somatic complaints can be dizziness, headaches, and nausea, which were indicative of a defense against or denial of countertransference by Lindy and Wilson. The somatic experiences of such countertransference phenomena are not only common but persist beyond the therapeutic interaction with the patient, and can manifest in a constellation of symptoms of compassion fatigue such as intrusive thoughts, images, memory losses, and reenactments. The avoidance symptoms in particular can then foster further devolvement into an internal exile whereby the therapist avoids sharing the experience in clinical supervision, peer consult, or personal psychotherapy. The avoidance can then foster a further blurring of boundaries, and self-imposed exile from colleagues and the profession.

The nature of clinical work and in particular intensive psychotherapy is both an intimate and a confidential undertaking. Close-in listening and bearing witness to complex and often severely traumatic details of the narratives of those who seek help for relief from suffering exposes the clinician to a host of "contagions." As the psychoanalyst Searles (1958) commented:

the therapist, at the deepest levels of the therapeutic interaction,

> temporarily introjects the patient's pathogenic conflicts and deals with them at an intrapsychic, unconscious as well as conscious, level, bringing to bear upon them the capacities of his own relatively strong ego, and then, similarly by introjection, the patient benefits from this intrapsychic work which has been accomplished by the therapist. (Searles, 1958, p. 214)

Barring the narcissistic traces of the above statement, the process of taking in the pathogenic components is relevant to one of the means that contribute to resulting in diminished well being in the clinician, today known as compassion fatigue. Searles (1958) identified that the burden remains with the analyst/therapist for the responsibility for prevention of such decline and to maintain professional integrity. Sedgwick (1994, 2001) suggested that the clinician continuously engages in a type of transferential fusion through close work with the patient. He described the work of psychotherapy as a "psychic infection" (p. 67), whereby the therapist takes on the broken conditions of the patient and engenders a healing process that influences the healing process for the patient. As Jung (1946/1954) discussed, transference entails the infection of the doctor with the illness. According to a Jungian perspective, the therapist "quite literally 'takes over' the sufferings of his patient and shares them with him" (pp. 171-172). Jung warned that this process is fundamentally an occupational hazard to the work of the analyst. In the healing process for the patient, the therapist can become ill. Jung described this as follows:

> The doctor, by voluntarily and consciously taking over the psychic

> sufferings of the patient, exposes himself to the overpowering contents of the unconscious and hence also to their inductive action….The patient, by bringing an activated unconscious content to bear upon the doctor, constellates the corresponding unconscious material in him, owing to the inductive effect which always emanates from projections in greater or lesser degree. Doctor and patient thus find themselves in a relationship founded on mutual unconscious. (p. 176)

Sedgwick (2001) admonished that caring for others deeply "involves some degree of struggle for the therapist and necessitates critical self-examination both before and during psychotherapy" (p. 68). Furthermore, as outlined by Sedgwick, Jung advised focusing on the inner dimensions of the experience in terms of establishing a therapeutic space between self and other. He referred to this as "temenos," which in ancient Greece was considered a sacred sanctuary (pp. 120-121).

Simultaneous to the requirement to be aware of the risks involved, the therapist needs to be present, to empathize, and yet to separate enough to gain perspective, stepping into the shoes of another, and also remembering to step out of them. Researchers Pearlman and Caringi (2009) had suggested that the therapist's initial awareness is a single aspect of preventing vicarious traumatization, though this was not elaborated. Still others, such as Gelso and Hayes (2007), considered empathy an "inner experience—a partial and temporary identification with the patient, in which the therapist for a period of time … puts at least aspects of him or herself aside and dwells in the patient's inner world"

(pp. 72-73). Extended dwelling there "in the shoes of other" may be ascribed to a certain vulnerability on behalf of the clinician to engage, as Pearlman and Saakvitne (1995a) outlined, "the part of rescuer or of having a sense of omnipotence as a way to defend against feelings of helplessness, violating therapeutic boundaries, and identifying with the victim's (or sufferer's) rage and grief" (p. 5). The inherent fluidity and structure, expansion and contraction within the therapeutic experience are well represented when considering such boundaries and how they may influence compassion fatigue.

Casement (1991) considered boundaries as a "search for space" (p. 158). He encapsulated his understanding of this through the following description of his experience:

> I had to discover how to read the (unconscious) cues of this patient, which I did by trial-identifying with her or with the objects of her relating. From this way of listening it was possible to recognize what the patient (needed that) that she had not been finding. She dramatically demonstrated her need for clear boundaries to the analytic relationship, and for a genuinely neutral space in which she could become autonomously herself. (p. 158)

Similarly, boundaries are also a consideration for the analyst or clinician to differentiate self from other in the frequent numbers and intensities of experiences through which the clinician delves into empathic connection with other. On the other side of boundaries, Lazarus (1994) suggested that too artificial or rigid boundaries could be obstructive to the therapeutic relationship. Although Lazarus discussed the potential impact primarily on the patient, he did infer ideas about

the implications for the clinician. He specified that clinicians who "practice psychotherapy responsibly—with compassion, benevolence, sensitivity, and caring"—would also be influenced by feelings of compassion (p. 260).

According to Casement (1991), the establishment of boundaries connotes a process of separation. The awareness of separateness is important for the patient to discover the independent reality of the clinician, and to reify for the clinician the space of discovery between self and other. A clinician can care too much, or alternatively crosses boundaries to acquiesce to what Celenza (1991) termed narcissistic vulnerabilities, such as rescue fantasies, the usurping of authoritative power, or sexual transgressions.

Casement (1991) shared in his review of boundaries that in situations in which he felt overwhelmed, he often felt tempted to control the situation through interpretation. This process allowed some assurance that he could still be rational and functional in the midst of chaos. It is reassuring that the infamous British pediatrician and psychoanalyst Winnicott (1971/2005) also experienced this process, though he admonished other therapists to delay what he considered the defensive maneuver of interpretation until after the chaotic phase was over.

Freud (1915/1957) warned that the clinician "must recognize that the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person; so that he has no grounds whatever for being proud of such a "conquest," as it would be called outside analysis (pp. 160-161). The clinician who mistakes the transference as real is one of those considerations that lend toward boundary violations in the therapeutic

relationship. However, even more subtly, the clinician may experience the bounds of compassion and love for the patient in a way that inevitably transforms the clinician. The eroticized transference can occur in the clinical context and has been interpreted by Celenza (1991) as a defense against rage, disappointment, or hate in the transference. The risk of boundary violations then would be enhanced with defenses in difficult cases in which the analyst or clinician is bearing witness repeatedly to severe traumatic experiences, whether by the patient's story or enactment in session. Furthermore, Celenza elaborated on the contribution of countertransference experience, and considered the unconscious and unresolved early conflicts of the therapist, which may emerge at times of impasse, or may persist through the countertransference without awareness. Celenza described the psychodynamic experience in a case that challenged her to examine the emergent patterns:

> In the case presented, the dynamic pattern (including the unconscious selection of the victim-patient) recapitulated unconscious, unresolved conflicts on the part of the therapist in relation to early parental figures. Interestingly, the pattern emerged when the treatment was at an impasse; the seduction of the patient occurred in response to intolerable feelings in the counter-transference of which the therapist was unaware… (this was) an unconscious attempt to circumvent the negative transference and to sustain a positive idealizing transference easier for both parties to bear. (p. 508)

The suggestions to ameliorate these reactions include acknowledging feelings and engaging in understanding how the emotions can be recruited into other goals than those the clinician is aware of; attending carefully to unresolved and personal vulnerabilities; training to heighten awareness to lessen the corroboration of transference as reality; equitable management and distribution of power; exploring personal conflicts that are best addressed in personal therapy and compassionate clinical supervision; and examining the ability of the therapist to handle rage and hate directly rather than averting in other ways such as through boundary violations.

Winnicott (1969) addressed human psychological developmental through individuals finding externality through the other who is separate. Casement (1991) stated that it was not enough for the patient to think of him as simply a separate object, a container, in which to dump projections. The developing human being, Winnicott (1969) explains,

> is creating the object in the sense of finding externality itself, and it has to be added that this experience depends on the object's capacity to survive…. If it is in an analysis that these matters are taking place, then the analyst, the analytic technique, and the analytic setting all come in as surviving or not surviving the patient's destructive attacks. (p. 714)

The patient needs the assurance that the clinician is a separate empowered being in his or her own right and who has the capacity to withstand and survive in a psychic sense the intensity of what is experienced. When a clinician succumbs to ever devolving sense of self through compassion fatigue, the patient is more likely

to perpetuate similar experiences, and recognizes a personal loss in the ability to survive severe and deadly perceptions and feelings. The rage has killed the messenger, in a fantasy of utter destruction.

The mental perturbations of sensorial descriptions of narrative can influence the clinician both within sessions and beyond, erupting in the therapist's life through dreams, associations, and intrusive images. Secondary traumatic stress as elaborated by Figley (1995a, 1995b) as well as Kadambi and Ennis (2004) emerges in the response to the direct interactions with those traumatized, specifically to the intersubjective demanding experience with patients, and can suddenly "catch" the therapist off-guard.

Wilson and Lindy (1994), in their review of therapists who work with those with posttraumatic stress, found that the responses involve both avoidant symptoms and over identification with patients. In Danieli's (1984) work with Holocaust survivors and their families, sequelae involved fear, rage, guilt and shame, and defenses that were also avoidant, such as emotional numbing, dissociation, or denial. Lindy et al. (1988) found that those working with combat traumatized survivors were distressed and had increased affect. Others spoke of the importance of examining the role of enactment and responsibility of the therapist.

Davies and Frawley's (1994) work with those who had experienced childhood sexual abuse elaborated on the role of reenactments, which are central to countertransference. They emphasized, however, the responsible and carefully detailed process of working through the imposing dynamics through clear

interpretation. From these studies, it was found that both empathic listening and access to the experience of other is one step in the process. The next step is being able to provide for interpretations that are understandable and useful for patients.

Figley (1995a) emphasized that the strain on clinicians who provide care for those who are suffering and or traumatized in some capacity is related to empathy, and places the therapist in vulnerable risk. As Pearlman and Saakvitne (1995a) stated, "the literature has not yet provided a systematic theoretical framework for understanding the complex interplay of therapist, client, and contextual factors that impact upon both the work and the self of the therapist," and this is what follows in this textual interpretation (p. 8). The following will address empathy, the clinician and his or her attitude/stance, countertransference, deep listening, and the intersubjective or analytic field, as these contribute toward understanding of the complex phenomena known through compassion fatigue, vicarious traumatization, and secondary stress as experienced by clinicians.

Empathy in Therapeutic Relationship: Psychodynamic Dwelling

Snell (2013) suggested that psychoanalysis is embedded within a phenomenological framework, which provides perspective on the analytic stance or way of being with other. Moran (2000), in his review of phenomenology, relied on Husserl's thought that phenomenology is a way of considering consciousness without presuppositions. Moran (2000) considered the clinician's stance would be best served "in absolute poverty, with an absolute lack of knowledge" (p. 127). He elaborated further that this meant

> a kind of Cartesian overthrow of all previous assumptions to knowledge, and a questioning of many of our "natural" intuitions about the nature of our mental

> processes or the make-up of the objective world. Nothing must be taken for granted or assumed external to the lived experiences themselves as they are lived. (pp. 126-127)

Moran's position revealed the important consideration of being open to the possibility that perspective is limited, the importance of knowing oneself, and the relevance of the evocative material presented by troubled, "difficult," and suffering patients in one's clinical work. It brings to mind the value of understanding that there is endless unconscious material that the clinician may never be privy to, and yet awareness breeds understanding that can never fully know the internal world of other or self, nor what transpires between self and other. The phenomenological stance of "absolute poverty" noted above could be equated with a classic neutral stance, which leaves the clinician openly curious about what may emerge within the subjective world, the patient, the intersubjective experience, and the "analytic field" (Baranger, Baranger, & Fortini, 2009; Ferro & Basile, 2009a, 2009b).

Whereas Green (2009) described a classical analytic neutral stance as a form of "benevolent neutrality" (p. 43), Snell (2013) identified it as a means of maintaining a "calm attentiveness" (p. 45). Both descriptions appear to connote an abiding warmth rather than the cool aloof paternalistic figure. From the stance of benevolent neutrality, the clinician listens intently on multiple layers for what arises within the patient, within the analyst-self (i.e., as differentiated from the self), and within the space between the two. Schafer (1983), in his book *The Analytic Attitude,* described the classic psychoanalytic maintenance of neutrality as vital to the need for consistency in every aspect of the work with the analysand or patient. Schaefer considered that the rationale of

the third ear was to afford the patient the opportunity to allow conflictual material, whether verbal or nonverbal, conscious or preconscious, or unconscious distress, to arise for review and interpretation. The process of rising of the material can be abrupt or insidious, or lagging behind under the psychic surface which then influences the clinician. The incredulous forces behind such a process influenced Anna Freud's (1936/1966) concern to maintain an equidistant stance from the imposing forces. This sort of equidistance is analogous to mindful presence, which draws the clinician into a firm receptive presence that is both empathic and deeply compassionate. I turn toward empathy to examine this phenomenon in terms of compassion fatigue.

Halpern (2001), in *From Detached Concern to Empathy: Humanizing Medical Practice,* discussed the inappropriate admonitions in medical training to avoid emotional connection with patients as a means to provide medical care and to prevent burnout. Halpern argued that although this philosophy was formulated to desensitize physicians in order to better provide objective care, the results were likely the opposite. Clinicians lacked awareness of their own emotional reactions to both clinical dilemmas and patients, and had suffered long-term impacts on their sense of well-being, which ultimately impacted on the medical care they provided.

The philosophical understanding of Descartes (1911/1985), Heidegger (1962/1996), Sartre (1948/1975), and Stein (1916/1989), among others, led Halpern (2001) to the conclusion that though emotionality introduced "risks of error, there is an important place for subjective, or experiential knowledge in understanding of other people" (p. xiii). The recognition of emotional reactions, associations, cognitions, images, and emergent patterns, provided the clinician with important cues of self and other. Such

emotional experience through an empathic response subsequently avails the clinician more effective work with complex psychodynamic intrapsychic and intersubjective phenomena. Such complex phenomena include countertransference, projective identifications, primitive states or unformulated experiences, and the notion of emotional contagion, which will be further elaborated in this chapter.

Importantly, the experience found within the inner life of the clinician may reveal more data on the patient, the therapeutic relationship, and aspects of the clinician's facility in working through intimate intrapsychic patterns. The process of "working through" the emotional and transferential material is in itself a hermeneutic interpretative process manifested through the embodied and the dynamic process in the "third" of the therapeutic encounter.

Engagement with others can be, as Maček (2014) suggested, an engagement through deeply listening which in turn shapes further clinical work, research, teaching and supervision. Listening connotes a leaning in toward other and a certain taking on of emotionally demanding psychic material. The preliminary awareness of the nuance of the layers of psychological strata through somatic, emotional, and psychic response to other is a first step in recognizing steps best taken in minimizing the ramifications of this difficult and challenging work. Empathic and deep listening can be a process of reflexive understanding, which further enhances sustainability and engagement with the experience of other especially within the context of repeated exposure to chaotic, primitive states, and severely traumatized and psychically fractured individuals.

Maček (2014) developed a compilation of articles on the phenomena of researchers' global engagement with trauma, which I found are similarly applicable to

clinicians. Maček concluded that scholars exposed to traumatic events, whether through stories of their interlocutors or directly, can be emotionally overwhelmed or bewildered existentially in terms of the meaning of life. Kubai (2014) exemplified this phenomenon through her description of the engagement in an environment where the researcher experienced the smells and intimate examination of the carnage of genocide. Weiss (2014) outlined specific ways in which the strenuous research or clinical work done under the duress of severe occupational constraints, coercion, or threats of violence affects the individual and his or her ability to process material witnessed. In her fieldwork with the Kurds, Weiss found that the detrimental affects of such work impacts the individual researcher and the work done. However, she also found that when the researcher was engaged in a conscious and reflective way, internal processing of the material was more effective and ultimately benefitted the ensuing work.

Exposure may be direct, as with social workers in the domestic violence field who bear witness to family violence. This exposure can be indirect, as occurs when a psychotherapist listens to traumatic stories of patients. Further, exposure can be at a tertiary indirect level, for example with clinicians who work with characterological problems and primitive states that are the result of historical severe developmental trauma. There can also be a combination of levels of exposure, as with journalists in a war zone who listen to and write traumatic stories, directly witness trauma perpetrated on others, or suffer from trauma such as being wounded.

In such circumstances, Dwork (2014) considered the importance of the clinician or researcher's temporal, geographical, and emotional separation from the trauma to self-protect against the traumatic material. This perspective on empathic involvement

suggests a type of analytic distance. Temporal separation may include exploration of whether or not the clinician needs to immerse into the experience of other in such a deep way that one's own analytic capability is subverted. Empathy does not connote merging with other, but selective immersion whereby the clinician gains a sense of the experience to more effectively work with the patient.

The clinician who is with the other in an empathic stance can both enter and distance in reflection during the process of bearing witness, through an exploration of an individual's lived experience and its traumatic elements. Weiss (2014) considered analysis as the contextualization of the experiences and what transpires between self and other, whether in psychotherapy, other clinical work, or between researcher and participants/subjects. The experience of remembering trauma, reenactment, and retelling of it can present a kind of projective identification that is used by the individual to relay emotional states viscerally rather than symbolically as through words.

The unbearable discomfort at times experienced by clinicians may mirror that of the patient, and presents the clinician with the patient's desire to work through difficult and unsymbolized experiences in the mind and body of the other. This perspective was reflected in Kaplan's (2014) core research on the child survivors of the Holocaust, and the 1994 Rwandan genocide. Her approach had been best reflected by the idea that she engages in "psychoanalytic listening, [and creates] a space for possible deeper understanding" (p. 159) in the process of bearing witness to the oral recounting of life histories. She struggled with choosing what to systematize in the writing of their experiences, knowing that it was inevitable to omit certain factors through making assumptions about their experiences, which may then leave the story without key

elements. Kaplan further questioned the intrusiveness of assumptions about the participants in her work, and revealed her tendency to be on the margins of experiences in favor of being more of a "guest" (p. 160) in their sessions. Kaplan reflected on her readiness to move from one house to the next for her research. She posed the question:

> Am I a person who quickly tries to get an overview of the current situation, who has my "luggage ready," prepared to move on? Could this attitude of a need to be independent and also to be prepared to move—among other factors—be a trans-generational phenomenon with roots in my grandmother's flight from Nazi-occupied Norway in 1942? (p. 160).

Similarly, the work of Kaplan suggests that clinicians can experience such phenomena. Within the clinical intersubjective experience, the therapist utilizes a dynamic lens, which mirrors what the patient presents, links with past personal traumatic experiences, and accesses transgenerational trauma. This perspective further suggests the relevance of avoidances in-session, such as too quickly changing the subject, applying skills training rather than allowing space for emotions to emerge. The clinician who too quickly provides a huge box of tissues as a seemingly caring gesture, may unconsciously protect self from the expulsive eruptions of deep sorrow of the patient. As Gadamer (1975/1989) stated, "The person with understanding does not know and judge as one who stands apart and unaffected; but rather, as one united by a specific bond with the other, he thinks with the other and undergoes the situation with him" (p. 288).

Contemporary psychoanalytic thought has been considered "a land of inexhaustible fertility" (Bolognini, 2004, p. 20) in which therapists are informed through encounters with others, whether patients, colleagues, or the numbers of historical

psychoanalytic figures who built psychodynamic models of mind. Empathy has been found in classic psychoanalytic literature, but it takes some effort to capture. As Pigman (1995) noted, in classical Freudian literature, the term Einfuhlung or empathy occurred up to twenty times, half of which were found in his least studied work by clinicians. Freud (1905/1960) considered empathy as follows:

> Thus we take the producing person's psychical state into consideration, put ourselves into it and try to understand it by comparing it with our own. It is these processes of empathy and comparison that result in the economy in expenditure, which we discharge by laughing (p. 186).

The interesting aspect of this perspective relative to compassion fatigue is that once the clinician begins to experience the constellation of symptoms of compassion fatigue, such as paling of affect, avoidance, and diminished beliefs about the world and significant others, there may be diminished sense of levity, the laughter of which Freud addresses, which impacts on joy in the work. This is an apt description of compassion fatigue.

Empathy in the clinical hour was considered by Snell (2013), who looked at the process of acute observation and mimicry as "enquiring empathy or mirroring, which gives rise to what psychoanalysis would later call counter-transference" (p. 159). Quotations from Poe's "The Purloined Letter" appear often in narratives related to empathy (see Ickes, 1997, p. 59; Snell, 2013, pp. 59-60). Poe (1845/2013) stated:

> When I wish to find out how wise, or how stupid, or how good, or how wicked is any one, or what are his thoughts at the moment, I fashion the expression of my face, as accurately as possible, in accordance with the expression of his, and then

> wait to see what thoughts or sentiments arise in my mind or heart, as if to match or correspond with the expression. (pp. 176-177)

Interest in the ability to feel into another was described in ancient times. French philosopher Montaigne wrote of the connection between introspection and empathy, and the propensity to language emotion, understanding, and spatial intimacy. Conley (2005) described Montaigne's essay: "Without empathy for things unknown or for potential beings and places that remain over and beyond the horizon of a person's own experience, sentience tends to wither. Life becomes deadened if a relation with the unknown is forgotten" (p. 75). The deadening is similar to compassion fatigue, where there is a sense of loss of other, and the self, a certain deadening and forgotten proximity to others. The psychotherapy session emulates Montaigne's conceptualization of the "language of emotion is couched in a language of spatial intimacy: we feel 'close to', 'attached to' and 'touched' by others" (Frampton, 2011, p. 75).

Italian psychoanalysts Bolognini and Borghi (1989) reviewed the term *Einfühlung* or empathy, and noted it appeared first in the work of the Disciples of Sais by the poet Novalis in 1798. Empathy was found to be a fusion of thought and poetry in the worlds of feeling and nature. At that time, the external forces and macrocosm mystically mirrored and fused with the internal and subjective. Psychoanalyst and professor of literature G. W. Pigman (1995) outlined the history of empathy and noted that the importance of the concept was minimized in examination of the psychoanalytic literature due to mistranslation of the term. Comparatively, the term *sympathy* dates back to the Greeks over 2000 years ago. The concept of empathy was termed *Einfuhlung* over a hundred years ago by German philosopher Vischer in reference to "in-feeling" or "feeling-into" in

aesthetic appreciation through the projection of self into the aesthetic object (Pigman, 1995, pp. 243-244). The concept was reworked by the behaviorist Groos during the latter part of the19th century, and considered as an active "inner imitation" by Vischer, according to Pigman. As described by Wellek (1970), the English novelist Vernon Lee brought the term *Einfuhlung* to a wider audience and blended both the muscular responses in mimicry especially when viewing the arts, and also the feeling component. He suggested that feelings gain entry into what is perceived through a process of sympathetic feeling-with and feeling-into the form perceived.

Wispé (1990) further elaborated on the conceptual development of the construct of empathy. In the early 20th century, Lipps and Prandtl further developed the psychology of empathy. Lipps analyzed perspectives on how we arrive at knowing another person or object. He described the default in the nature of language in attributing the fullness of the object rather than considering the important aspect of the beholder's resonating with the object. The philosopher Stein (1916/1989) stated that the individual "sees shame in the blushing, anger in the clenched fist, joy in the radiant smile" (p. 70).

Wispé (1990) noted:

> It is in the nature of language to designate these as a unity of experience, but it is rather the inner activities of the person, which resonate with the stimulus of the object to which it is inextricably bound, that provide the meaning. (p. 19)

Wispé furthermore described Lipps's view of the three spheres of knowledge of others, one being *Einfuhlung*, and the next two as self-knowledge and knowledge of things. A person attains self-knowledge through apperception and knowledge of things through sensory information. Therefore Lipps in *Einfuhlung* meant that, for example, the one who

beholds a sense of pride in other, simultaneously experiences that other as experiencing pride. What she or he sees as a finite descriptor is enacted in the individual. Wispé stated, "This is the only way to grasp certain kinds of aesthetic appreciation, the only way to grasp the leafless tree that stands naked against the wind, the person weighed down with sorrow" (p. 19). Lipps posited that there are certain qualities of the experience of other that are perceived as "in" rather than "about" the other, suggesting that there is an embodied sense of other. Not only is the other seen, but also felt experientially. Although Lipps did not specify this, the felt sense hints toward an emotional as well as sensorial feeling. Wispé noted that Allport took this argument further, toward the concept that knowing others goes beyond mimicry and into the realm of understanding that this sentient "other" is a conscious being. This perspective opens the possibility of considering the other in a compassionate way and not "just" empathically.

Wispé (1990) added that Prandtl, less well known than Lipps, did discuss the nature of empathy in terms of knowing self through "empirical empathy" in addition to Lipps's feeling empathy. Empirical empathy referred to the individual as able to understand other through reproducing former experiences. The individual in this case infers the perceived experience of other as the witnessing of that other person's experience links with past experience.

The clinician who considers his or her interaction with other, therefore, is not simply bearing witness to another's experience, but commensurately feeling with and into the other's experience in a way that brings the experience into a kind of psychic enactment in the self. In consideration of the clinician, this can be interpreted as a way that clinicians bear witness for example through listening to others' stories, feel into the

story, interpret the story through the feeling in process, and experience the story within. With repeated stories with multiple individuals, the clinician may hold the residue of multiple layers of experiences. Furthermore, empirical empathy can be thought of as the clinician's attunement with self and the origins of countertransference reactions to other. This will be further elaborated in the chapter section on countertransference.

Lipps and Prandtl exemplified how individuals were able to garner understanding of other, whether aesthetic object or the other person's consciousness. The fundamental process appeared to be inner imitation, later known as motor mimicry. By the early 20th century, Einfuhlung appeared to fuel the understanding of participation with other, including a greater understanding of meaning in the consciousness and aesthetics of other. Wispé (1990) stated that:

> inner Nachahmung, inner imitation, and motor mimicry, were precursors—and psychologically richer versions—of what today we refer to as vicariousness. This does not mean that these terms are synonymous. It merely means that the problem of explaining that objects are felt as well as seen is still with us. (p. 20)

The experimental psychologist Titchener (1909) elaborated on the use of inner imitation as the only way to know the consciousness of another: "Not only do I see gravity and modesty and pride and courtesy and stateliness, but I feel or act them in the mind's muscle. This is, I suppose, a simple case of empathy, if we may coin that term as a rendering of Einfuhlung" (p. 21). Given that Titchener had been a Greek and Latin scholar, his translation of this concept into *Einfuhlung* and empathy meant that there was a literal meaning of feeling into the passion or the deep suffering of another and hence could be construed as analogous to sympathy.

Social aspects of empathy have been elaborated through anthropologists Mead (1934) who emphasized the importance of the individual's assumption of roles, internalization of norms and interactive responsiveness, as well as a working knowledge of the reactions of significant others in the community. Mead (1934) considered the relevance of being socially adept, which depended on the individual's capability in assuming roles which "put himself in the place of" (p. 218) other to access the perspectives and roles of community members.

The concept of empathy has been associated with a number of psychotherapists, including Rogers (1980), Kohut (1959, 1984), and Kahn (1985). Freud discussed *Einfuhlung* in terms of humor and social psychology (1922/1949). Freud (1905/1960), stated that as therapists, we take "the producing person's psychical state into consideration, put ourselves into it and try to understand it by comparing it with our own" (p. 186). Freud, in his writing on Group Psychology (1922/1949), declared that empathy "plays the largest part in our understanding of what is inherently foreign to our ego in other people" (p. 66). According to Freud, empathy assisted the individual "to take up any attitude at all toward another's mental life" (p. 70) and provided a means of understanding. Freud however, was further interested in the way that identification led to the process of empathy through imitation.

Downey (1929) described the process of empathy in terms of both aesthetics and personality:

> Famous analysts among psychologists and art-critics have given us many subtle modulations of the doctrine of inner imitation and of psychic participation. Their technical term for this process of psychic participation is empathy, or a process of

> "feeling-in" in which motor and emotional attitudes, however originating, are projected outside of the shelf…. From one point of view we subjectively an object; from another point of view, we objectify the self…Our understanding of persons is molded by something akin to empathic processes. Through subtle imitation we assume an alien personality, we become aware of how it feels to behave thus and so, then we read back into the other person our consciousness of what his patterns of behavior feels like. (pp. 176-177)

Downey pointed toward the notion that one of the challenges with empathy is that there is continued moment of projection into the object. Primarily though Downey, not only reengaged empathy with its original aesthetic origins, but also applied it to enhance the understanding of psychology.

Until the 20th century, empathy was characterized by projections in understanding empathy. The *Oxford English Dictionary* (2014) provides a definition which is instructive of this view: "The quality or power of projecting one's personality or mentally identifying oneself with an object of contemplation, and so fully understanding or appreciating it" (n.p.). Later, the term *empathy* was considered the ability to appreciate or understand through specific use of sensing, feeling, or experience. This perspective was later replaced through the intrapsychic and then the relational. Freud (1905/1960) early focused on intrapsychic phenomena particular to the importance of the therapist such as neutrality and "evenly suspended attention." In his later work on identification in *Group Psychology and Analysis of the Ego*, Freud (1922/1949) considered empathy as a means by which we derive comic relief, and the human capacity to experience pleasure from the

absurdity of those in dire straits. He viewed the ensuing empathy, and the utter relief that one experiences that it is someone else. Freud stated:

> it is noteworthy that we only find someone's being put in a position of inferiority comic where there is empathy—that is, where someone else is concerned: if we ourselves were in similar straits we should be conscious only of distressing feelings…which plays the largest part in our understanding of what is inherently foreign to our ego in other people. (1922/1949, p. 66)

The comic relief then may create a buffer between self and other, beyond its primary function of defense, it is a way the self, as we refer to the analyst or clinician, separates from the other or patient. Although it appears antithetical to empathy, it may be viewed as the necessary valve by which empathy can be sustained. When compassion fatigue is considered a loss in empathy, it naturally follows there is a loss in this "comic relief" and hence separation psychically from the sufferer.

Bolognini (2004) brought contemporary continental psychoanalytic perspectives on empathy into the fore. He considered empathy as either a conscious or unconscious process by which the therapist ascertains understanding of the patient's experience. Empathy has been viewed as foundational to the positive transference (Freud, 1905/1960) and therapeutic relationship (Bohart, 1991; Bohart & Greenberg, 2013; Rogers, 1980). Campbell (2004) suggested that the empathic clinician utilizes imagination to "tap the recesses of our experience to find within ourselves an approximation of what we think another person might think and feel" (p. 9), though this is an elusive process. Alternatively, however, Freud also cautioned the therapist on the use of empathy due to its potential for impacting one's personal feelings. Bolognini in particular assisted with

the changing views of unconscious processes through his interpretation of Italian texts on the subject (as exemplified by Spacal, 1990; see Bolognini, 2004). Bolognini was especially helpful in drawing connections between empathy and countertransference that had surfaced through the translation of such continental texts.

Bolognini (2004) disagreed, as do I, that empathy is solely disposed as a concordant process. Kohut exemplified this in the suggestion in the literature review of this study that even Hitler had empathy when he instilled bombs with sounds, knowing this would heighten the fear of his targets. Bolognini also considered the relevance of empathy in terms of aspects that were dystonic to the patient, which likewise provided a way for the clinician to step into the shoes of other rather than through consistently ego-syntonic ways of knowing. British psychoanalyst Campbell emphasized that empathy cannot be forced or automatically accessed, but it can be recognized to be absent through

> awareness of a loss of internal contact, a feeling of being uncentered, and not analytically integrated is a signal to begin finding one's self again through a process of self-empathy, which repairs and reintegrates his or her personal and professional internal objects. (2004, p. 10)

The "loss of internal contact" and being "uncentered" would likely be suggestive of an embodied sense of loss of self in the process of being in relationship with other. These early signs of lost sense of self suggest a means for both self-assessment in the midst of other, and recentering through what Campbell terms self-empathy, to repair one's internal objects. Thus the unforced unfolding empathic response serves to flexibly address and support both the self and the other.

Empathy implies dwelling with the other, entails what Freeman (2014) described as a "mystery of being—but only if we are attentive enough to its objects and devoted enough to the causes and purposes" (p. 43). Freeman accepted the difficulty of empathic response to the other and spoke to French philosopher and playwright Gabriel Marcel's suggestion that those who no longer love life can no longer experience the spontaneous living fresh upsurge of the world. This can, in Freeman's terms, eclipse the other and become a space in which there is no longer the energy to heal or become whole again:

> Far from being a place of sacred value, it can become a place with no value at all. More to the point still, it can become a kind of *non*-place, an empty extension of the person's alienation and misery. There will be no beauty and no wake-up calls to perception—only, perhaps, a perpetual sleepiness. For these people, the world may be essentially dead, a lunar landscape through which they roam interminably and without purpose… (without) sources of sustenance and nourishment, no sources of light. (p. 43)

Freeman's perceptive is closely aligned to what appears in the loss of meaning that can ensue with progressive compassion fatigue, the "dead, lunar landscape" expresses the alienation and blocking of emotional feelings and a sense of personal meaning in the work, the self, other and the world. Freud's description of locating the other noted above, infers mitigation against the clinician's ability to discern in the interpretation of self and other, inner and outer. This process further implies a diminished sense of a well-demarcated boundaried self, which thereby influences susceptibility to emotional contagion, such as exemplified by repetitive bearing witness to trauma.

Psychoanalyst Bollas (1992) provided details on the self-other, self-world relationship that can aid in conceptualizing this inner object world of the clinician. Bollas stated that "memory becomes a kind of gathering of internal objects, developing an inner constellation of feelings, ideas, part images, body positions, somatic registrations, and so forth that nucleate into a sustained inner form" (p. 59). He further described this inner object world as he experiences it as follows:

> I am inhabited, then, by inner structures that can be felt whenever their name is evoked; and in turn, I am also filled with the ghosts of others who have affected me. In psychoanalysis we term these "internal objects," which clearly do not designate internal pictures, or clear inner dramas, but rather highly condensed psychic textures, the trace of our encounters with the object world … as we encounter the object world we are substantially metamorphosed by the structure of objects; internally transformed by objects that leave their traces within us, whether it be the effect of a musical structure, a novel, or a person. In play the subject releases the idiom of himself to the field of objects, where he is then transformed by the structure of that experience, and will bear the history of that encounter in the unconscious. (p. 59)

The ongoing and repetitive nature of clinical and therapeutic empathic moments are thought to likely build momentum in such gathering of internal objects which then prod an inner way of constellating feelings and conceptualizations within, including within the clinician. The clinician then becomes "filled with the ghosts of others" that builds up over time, and rarely exorcised, as is mirrored in compassion fatigue. A further exploration of empathy is relevant here as Bollas suggested that empathic relatedness is like a "psychic

key" (p. 17), an abiding resource in the exploration of self and other. The Italian psychoanalyst Bolognini (2004) brought attention to the confusion surrounding the term *empathy*, including that empathy can be construed in a too sanitized manner, as a way to connote a relational sentimentality that is simplistically sanguine. Rather, he advanced the perspective that empathy connotes something about the unconscious, as Orange (1995) suggested countertransference leads to empathic response.

Bolognini (2004), referred to prior writings when he considered past experiences of the clinician as a fundamental basis for empathic connectedness with other, in both feeling and thinking with the patient. Beres and Arlow (1974) emphasized within the empathic response, a transient identification with the other, which is followed by a disconnection, a separation. The ensuing separation is inherent to the traces left of the other that includes both the feeling with and the feeling about other. Such identification infers a temporary oceanic feeling of oneness with other, which is then followed by the embodied sense of aloneness. The clinician mirrors this through a felt sense of residue of emotional feeling with the patient, and good enough separation to think about and interpret for the patient.

At this juncture, what Beres and Arlow's (1974) perspective alternatively suggests is that the clinician who has difficulty on either end of the empathic connection (i.e. too much feeling with or the lack of separation), is more likely to develop symptoms of compassion fatigue or vicarious traumatization. The therapist in a way is in a precarious position: he or she needs to be empathic to gain understanding, but not so empathic that there is a loss of self in a suspended oceanic feeling. Furthermore, the empathic connectedness can temporally continue through dreams, associations, images,

and embodied sense that can be eruptive in the clinician's life long after the session is over. Bolognini (2004) emphasized that "true empathy requires … above all separation and differentiation, attention, and an ability to keep theoretical thought in operation" (p. 15). This perspective points toward an empathy as a subtle containing process, which allows for some permeability for the clinician to maintain a good enough role and process. As Strachey and Strachey (1986) noted, the word *empathy* is "a vile word, elephantine, for a subtle process" (p. 171).

The empathic response hinted at above emphasized the value of engaging with other through a dual process of engagement and separation with differentiation. The separateness implies a counterpoint to Emde's (1990) "empathic availability" (p. 881). A further analogy is a sense of leaning into and feeling with the experience of other, in a state of possibility of stepping into the others' shoes. Such empathic experience provides a bridge for the patient as well as perhaps more subtly for the clinician, between earlier experiences with significant others, and the current clinical experience. This interactive clinical process has been known to avail the opportunity to a corrective emotional experience (Alexander & French, 1946). The psychoanalyst and empathy theoretician Kohut (1977) felt that these episodes of such corrective emotional experiences could remediate past empathic failures.

The works of Beres and Arlow (1974), Friedman (1978), Schafer (1959), Shapiro (1981) as well as Stolorow, Brandchaft, and Atwood (1987) emphasized the important place empathy holds in the clinician's psychotherapeutic work. The clinician's sense of empathy is of fundamental concern in the role of the therapist, and has been considered in much the same way as that of the mother toward her young child. Various psychoanalytic

theorists and clinicians (Deutsch, 1926/1953; Fraiberg, Adelson, & Shapiro, 1975; Loewald, 1960; Main, Kaplan, & Cassidy, 1985) have addressed empathy in parallel to early roles and the mutuality of experiences within the analytic or clinical dyad as a mirror of the mother-child dyad. The pediatrician and psychoanalyst Winnicott (1949, 1953, 1956, 1987) was one of the first influential researchers, clinicians, and writers to consider the caregiver, the mother, and her side of the experience. As Winnicott suggested, there are two in the dyad, and much of the attention has been relegated to the one, the baby, to the neglect of the mother. He advised it was vital to explore the mother's experience in order to enable her to continue in her role and address the needs of the baby. In a parallel way, Winnicott's thought can be applied to the therapist/clinician, and is evident in how the clinician gazes at, listens to, and nourishes the interaction.

Spitz (1956) and Gitelson (1952) described this sustained supportive function of the analyst as a living process. The analyst-therapist contributes to ongoing caregiving in a healing way through reification of healthy relationship. Austrian-Hungarian psychoanalyst Rene Spitz (1956) explained this in the following way:

> The patient is helpless while the analyst role is to be helpful, the situational stimulus in the analytic setting which acts on the analyst is, therefore the patient's helplessness. It evokes in the analyst fantasies derived from the ego ideal, which he formed in identification with his parents. We have postulated that the analytic setting places the patient into an anaclitic relationship. I may be permitted to suggest a distinctive role of the analyst's in this setting. Anaclitic means leaning

> onto; I recommend for the analyst's attitude the term diatrophic (from the Greek, to maintain or support), which means supporting. (p. 260)

The diatrophic function of the analyst is viewed as his or her intention to support and maintain the patient. According to Spitz, the diatrophic function arises in response to need similar to a parent's response to the need of the child, all of which then form the foundation for empathy as a means of consolidation with the patient's need. The analyst, similar to the mother, provides an auxiliary ego, which then further provides for patient and therapeutic goals and direction.

Of relevance to compassion fatigue, Spitz (1956) further suggested that anaclitic and diatrophic aspects of the relationship operate across the conscious, the unconscious, and fantasy life. He warned against reenactment in the life of the analyst. Spitz also interjected that the clinician should understand his or her own origins of the fantasies in order to hold the material in the state in-between conscious and unconscious, and between self and other. Spitz stated that the therapist "has to understand the origin of his diatrophic fantasies sufficiently to be able to accept as a matter of course that the rule of abstinence operates for himself as much as it does for the patient" (p. 261). The idea of abstinence is relevant to the prior discussion on separation, and in classical psychoanalytic literature this is of primary concern.

A fundamental concern of Freud was related to excessive involvement with the patient. In one of his letters to Carl Jung, in 1911, Freud admonished Jung of the necessity to detach. He wrote:

> I gather that neither of you has yet acquired the necessary objectivity in your practice, that you still get involved, giving a good deal of yourself and expecting

> to give something in in return. Permit me, speaking as the venerable old master, to say that this technique is invariably ill-advised and that it is best to remain reserved and purely receptive. We must never let our poor neurotics drive us crazy. I believe an article on "counter-transference" is sorely needed; of course we couldn't not publish it, we should have to circulate copies among ourselves. (1911/1974, pp. 475-476)

As Keenan (1995) noted, it has been over a century, and discussion of boundaries is no longer shrouded in secrecy and it is well known that the therapist countertransference and enactments are inevitable. However, Keenan also admonished that now it is assumed "that **enactments** are partial—that the analyst 'catches himself'" (p. 853). This rhythmic movement from empathic connection back toward separation was touched on through the literature reviewed and has implications for conceptualization of the dynamic nature of the therapist's ongoing development and perpetuation of compassion fatigue. Freud (1912/1945) advised his colleagues to

> model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible…The justification for requiring this emotional coldness in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help that we can give him today. (para. 12)

Freud briefly considered that both the patient and analyst are required in the analytical situation to do or not do certain things. The patient is supposed to reveal without

hindrance or filter what he or she observes inside. Then he implored the clinician the opposite:

> the doctor must put himself in a position to make use of everything he is told for the purposes of interpretation and of recognizing the concealed unconscious material without substituting a censorship of his own for the selection that the patient has forgone. To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free association. (para. 13)

Freud admitted that this is a challenging position for the analyst as it demands a high degree of control to not "hold back from his consciousness what has been perceived by his unconscious" (para. 14), but encouraged the analyst to do so to keep the analysis pure from distortion. Freud considered his psychoanalytic protective gear as receptivity through association, deciphering what emerges, and interpretation rather than loose affiliation and dangerous identification with the patient. These admonitions hold relevance toward the therapist today in balancing empathic involvement, a leaning in process, and separation, a process of leaning away.

Compared to Freud, the psychoanalyst Deutsch (1926/1953) delved into the mutual identification of the analyst and the patient through a process in which they

communicate and tune into one another's unconscious. Bolognini (2004) provided the following translation of Deutsch:

> The affective psychic content of the patient, which emerges in his or her unconscious, becomes transmuted into an inner experience of the analyst's, and is recognized as belonging to the patient only in the course of the analyst's subsequent intellectual work. (p. 36)

The focus within this analyst's work is on the clinician's receptivity to processes of a personal regression, which can result in a certain amount of blurring of the experience between self and other. The perspective encourages the analyst's intellectual work referring to interpretation, clinical supervision, his or her personal analysis or psychotherapy, and the awareness in the clinical moment. As Bolognini stated, a realization that "I am feeling this because I am identifying with him, but in fact it is the patient who should be feeling this!" (Bolognini, 2004, p. 37). O'Hara (1997) described the similar relational consciousness,

> the organic connections and shifting interpenetrated realities where boundaries, if they exist at all, are shown as fuzzy and situational. This is a world where reality is experienced as an emergent process, not a clearly delineated stable product. This is a fluid, sensuous, undulating world in which the mind moves from place to place and figure and ground continually shift in response to its own particular priorities. Attention is self-transcendent or holistic—directed outwards beyond the skin of individual person, involving itself in the group, community, and natural world. (p. 302)

The Rabbi, philosopher, and scholar Martin Buber (1958/1986), who had been abandoned by his mother and reunited decades later, drew on this experience to decipher the grace one should have in an authentic meeting. Buber stated:

> In the *I-Thou* relationship, human beings do not perceive each other as consisting of specific, isolated qualities, but engage in a dialogue involving each other's whole being. In the *I-It* relationship, on the other hand, human beings perceive each other as consisting of specific, isolated qualities, and view themselves as part of a world which consists of things. *I-Thou* is a relationship of mutuality and reciprocity, while *I-It* is a relationship of separateness and detachment. (p. 26)

The concept of structure has been considered in reference to stable patterns of psychological processes, which emerge from underlying deep foundational matrices. Stern (1994), in his analysis of readings on field and structure, considered structure ubiquitous from neurophysiology through theoretical constructs. In arriving at an understanding of the intersubjective experience in the field, the clinician considers both structure as well as the diaphanous fluidity. I suggest that exploring the structural component with this openness lays the foundation for prevention of compassion fatigue.

Freeman (2014) considered the coming of age of psychology under the influence of "Descartes and other champions of the *ego cogito*, the thinking 'I,' came to delimit its focus largely to what was happening inside the self, within the enclosure of the skin" (p. 1). Freeman called to clinicians to consider, as posited by the French philosopher Levinas, and as his book was entitled, the *Priority of Other*. Freeman described this relevant perspective as follows:

> I refer to the rather less broad tradition of thinking that looks instead to the various "objects" outside ourselves—other people nature, art, God—that draw us beyond our own borders and thereby open up the possibility of there emerging a larger, unbounded Self, one that knows and feels, its kinship with the world. One might think of this perspective as *ex-centric* (p. 2).

H. S. Sullivan (1931) also had moved beyond the classical psychoanalytic separation of the individual apart from the interpersonal and contextual lived experience. He wrote:

> Psychobiology… is a study of human persons in dynamic interrelationship with other persons and with personal entities (culture, tradition, man-made institutions, laws, beliefs, fashions, etc.). To isolate its individual subject-matter, a personality, from a complex of interpersonal relations involving most meaningfully other persons physically exterior to the subject-person, is preposterously beside the point and indicative of more perverted ingenuity than the speaker finds himself possessing. In yet more violent brief: psychiatry, if it deals with anything, must deal with disordered living of subject-persons in and within their personal complexes. It is not an impossible study of an individual suffering mental disorder; it is a study of disordered interpersonal relations nucleating more or less clearly in a particular person. (pp. 978-979)

Sullivan's perspective, taken in application to the clinician, alludes to the clinical endeavor as inherently dyadic and dynamically responsive to the exchange between the clinician and patient and within the context of the environment. Sullivan suggested that the individual, at times unwittingly, maintains a communal existence.

The emphasis on the interpersonal influence on mental states was likewise emphasized by Stern's (2000) infancy research, in which he discovered subjective reality to be fundamentally a socially negotiated experience. The patient is not alone, and neither is the clinician who also negotiates a kind of presence, a space, within the relatedness, similar to what Stadter (2012) referred to as a presence in time and relationship. Therefore the clinician experiences feelings that are uniquely individual but which constellate and emerge out of being present with other. An interactive process dismantles the illusion of individuality. Various intersubjective exchanges coalesce in a fundamentally dynamic interactional reality, which has been referenced to as a field Baranger et al., 2009; Ferro & Basile, 2009a, 2009b), which will be elaborated further in this chapter.

The relational psychoanalytic psychotherapy movement emphasized a shift from the intrapsychic to a focus on the intersubjective and relational experience. The relational therapist aimed to engage in tracing connection and disconnection from the past to the present, and into the experience between the clinician and therapist (Jordan, 1986). In a relational model, awareness in the here and now is essential to accessing understanding self, other, and the in-between in relationship. Empathy becomes central to an enhanced sense of connectedness simultaneous to an improved appreciation for one's inner world. The mutuality of empathy described by Jordan befits the relational component of relationships in general. There are differences, however, in the therapeutic relationship whereby the clinician may not necessarily experience the mutuality of empathy, but rather holds the intention and empathic space for the other. Jordan described this as follows:

> One is both affecting the other and being affected by the other, one extends oneself out to the other and is also receptive to the impact of the other. There is openness to influence, emotional availability and a constantly changing pattern of responding to and affecting the other's state. There is both receptivity and initiative toward the other. Both the wholeness and the subjectivity of the other person are appreciated and respected…. When empathy and concern flow both ways, there is an intense affirmation of the self and paradoxically a transcendence of the self, a sense of self as part of a larger relational unit. (p. 1)

Empathy has also been considered by Polanyi (1967) as a way of "indwelling" with other or others. This indwelling connotes a lived experience, a way of being in relationship to other rather than merely a means of sensing of other. As such, this more contemporary view of empathy is more along the lines of compassion, feeling with other and a heart felt desire to relieve suffering.

Training analyst Morgan (2010), in her detailed exploration of the world of the analyst and the analysand, suggested that a focus on the present may act as a defense against examining the unconscious of the analyst and neglectful of the interaction between the two individuals. In consideration of compassion fatigue, at least two areas of focus, namely on the clinician's intrapsychic and intersubjective experience hold potential implications for examining compassion fatigue.

The psychoanalyst Benjamin (1990) discussed that intersubjectivity is crucial to uncovering the "representation of the self and other as distinct but interrelated beings" (p. 20). The particular emphasis herein is that the intersubjective experience considers the complementarity between two "subjects" in the analytic dyad, and as Morgan (2010)

said, the unconscious. This particular perspective on the intersubjective and the unconscious has been for the most part neglected, and the focus has instead been relegated to individual intrapsychic phenomena. Whereas the analytic field between can provide an anchor carrying both self and other in the interpsychic experience, it also constitutes a frame through which the clinician can explore self in the process of bearing witness to the suffering other. The schemata of Jung are helpful as a basic understanding of self and other and the various interactions between the conscious and unconscious elements. For this the reader is referred to Jung's work.

The neglect of the "other" and the space between may be considered based in the Western perspective that human beings are sole intrapsychic entities. This belief, nuanced by the Cartesian split and influenced by Freudian intrapsychic emphases, fueled an assumption of the clinician as personal absentia, neutral, or superior to the patient. As described by Morgan:

> This analyst, drained of subjectivity but able and alert, could–and indeed should–understand and interpret the transference at the earliest opportunity to avoid any hint of collusion.…Where the analyst *is* considered as a subject, it is as the subject-who-knows. (p. 35)

The parameters around psychoanalytic work has been worked over and reworked over the decades from that of the intrasubjective toward the relational. This is reflective of a postmodern perspective change from the Western reductive individualistic to a more expansive cosmological view of psyche. Human beings are not isolated alone, and rather live and work in context with other, other meaning other persons, other sentient beings, and the environment. This attitude permeates trauma work when it has been re-

discovered that healing occurs in context of other, whether that other is another individual, a tribe, or a globally. Greenberg and Mitchell (1983) developed a model that shapes a conceptualization of the person as embedded in a relational context, while actively both maintaining contact, but also differentiating self from other. Mitchell (1988) described the paradigm shift as the "mind has been redefined from a set of predetermined structures emerging from inside an individual organism to transactional patterns and internal structures derived from an interactive, interpersonal field" (p. 17).

Bolognini's (2004) psychoanalytic description of empathy is helpful in terms of considering compassion fatigue, as it incorporates the value of considering the unconscious aspects of the phenomenon:

> Empathy is a condition of conscious and preconscious contact characterized by separateness, complexity, and a linked structure, a wide perceptual spectrum including every color in the emotional palette, from the lightest to the darkest; above all, it constitutes a progressive, shared, and deep contact with the complementarity of the object, with the other's defensive ego and split-off parts, no less than the other's ego-syntonic subjectivity. (p. 141)

Bolognini's definition noted above can be enhanced through tracing the unconscious aspects of empathy, which form a residue of dreams, thoughts, memories, and symbolic images, which thereby infuse into the clinician's life beyond the session. The "split-off parts" referenced may be further amplified through the difficult primitive or borderline states of patients. These unconscious remnants influence the clinician's development of vicarious traumatization and the perturbations of compassion fatigue. Early in Western psychology the intrusiveness of such phenomena was recognized. The clinician was

warned of the dangerousness of close empathic proximity to the patient on the borderlands between sanity and insanity out of fear of contamination (Showalter & Shaughnessy, 1995). Freud considered empathy as a process by "which we are enabled to take up any attitude at all towards another mental life" (Freud, 1922/1949, p. 70). Over time, empathy was valued, in particular through the psychodynamic and humanistic psychology traditions, for its usefulness in accessing data on others minds (Levy, 1985).

Object relationists such as Greenson (1960) suggested empathy as a means of constructing a model of the patient. Another psychoanalyst, Buie (1981) suggested that empathy entailed a comparison between what the patient's cues evoke in the analyst's mind and in that same analyst's behavior. The analyst then would consider how his or her inner experience matched that of the patient. Kohut (1984) considered empathy along with introspection as heuristic tools to understand patient's intentions. Empathy in particular according to Kohut was "the capacity to think and feel oneself into the inner life of another person" (p. 82). Feeling closely in to the other has been further emphasized by Rowe and MacIsaacs (1991), who considered this very same process of leaning into the patient's experience "as closely as possible" (p. 16). Researchers and clinicians are quick to emphasize the distinction of healthy empathy from an enmeshed empathic response, or which Buie (1981) termed merging. Interestingly, Kohut (1984) later in his career considered it normal for the therapist to bond closely with the patient, similarly to a parent and endearing infant.

Tending the Field: Presence in Unconscious Material

The therapeutic relationship is uniquely enfolded in multiple layers of deeply felt and imaginal dynamics, which require an openness and curiosity in conceptualizing

experience. The clinician and patient are, as Stern (2003) claimed, "caught in the grip of the field" (p.192) in a relatedness that goes beyond the consulting room. The process can be viewed as a revelation of new perspective while both discovering and uncovering the old formulations and patterns of understanding. The field connotes the changing dynamic of the work in its ceaseless frame for reconfiguring experience, intention, and realization.

Inherent to therapeutic relationship from an analytic view is the inevitable countertransference, which has gone through a history of shifts in perspective over the decades of awareness of it being an element. Kraemer (1958), in an early article, wrote on the dangers of not recognizing countertransference while it had been recognized as integral element in psychotherapy by several analysts, including Heimann (1950) and Little (1951). Early thought on countertransference, however, was focused on its undesirability in psychoanalysis, and as an indication of something residing within the patient that is evoked in the therapist (Money-Kyrle, 1956). Countertransference feelings were thought to emerge from the therapist's empathic insight into the patient's experience.

There was a perspective circulating that the clinician needs a certain amount of mindful control in order to provide a safe anesthetic environment, which would provide commensurate protection for the patient, and the analyst. Vestiges of this kind of security continue, and a view that the place of therapy should be one in which the patient can speak to and find meaning from trauma, unmet needs and expectations, sorrows, shame, and a number of other difficult emotional, cognitive, and functional despairing experiences. The "tool" and primary mode of healing from trauma, for example, is found in the context of therapeutic relationship, a relationship developed over a number of

conscious and unconscious elements in the intersubjective experience of the clinical session. These elements then bob between submersion and emersion in the clinical session and over time. Submerged elements can then interact within the subjective experience of the therapist who then is vulnerable to vicarious traumatization, and compassion fatigue. The submerged interactions can evoke eruptions into the therapist's inner world through dreams, memories, and associations.

Physician and psychoanalytic object relationist Scharff (2012) noted the centrality of relationship and the context of time in the preface of a book on presence:

> The shifting dimension of time: that provides one of the most interesting and perplexing elements of our work. How can we be present when time for the patient is such an elusive and yet critical element? In our daily lives, we are used to thinking of time as a dimension that marches steadily forward. Yet we can grasp the past reaches of our history in a way that brings them into our present life. Still, this is a linear conception of time that is not enough for our work, for in the mind, time is present, past and future in many ways. Time can be uncomfortably near to us, fleeting and disappearing, or it can extend itself almost indefinitely in to the past and future as it folds back upon itself. Past, present and future can all be with us simultaneously. It is the mind's capacity to play with time that allows us to construct narratives about ourselves that grow in complexity and richness over the span of our lives. (p. x)

Scharff's narrative above implied a certain psychodynamic vertical movement from unconscious submersion toward a lifting or bobbing up into consciousness. He also described a perception of chronos or time as a horizontal conceptualization with a

forward and backward movement though the individual can have accessibility to any of the dimensions in a given moment. What has emerged in this inquiry is a third movement, which the clinician assumes in an analytic stance. This stance visually would appear to be more at a dynamic angle rather than horizontal or vertical. This stance enables the clinician to remain both accessible to other and stable within, and is related to understanding the transferential elements, such as countertransference, transference from the unformulated primitive mind (i.e., projective identification), a visceral embodied sensibility in the interaction, and mindful reverie. The psychoanalyst and philosopher Lear (1998) thought the analytic stance would enable an improved possibility of better accessibility and interpretation of hidden "phantastic distortions" (pp. 141-142), a well-situated therapist. The purpose would be to enhance the stable positioning of the clinician so that the immanent energy dominated with such distortions would be managed by both clinician and have value in organizing the lived experience of the Other. Considering the multiple "difficult patients" for whom the clinician might be involved in care, the phantastic distortions, which accumulate may also likely influence the development of compassion fatigue.

A turn toward examining the position of the clinician not only provides a more complete picture of what occurs therapeutically for the patient, but also an opportunity to construct understanding of the precursive influences on compassion fatigue. In the literature, compassion fatigue is overwhelmingly considered in terms of its development as a result of listening to traumatic stories, because of the difficulty entailed in emergent kinds of clinical work, or as a problem due to poor self care on behalf of the clinician, all as formerly elaborated in the literature review. Further, Morgan (2010), in her paper

"Frozen Harmonies: Petrified Places in the Analytic Field," suggested that an exclusive focus on the patient's transference defends against focusing on the intrapsychic and unconscious world of the therapist. An understanding, which culminates from the immersion into the psychodynamic inner workings behind the scenes of bearing witness with deeply troubled individuals, aids in the exploration of the clinician's subjective experience. Morgan (2010) stated:

> Once we engage in analytic work with an individual we are inevitably drawn into a "dance" together with its own particular rhythms and harmonies. Each analytic couple creates an analytic field from their idiosyncratic energy flow. Within this field, interruptions to the "dance" occur; mis-steps and disharmonies involve an unconscious refusal within the analyst as well as the patient. Both the dance and the refusal are crucial for the work, and I suggest that our attention needs to be directed here, to the blocks or "petrified places." (p. 33)

Consideration of the unconscious broadens the context in exploration of compassion fatigue. In classical psychoanalysis, Freud (1923/1950), exemplified the stance to access the subtle unconscious. As Bollas (2007) noted, psychoanalysis is interested in the unconscious and the receptivity of the therapist. Freud (1912/1945) emphasized the therapist's ability to turn his or her ear toward receiving from the transmitting unconscious. He emphasized the doctor surrendering to his or her own "unconscious mental activity, in a state of evenly suspended attention … to catch the drift of the patient's unconscious with his own unconscious" (p. 239). Ogden (1989, p. 110) has termed this place of reception the "intersubjective analytic third."

In the realm between, the therapist is challenged to hold unwavering and "evenly suspended" (Freud, 1923/1950, p. 239) attention to other, while holding awareness of subjective experience and those aspects of the inner world that are unknown. This process brings the therapist toward deeply listening, even through silences and explosive eruptions. Jung (1946) suggested that the mutual personalities of both the patient and clinician are far more influential than any particular treatment employed. He stated that the meeting of the two

> is like mixing two different chemical substances: if there is any combination at all both are transformed. In any effective psychological treatment the doctor is bound to influence the patient: but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence. (Jung, 1946/1954, para. 163).

The silences are not necessarily viewed as absence nor the eruptions as presence. The clinician remains positioned to grasp hold of bearing witness, tending to the troubled in the alchemical process in intersubjective field.

Zetzel (1965) noted that a therapeutic relationship was contingent on the nature of the patient. For example, she posited that an individual with a primitive personality would have impaired ego development and diminished ego strength. This subsequently increased the likelihood of a predominantly aggressive transference, which is elementally challenging as well for the clinician. Zetzel further suggested with such a patient to use an implicit positive transference and supportive approach. This lessens the aggressive response, which would defend against the poor ego strength. Though Zetzel did not

mention this approach, it would more likely be derived from a caring and compassionate stance, which is turn reduces the resistance to moving forward in the clinical work.

The implication with such work with those who have transference neuroses is that the working alliance is essential to the process of psychotherapy, as Greenson (1960) suggested. Zetzel (1965) referenced the importance of maintaining the therapeutic alliance through having "a consistent, stable nucleus" (p.50) within oneself as a clinician, and in the genuine therapeutic relationship. The clinician who empathically understands the process incurred by the patient shapes the interaction. It follows that the attuned clinician may thus be instrumental in also averting redundancy in compassion fatigue.

Psychoanalytic literature offers recommendations to clinicians to enhance their response to difficult and evocative experiences and sensations. Langs (1990) termed one of those processes "noncountertransference" (p. 217). Noncountertransference refers to those aspects of the therapeutic situation that the analyst has some control over such as the stance with the patient, means of listening, management of the setting, perspective on assessment and understanding of therapeutic interventions, among others. Noncountertransference suggests an enhancement of the therapist's ability to sustain what Freud (1912/1945) considered an "evenly suspended attention" and Bion (1967a, 1970) considered entering the session without preconception.

The concept of noncountertransference connotes neutrality, and implies a means of buffering the clinician from difficult responses that can occur when bearing witness to trauma and other suffering. The evenly suspended empathic attention signifies a certain way of listening (Langs, 1990), as Reich (1951) considered in the space between self (clinician) and other (patient). Bollas (1992) paralleled this view, albeit from the

perspective of chronos. He stated: "Each entry into an experience of an object is rather like being born again, as subjectivity is newly informed by the encounter, its history altered by a radically effective present that will change its structure" (p. 59). Bion's formulation referenced the freshness needed to enter the experience with other without preconditions. Alternatively it could be argued that we never quite enter any relationship anew as we always have internal object relations, with perhaps the only new encounter being upon birth with our mothers.

Freeman (2014) described the work involved within the encounter between self and other. He surmised that while the object is important, "what the object is for the experiencing person remains thoroughly contingent on what he or she brings to it, by way of knowledge, commitment, care, and so on" (pp. 187-188). Freeman felt that Bollas outlined this well as follows:

> As we encounter the object world we are substantially metamorphosed by the structure of objects; internally transformed by objects that leave their traces within us, whether it be the effect of a musical structure, a novel, or a person. In play, the subject releases the idiom of himself to the field of objects, where he is then transformed by the structure of that experience, and will bear the history of that encounter in the unconscious. To be a character is to enjoy the risk of being processed by the object—indeed, to seek objects, in part, in order to be metamorphosed, as one "goes through" change by going through the processional moment provided by any object's integrity. Each entry into an experience of an object is rather like being born again, as subjectivity is newly informed by the

> encounter, its history altered by a radically effective present that will change its structure. (1992, p. 59)

None of us is immune from this process, including and most especially therapists and other clinicians. Bollas alludes to the accumulation of "history of internal objects, inner presences" (p. 59), which are residue traces from encounters that can inhabit the therapist's mind beyond the direct encounter with other.

The therapeutic relationship therefore becomes a key to a way of knowing other, as well as provides a key to lifting up to an understanding of self. The process incurred through the self-other/self-world relationship is, as Bollas (1992) suggested an invitational moment whereby, ideas, feelings, images, and perspectives are brought up, lifted up, in the field between self and other. The process of accepting and rejecting the invitation has both conscious and unconscious elements, such as in the experience of countertransference, which the clinician in respect to the patient can likewise accept or reject, incorporate through identification, or defend against.

The intense involvement known through therapeutic relationship has been considered to impact the clinician adversely relative to secondary traumatic stress or compassion fatigue. The roles of empathy and countertransference are crucial to an understanding of the underlying dynamics in the therapeutic relationship that contribute to susceptibility to and prevention of compassion fatigue. The following description is related to the dialogue with psychoanalytic perspectives on empathy and countertransference in the therapeutic situation, and suggested influences on compassion fatigue. Goleman (2006) emphasized this notion of as follows:

> When two people interact face to face, contagion spreads via multiple neural circuits operating in parallel within each person's brain. These systems for emotional contagion traffic in the entire range of feeling, from sadness and anxiety to joy. Moments of contagion represent a remarkable neural event: the formation between two brains of a functional link, a feedback loop that crosses the skin-and-skull barrier between bodies. In systems terms, during this linkup brains "couple," with the output of one becoming input to drive the workings of the other, for the time being forming what amounts to an interbrain circuit. When two entities are connected in a feedback loop, as the first changes, so does the second. As people loop together, their brains send and receive an ongoing stream of signals that allow them to create a tacit harmony—and, if the flow goes the right way, amplify their resonance. Looping lets feelings, thoughts, and actions synchronize. We send and receive internal states for better or for worse—whether laughter and tenderness, or tension and rancor. (pp. 39-40)

Studies have demonstrated such influences from one to another, especially as encapsulated in the affective state. This appears to impact one another physiologically and psychologically, starting at infancy if not before during the prenatal period (Hatfield et al., 1994). Often nonverbal, the response to other is well developed for primitive survival. Psychoanalytic thought has contributed to understanding these mutual influences on "catching" compassion fatigue through the influences of unconscious, empathic response, and countertransference, and speaks to the stance of the analyst or therapist. The poet Samuel Taylor Coleridge predated Freud by 91 years in his conception of the word *psycho-analytical* (Snell, 2013, p. 1). Coleridge (1961)

considered the importance of accuracy in understanding other and the utilization of an imagination in accessing an analytical sensibility of the actively receptive stream of what Eng (1984) termed an "anonymous hidden life" (p. 463)

Psychoanalysis respects an analytic stance, which connotes a state of mind, which is both active and receptive. Freud referred to this state as "oceanic," "free-floating" or "evenly suspended attention" (Freud, 1912/1945, p. 110). The British analyst Bion (1970) called this state "reverie," which followed the poet Keats's (1988) use of the term "negative capability." These states refer to the person's capacity to inhabit and transcend a space of uncertainty, doubt and mystery rather than follow presuppositions, or contextual constraints (Bion, 1990, pp. 45, 47). This process brackets predetermined thought, much in the same way that phenomenological studies bracket certain aspects of investigation. Snell (2013) described this state similar to Jungian free association, as related to what may arise. Snell describes this as

> a kind of "free" listening, the counterpart to the free association that psychoanalysts encourage in their patients, through which the unconscious, like contraband in the ordinary unchecked stream of thought, might have a chance of declaring itself. It is an emotional orientation in the therapist, a commitment, founded in respect, to maintaining a radically open-minded stance: a suspended state somewhere between passivity and readiness for emotional and verbal activity. (p. 15)

The clinician in such a mode is in a posture of creative receptivity, and openness to being influenced by other in the process of engagement. The therapist thus openly receptive allows any trepidation or self-protective defensive influences to give way to being

engaged with other. In a sense this disrupts hesitation and enables the clinician to more readily empathically move into the experience of other. With this dynamic movement, it is as if there can be a psychic loosening of the tight binding to the story portrayed by other, and a loosening of the adrenergic arousal sensations that the therapist experiences, especially with particularly troubled patients. Further exploration of this state will occur in the following chapter in relationship to the analytic field. In summary, though, the purpose of this stance is to gain access to understanding other through engagement and living into the other's experience, while also moving through the experience simultaneously to tending to other.

The analytic psychologist Hillman (1975) considered what he termed the "poetic basis of mind" commensurate to Henri Corbin's "mundus imaginalis." Both of these perspectives encouraged Hillman (2001) to engage within the analytic experience with a conversation, which is richly imbued with "depth, resonance, and texture" (p. 15). The poetic and imaginal perspective illumined the intersubjective world through what Hillman considered a "distinct field of imaginal realities requiring methods and perceptual faculties different from the spiritual world beyond it or the empirical world of usual sense perception and naïve formulation" (Hillman, 2004, p. 15). From this perspective, psychology is based in a rich cosmology of multiple centers or containers that characterize a holistic archetypal topology (Hillman, 1975, p. 26). Hillman (1975) argued that psychology's concern for "psyches therapeia or care of soul" (p. 119) relates to the deeper psychological questions related to body, death, beauty, love, power, relationship, illness, and the world. In practice, the clinician informed by such reflection works in "seeing into things and speculating about them by means of fantasies" (p. 118),

and through great respect for the mystical, the unconscious, and the never knowable. Hillman reminded us that ideas are embodied in words and movement, and that always we are "in the embrace of an idea" (p. 121).

Clinical Empathy and Compassion Fatigue

The therapeutic relationship and clinical moment can be thought of as a reenactment of the original interaction with other experienced by the patient, which can be absorbed in varying levels by the clinician through bearing witness to the stories, or via repeated episodes of being in close proximity with the patient(s). As discussed before in this study, empathy has been considered paradoxically both a necessary asset (Halpern, 2001; Stephan & Finlay, 1999; Suchman, Markakis, Beckman, & Frankel, 1997) and a risk associated with the work with other. Figley (1995a) also suggested that empathy induces more vulnerability to succumbing to secondary stress and compassion fatigue.

Crumpei and Dafinoiu's (2012) survey of 75 clinicians supported this dual aspect of empathy, namely that of engagement with and understanding of the patient, which the patient can experience as being appreciated, valued, and understood. Alternatively, though, empathy was found to threaten the clinician's objectivity and sense of personal well-being. The interesting perspective on this study's outcome is that there really is no clinician "objectivity," and it can be argued that the work consistently entails both subjective and objective components. The remarkable work of the clinician can best be viewed through a dual lens which appreciates the subjective conscious and unconscious awareness and interpretation, in addition to what is not evident, perhaps in the unconscious, of the patient, the "other." In this sense, the clinician notices the

perceptively avoided aspects, the negative space in the interaction, which can provide a more full contour of the creative clinical moment. Though empathic clinicians appear to have better patient outcomes and satisfaction, according to Crumpei and Dafinoiu, empathy is equated with "emotional involvement (which) threatens decision objectivity and exposes the specialist to secondary traumatic stress symptoms" (p. 441). This latter perspective echoes Figley's (1995a) aforementioned concerns.

Crumpei and Dafinoiu (2012) ascertained that bearing witness to the patient who suffers is a central source of stress for the clinician. This finding was also consistent with the works of Healey and McKay (2000), McGowan (2001), as well as Stordeur, D'Hoore, and Vandenberghe (2001). The stress of non-relief from suffering connotes a desire to relieve suffering, which vicariously relieves the suffering for both self and other. Compassion connotes a tendency to want to relieve suffering. If empathic involvement fosters stress in relentless suffering, the clinician who wants to relieve suffering may access the phenomenon of compassion. It follows that arguably empathy with compassion provides both an experience for the patient as being valued and cared for, and diminishes the threat to the clinician thereby relieving suffering even within oneself. Omdahl and O'Donnell (1999), for example, included in their definition of empathy, along with concern, a desire for communication. Communication can be an instrument of compassion. Although I could not find one psychoanalytic reference to compassion, much is written on Eros in the psychoanalytic relationship. Rather than the view of psychoanalytic practice as stoic, contemporary psychoanalysis includes much in terms of positive regard and love for other (Orange, 1995, 2011; Rogers, 1961/1995; Winnicott,

1971/2005). Interestingly, Bertakis, Roter and Putnam (1991) considered emotional contagion as a part of compassion as compared to empathy.

Countertransference

> The carpenter has a hammer, the surgeon has a scalpel, and the therapist has the self (Hayes & Gelso, 2001, p. 1041).

Historically, the concept of countertransference though initially considered as something dangerous, an obstacle, described by Tansey and Burke (1985) as the "poltergeist view" (p. 43), this has given way to a positive view of countertransference within the context of what Gill (1983) considered an interpersonal view of psychotherapy. Polish psychoanalyst Racker (Benveniste, 2013; Racker, 1988) developed the construct of countertransference further as an inherent part of the psychotherapeutic situation, and as an inevitable component of the analyst's experience of the patient's psyche.

Racker's seminal work on countertransference was outlined in a paper presented in the early 1950s whereby he spoke of the analyst as responsive and involved in reacting to what the analysand brings to the therapeutic encounter. Countertransference was considered a means by which the analyst is privy to what the analysand experiences. Racker (1957/2007) wrote about the experience of using the countertransference as a clinical tool. According to Benveniste (2013), Racker stated:

> We let the material penetrate into us and at times the chord which was "touched" vibrates immediately; but at other times this reception must be followed by an active process in which we "touch" and detect what has penetrated in us with our unconscious feeling and thinking, so as to be able finally to unite with it. (p. 3)

Further, the countertransference can provide information to the clinician on the psychodynamics underlying the process of the therapeutic relationship. Racker addressed this through a description of the mythical nature of the analytic relationship as

> an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependencies anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities–that of the analysand and that of the analyst–responds to every event of the analytic situation. (Benveniste, 2013, p. 3)

Furthermore, Racker (1988) outlined two kinds of countertransference, including concordant identifications and complementary identifications. Concordant reflects the homologous aspects of both the analysand and analyst, and is experienced as an empathic response. Complementary identifications are different as exemplified by the analysand who sees the analyst as an internal object and the analyst experiences this as an enactment.

Several other clinicians who proposed alternative views countered this perspective. Helene Deutsch (1926/1953), the Austrian-American psychoanalyst and contemporary of Freud, regarded more keenly the inner life of the therapist and spoke in terms of "intuitive empathy" and "complementary empathy" (p. 137). Regrettably, Deutsch had few brief publications, but was able to introduce aspects of the therapist's experience into the review of what transpires clinically for the patient. Though as Appignanesi and Forrester (2005) pointed out, her work has been relegated to the dusty enclaves of neglected psychoanalytic thought, it powerfully emphasized the affective

nature of countertransference in the therapist's experience. Deutsch emphasized that the unconscious identification of the therapist with the patient evolves by way of traces of memories from developmental processes, which parallel those of the patient. Deutsch (1926/1953) described *intuitive empathy* in terms of the unconscious of both the analyst and the analysand. She emphasized that the unconscious of the clinician contains the very same impulses and wishes emitted from the patient. Complementary empathy was related to the identification of the therapist with the patient's original objects and emerged from the experience of the patient's emitting infantile-libidinous wishes that had originally been thrown out upon the parents. Rather than delimited to only the identification with the patient's ego as with intuitive empathy, complementary empathy suggests vestiges of the inner other. Turning to Deutsch's writings directly, she described the inner process of the therapist as follows:

> It is not a specific, distinctive and characteristic aspect of the analyst's "free-floating attention" that that which has been unconsciously perceived in the patient and has then become the analyst's "own" experience, is subsequently communicated to the conscious as an inner experience.... Indeed, intuitive empathy is precisely the gift of being able to experience the object by means of an identification taking place within oneself…. This intuitive attitude, i.e., the analyst's own process of identification … represents a reviving of those memory traces which these already outgrown tendencies had left behind…. The process whereby one re-experiences the memory traces present in one's own psychic material is identical with the process by means of which the analyst's experience of the patient is transformed into an inner perception. In this sense, the psychic

> process of the analyst's preparatory intuitive work resembles that of the analysand. This process revives similar infantile urges in both of them: In the case of the analysand, by means of transference, and in the case of the analyst by means of identification. This…is known as "countertransference".… It also entails (in addition to identification) the presence of certain other unconscious attitudes, which I would like to designate by the term "complementary attitude." (p. 137)

Historically the inner experience of the process of countertransference has not been given the close attention it deserves by those engaged in intensive clinical work with the suffering, such as psychotherapists and other health care providers. Deutsch's brief writings aid in this process as they are so descriptive of the unconscious layering of psychodynamic processes that infuse the interaction between self and other.

Though as Gelso and Hayes (2007) stated, "there will be varying degrees and kinds of countertransference" (p. 1) in any therapeutic relationship, it can be argued that it is found in all relational experiences. Tansey and Burke (1989) pointed out that Deutsch's construct of complementary identifications were part of the empathic process via identification with the patient's internal objects, and what they termed "trial identifications" (p. 16), which lead toward empathy. During this latter identification and empathic response, forces that may be experienced as uncontrollable can encumber clinicians. If these experiences remain unconscious, and unmonitored, they can evoke adverse reactions in the inner world of the clinician, which then also seeps into the therapeutic relationship and influences the healing process for the patient. Deutsch urged the analyst to master and utilize the various forms of countertransference in service to the

progress of the analysis or therapy, as well as to sustain the analyst's own energy in the process. Therefore, Deutsch's insightful commentary on the analyst's experience provided a wealth of suggested actions to take to avert compassion fatigue.

Racker (1957/2007) highlighted, for example, that Freud described the transferential dynamics as being both the best of tools and the greatest of dangers in therapeutic work. Hayes and Gelso (2001) considered countertransference an "occupational hazard" (p. 1050). Gelso and Hayes (2007) described countertransference as the therapist's reactions to the patient relative to one's own unresolved issues, which can be conscious or unconscious. The spectrum of definitions of countertransference runs from a classical view of it being relative to unresolved conflicts to a totalist view, which encompasses all reactions to the client.

Nevertheless, Gelso and Hayes (2007) rightfully acknowledged the vital importance of the clinician exploring and identifying as much as possible the source of reaction to clients. This process may be exemplified by the difficulty the therapist has with listening and concentrating in the present session: it could mean poor concentration due to environmental distractions such as noise, a poor night's sleep, or being at the end of the day after having seen a large number of challenging clients. Alternatively, it could be due to a countertransference due to internal reaction to material that taps into the therapist's unresolved or never accessed internal conflicts or personal emotional experiences currently undergoing. In identifying the difference between, for example, the lack of sleep and the unresolved conflict as noted above, the remedy would be quite different. In the earlier example of environmental problems, sound proofing or getting more sleep would remedy, whereas in the latter scenario, remediation would occur

through continued introspection and management of evoked conflict through clinical supervision and personal work perhaps in depth oriented psychotherapy. There is a superficial easily remediable conflict in the environment/sleep and a deeper internal conflict of the unresolved psychodynamic material in the therapist's inner world. The adherence to a therapeutic frame creates a safe and authentic way to address the situation, and the boundaries between self and other. Although it is beyond the scope of this inquiry, the therapeutic frame deserves more thorough attention as an emergent theme, which can both prevent and treat compassion fatigue.

Hayes and Gelso (2001) described countertransference reactions as being multilayered in such a way that demands more introspection on behalf of the therapist than would at first glance be evident. Although all individuals and hence all therapists/clinicians have conflicts, not everyone is provoked by every patient. For example in a classic study by Yulis and Kiesler (1968), clinicians were studied relative to their being triggered by aggressive/seductive, dependent, or neutral clients. However, surprisingly the therapists responded equally across all three types of patients. The rationale was hypothesized to be due to methodological failure to assess the therapist's unresolved issues.

Further, as Hayes and Gelso (2001) described, it has been found useful to distinguish acute from chronic countertransference reactions. Acute are those reactions which happen sporadically whereas chronic are the usual reactions. The latter could be considered similar to a repetition compulsion in the therapist, which may infer its emergence as a characterological trait originating in early emotional injury. The chronicity may imply the clinician's indiscriminate work, as exemplified by the clinician

who seizes every moment to nurture others, even when this may not be the most therapeutically effective action for the patient.

Triggers of countertransference can occur through three categories (Hayes, McCrackern, McClanahan, Hill, Harp, & Carozzoni, 1998): attributes of the patient, the content of therapy (Cutler, 1958; Hayes et al., 1998), and the process of therapy. The therapist may then cultivate ways to avoid triggers, including engaging in limited contact with patients or limited inquiry into historical content in the assessment process. The therapist may dominate or limit sessions, or engage in modalities that limit emotional evocation such as cognitive behavioral therapy. As Hayes and Gelso (2001) described, countertransference (CT)

> may be manifested internally in the form of numerous thoughts and feelings, or externally through a wide assortment of behaviors…. Virtually every display of CT behavior is preceded by or has associated with it covert thoughts and feelings, and conversely, internal CT reactions that are not attended to or otherwise well managed will likely generate CT behavior. (pp. 1044-1045)

Affective manifestations of countertransference can manifest as red flags to the therapist, such as with anxiety, which alerts to assess for personal threat/danger in the immediate situation and/or as a manifestation of personally unresolved issues (Hayes & Gelso, 1991; Hayes et al., 1998). Other affective consequences can include feelings of anger, boredom, sadness, or inadequacy.

A key to perceiving countertransference is understanding that there is distortion of the perception of the patient (Cutler, 1958). The distortion can entail a misperception of the frequency or extent of the patient's descriptions of the material, which is connected to

the therapist's unresolved conflicts. Distortion can also immerge when as McClure and Hodge (1987) elaborated, the therapist tends more to misperceive patients for whom they feel affection or to whom they are similar. Countertransference can affect reflection on the patient's presentation, and may evoke a distortion into a detached stance with patients (Lecours, Bouchard, & Normandin, 1995; Normandin & Bouchard, 1993).

Studies in the countertransference behavior can be viewed from the extent to which the therapist/clinician avoids, withdraws, under involves, or over involves with the patient. Avoidance has similarly been noted to be related to the state anxiety of the therapist's (Hayes & Gelso, 1991), and the trait anxiety (Yulis & Kiesler, 1968). Hayes (1995) as well as Peabody and Gelso (1982) have described that empathy is inversely related to avoidance behaviors. As avoidance behaviors also parallel symptoms of compassion fatigue and vicarious traumatization, it follows that the clinicians awareness to self-reflect and thoughtfully identify countertransference can help diminished avoidance behaviors. Through a leaning in process toward the countertransference, there can be impact on avoidance, therapeutic encounter, and the experience of the clinician.

Diminished empathic connection, increased avoidance, and enhanced state and trait anxiety would appear to support the constellation of symptoms of decline found in compassion fatigue. Alternatively, increased empathic leaning in toward other through understanding and self compassion for those aspects that are unknown, within a limited and clear frame, would diminish the likelihood of compassion fatigue and more likely support a tending toward self as a human clinician. The clinician can self-examine through as Hayes and Gelso (2001) suggested a process whereby the clinician works backward from the experience of the countertransference reaction to the provoking

triggers, in an effort to explore possible origins. The clinician sifts through the psychodynamic material to ascertain its inner manifestations as opposed to what is elicited from other. The other's need for evoking in the clinician a similar experience can be related to the fundamental work to be done in the therapy. Hayes and Gelso provided the following elaboration on this process as working from the surface manifestation, for example, the patient is ten minutes late. Then the therapist considers his or her thoughts about this behavior, and identifies any further reactions or triggers. The therapist then can identify similarities to other persons in his or her life.

Effectively managing countertransference entails preventive approaches of self awareness, accessing understanding of internal struggles, and maintaining stable personal boundaries (Hayes, Riker, & Ingram, 1997). Empathy, anxiety management, insight into self, self-awareness, and conceptual skills have been associated with improved management of countertransference reactions (see Van Wagoner, Gelso, Hayes, & Diemer, 1991). Oppositely a cognitive and theoretical skill without self-awareness actually has been shown to increase unexplored countertransference behavior (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Importantly, the intent is not full amelioration of countertransference, as evidenced by a study by Hayes et al. (1998), which found that the best therapists experienced countertransference reactions during a majority of their sessions. To minimize countertransference reactions once they occur, containment through personal psychodynamic therapy, personal reflection, clinical supervision, examination of theoretical/conceptual framework, and exploration of empathic response.

In a focus on the response to the patient, certain countertransference responses could be explored with the patient in terms of their mutual response, which can deepen

the therapeutic encounter. When the therapist has a degree of resolution to internal conflict, the insight can foster empathic response in benefit to the patient. According to Bollas (1987), countertransference can be the portal for feeling into the relational and inner experience of the patient. He stated, "The patient not only talks to the analyst about the self; he also puts the analyst through intense experience, affectively inviting the analyst to know his self and his objects" (p. 250).

Reik (1936/1999) also devoted a significant discourse to the clinician's affective response to the experience of the patient. Though he did not specify the term *countertransference*, he spoke to the spirit of listening to one's internal affective signals as important to recognizing the unconscious processes of the patient that further influence the clinician's experience. In 1936, Reik described the experience of the therapist. He noted the process of the interaction, the role of bearing witness to the patient's words, and the relevance of nonverbal gestures, which represent implicit impulses. Reik noted purpose of the interaction was

> to rouse in himself unconsciously impulses and ideas with a like tendency. The unconscious reception of the signals will not at first result in their interpretation, but in the induction … of the hidden impulses and emotions that underlie them. (p. 193)

Furthermore, the clinician's initial response is not understanding but rather a visceral and affective response, which emerges from observation, or being in interaction with other. Reik (1936/1999) further elaborated that

> observation of other people's suppressed and repressed impulses are only possible by the roundabout way of inner perception. In order to comprehend the

> unconscious of another person, we must, at least for a moment, change ourselves into and become that person. (p. 199)

Therefore, Reik revealed two aspects of the interaction of the clinician with the patient that have bearing on compassion fatigue. First, the immediate response to bearing witness is not cognitive, but rather a rousing of the therapist's unconscious impulses, and affect. The nature of these impulses and felt sense precludes an immediate cognitive analysis, but instead a visceral and emotional sensibility. Second, in order to then understand other, this felt sense is vital to step into his or her shoes and experience within the self of the analyst as what Reik thought of as a "temporary introjection" (p. 199). Should the clinician cease interpretive processing at that point, thereby establishing a more permanent introjection, it is likely that he or she will continue to re-experience other, similarly to the repetitive nature of intrusive thoughts and re-experiencing similar to those of individuals with posttraumatic stress.

Reik considered in extensive detail the process of paying attention to affect responses with the patient, simultaneous to garnering their hidden meanings. This step is followed by consciously interpreting that which has been unconsciously evoked. The clinician's capacity for detailed perception was illustrated by Reik's (1948/1983) reference to Nietzsche's reference in *Beyond Good and Evil* to "the third ear" (p. 144). Reik elaborated:

> We can best compare the psychical process with the act of vision, in which a stimulus is transmitted to the brain by the optic nerve, and every ray of light is projected again into the external world. The other person's impulse, which has unconsciously roused a corresponding impulse in the observer, is seen externally

> like the image on the retina. The observation of other people's suppressed and repressed impulses are only possible by the roundabout way of inner perception. In order to comprehend the unconscious of another person, we must, at least for a moment, change ourselves into and become that person. We only comprehend the spirit whom we resemble. (p. 361)

Therefore, bearing witness to other reveals the impact on the person witnessing. Unconscious impulses and affect can be stimulated through the evocative experience of the psychodynamics of the therapeutic relationship. The somatic and emotional sense of the interaction can provide the clinician with understanding of the transferential process and the elements needed to manage the intersubjective experience.

Working with Other: Clinician Processes and Inner work

The scope of psychoanalytic psychotherapy over the past years has widened from classical psychoanalysis to include an understanding of the nature of relationship to other. These perspectives are particularly generative toward an understanding of what transpires between the clinician and patient in the clinical moment and beyond, as the foregoing preliminary discussion of Deutsch and Reik's works suggested. Object relations theories such as those found in the work of Klein (1975) and Bion (1963, 1967b) provide a means of examining early relational experiences as they manifest in the therapeutic process. Bion in particular emphasized the digestive metabolic processes entailed by the analyst whereby raw foodstuffs are thrown into the analyst who then metabolizes and gives back in a way that the analysand can gain nourishment. Bion (1967a) also suggested to listen through a stance of open receptiveness, without desire.

Kohut (1977, 1984) claimed that the analyst uses empathy to grasp a sense of other. Both observations of verbal and nonverbal behaviors and subjective reactions in approximating the experience of the patient are utilized to "capture the subject's inner life" (Muslin & Val, 1987, p. 5). Wolf (1983) emphasized a notion of "regressive listening" used by the therapist to attend to the regression of both the clinician and patient, which also subsequently allowed a way to be aware of defenses. Chessick (1989) noted that regression is considered a prerequisite for conferring the therapist a state of "evenly suspended attention" (p. 39), though it is recognized that there may be fear of dissolution as part of a regressive process.

Tansey and Burke's (1989) work on empathy, countertransference, and projective identification explored the implications for the clinician. They outlined several phases of the process of extending awareness of countertransference into the intersubjective experience, that inform the analyst, and which are adapted in the following overview.

1. Receptivity phase: The invitation.

The first phase involves reception, a kind of opening to the process. This is a phase in which the clinician may incur interactional pressures, and processes of identification with the patient, the other, especially in the moments of bearing witness to trauma. Tansey and Burke (1989) considered this phase as one that is characterized by clarity, presence, and extensive space for dwelling in Freud's (1912/1945) evenly suspended attention. It is also a phase of separation, in terms of sequestering feelings and thoughts of the outside world aside for the given interaction with the patient. Listening in this phase essentially means not bothering to maintain a certain stance or keeping anything in particular in mind, and allowing for thoughts and association to simply enter

one's conscious awareness. This phase connotes a time when, as Sandler (1976) noted, Freud saw the therapist as compromising between his own inclinations and those of the patient. Through a focus on such free floating attention to what comes across the mental screen, whether feelings, thoughts, associations, or the enacted behaviors in which the clinician engages, there is the possibility of learning about the patient. The clinician who allows for being in the present without concern for some time, may experience a soothing effect as he or she can suspend the continuous effort of separating from the present.

Tansey and Burke (1989) elaborated, the "free-floating responsiveness in actions–such as the use of humor or the particular way the patient is greeted–can thus be a potentially useful source of empathic insight" (p. 73). There can be disruptions in the ability of the clinician to endorse such free floating awareness, such as due to unresolved intrapsychic conflicts which unfold internally and are impacted by the interactional presence of other such as the troubled and suffering patient.

Furthermore, the clinician can have contextual situations that also impact on his or her ability to maintain a receptive mindset. The particular context can be attributed to a variety of personal issues as exemplified by excessive workload, sleeplessness, intrafamilial crises, and preoccupations with personal angst, all of which may hinder the maintenance of free floating attention. There is the possibility of the therapist likewise being hindered by preconceptions from a prior meeting with the patient. It could be argued that the therapist is incapable of purely meeting even the new patient for the first time, with a full and pure free floating attention, as every meeting is fundamentally colored by preoccupations, preconceptions, internal relational objects, and other filters that taint or tint our experience of other. There is not a pure therapist, just a good enough

one. And to that end, there is a calling forth of the need for all clinicians, therapists or not, to have some self compassion for our less than perfect selves as we meet with those who incur great suffering and by doing so we model our humanity.

The next aspect of the interaction is engagement in such a way as to be able to both withstand and work with the pressure that the patient provides toward the clinician in the interaction. The clinician in this aspect of the interaction sustains a receptivity and curiosity toward countertransference, the inner world of the clinician, and transference and projective identifications thrust forth from the patient. The resistance of the therapist manifested through rigidity, control, avoidance of the interaction, or redirecting the patient from relaying the projective identification is assessed. The overly permissive therapist who on the other extreme avoids structure and too fluidly responds to the patient, essentially corrupts the therapeutic frame. Although the clinician avoids and self protects in this latter situation, the patient may continue to be disrupted and re-traumatized through flooding, which then accentuates the provocative interactive cycle with the therapist. It is vital, however, to consider the possibility that in such cases the clinician is satisfying the regressive inclinations of the particularly disturbed patient through inaction. Kernberg (1965) exemplified this when he suggested that the patient unconsciously evokes the therapist to gratify his or her instinct. Balint (1968) referred to such instinctual and destructive tendencies as malignant forms of regression.

In terms of the therapeutic frame, there are varying opinions, all of which have to do with empirical knowledge on boundaries and classical perspectives on professional therapeutic relationships. It is difficult to distinguish rigidity in frame as necessary because of the style of the therapist as compared to the needs of the patient. However,

Flarsheim (1972) expressed that the style and tolerance of the therapist were paramount. The structure of therapeutic frame is an important consideration in self-management in the clinical arena and provides a perspective of safe expectation on behalf of the patient. Giovacchini (1972) in particular proposed that the basic establishment of a frame was to secure the well-being of the therapist so he or she would not resent the patient because of lateness, cancellations, and other logistical considerations.

This third phase is one of an empathic identification and evocation of an affective response. This phase, which is actually experienced throughout and yet most closely attended to here, is a time of focus on receptivity. There is a recognition of shifts in perception and signaling internally. There can be a shift at this phase in one's self-experience, and a loss of self, which can be modulated by attention to the detail in the shift. Schafer (1959) considered this an effect of signaling. Disruptions at this phase include either discomfort or pleasure, and a derailment from cognitively recognizing the signal. There may be an ensuing defensive posturing or being overly compensatory for ensuing (unconscious) guilt about personal impulses. As Tansey and Burke (1989) suggested, the outcome for the therapist can be "a countertransference impact without the absolutely vital awareness that this impact has occurred" (p. 82). It is in this phase when a countertransference phenomenon, coupled with the unconscious identification experience, culminates in further separation or alienation by the therapist. In addition, the transmission of intense projective identifications into the therapist by the patient can take hold in the therapist and impact on the progressive development of avoidances and emotional numbing well known in understanding of what connotes compassion fatigue.

Furthermore, the empathic process may be corrupted and dismantled, which can then lead to internal disruption for the therapist.

An illustration of the disruption summarized from Tansey and Burke's (1989) case presentation is as follows: The patient felt unable to tolerate her feelings of anxiety and loneliness, and though did not have self destructive behavior, proceeded to call the male therapist repeatedly at his home. Although initially the clinician responded with concern for her, he quickly felt intruded upon with both her insistence in calling him and his own inability to help her. He was not aware of the process of projective identification that he had experienced. It was only at the point that his valiant attempts to assist the patient had repetitively failed to do so that he became aware. The affective and embodied signals such as exhaustion, which had invaded him through the projective identification, precluded his ability to take steps to help himself and hence assist her. He advised her to seek medication from psychiatry, and she then terminated therapy with him soon afterward.

The patient may have had the experience of reification of past close relationships whereby she was rejected after expressing her needs. The therapist above was unable to recognize the projective identification thrust toward him and was unable to tolerate the ensuring exhaustion and inefficacy of his treatment. Essentially the clinician had lost the ability to empathize, and the frame insidiously was corrupted with the repeated accommodations of its inherent structure, such as time, place, and appointments. He no longer had the energy and was captured by unconscious projective identifications. Because he likely experienced numbing, this accentuated his inability to gain access to

the somatic cues of projective identification. As Tansey and Burke (1989) noted, the therapist

> blocked from consciousness the affective signals that he might otherwise have utilized to alert himself to the fact that he had received a projective identification. As a result, he could not apply his self-experience to increase his understanding of the patient and guide his interpretations. (p. 83)

2. Internal processing phase: The holding place.

The first step in this phase is to work on tolerating thoughts, feelings, experiences, impulses related to the interactive process with the patient. As with the first phase, discussed in the prior few pages, awareness is fundamental and mandates that the clinician be conscious, self-reflective and self-analytical of the shift in state of mind. Both difficult and powerful feelings such as hopelessness as well as grandiose feelings of being omniscient need scrupulous monitoring. As Tansey and Burke (1989) suggested, at this stage the therapist who suppresses the feelings such as inadequacy induced by the patient, may either overly compensate through an authoritative grandiose attitude or alternatively through hostile interpretation, subtle lateness for appointments, abruptly terminating the patient from treatment, or other over-compensatory reactions. As Greenson (1960) recommended, in a similar situation, the therapist would find it helpful to get away and gain psychological distance to relieve the intersubjective pressure and the related feelings to gain back the neutrality required to examine the process. Further, neutrality is not equated in this sense with numbing mechanistic objectivity, but rather, as Reich (1945/1972) elaborated, a means to perform an objective review of one's own subjective experience.

Fliess (1942) offered the importance of the therapist suspending harsh judgment of self and to recognize the temporary nature of the introjective identification. Ogden (1979) specified, for example, that the therapist who takes time to distance from the outer work reestablishes self-efficacy in the inner world, including reestablishing oneself as the autobiographer of feelings. Tansey and Burke (1989) further accentuated that the therapist who fails to separate sufficiently from the person, and the introject, can suffer from residual excessive feeling or numbness. These states of psychological anesthesia or hyperesthesia can both accentuate a loss of meaning and mirror the troubling symptoms numbness or overwhelming intrusiveness of compassion fatigue.

The therapist who is then able to engage in working on himself or herself through access, separation, framework, and acceptance of the unknown, has more of a model through which to work. Furthermore, this working model should include a conscious unlayering of the introjects simultaneously with empathic response to the work with other, which ultimately creates a clearing for both the patient and clinician. Greenson (1967) described that such work involves the therapist developing an internal mirror image of the patient constructed from the patient's physical, emotional, cognitive, and behavioral attributes. As he described,

> This working model was a counterpart or replica of the patient that I had built up and added to from my new observations and insights. It is this working model which I now shifted into the foreground of my listening. I listened through this model. More precisely: I listened to the patient's words and transformed her words into pictures and feelings from *her* memories and *her* experiences and in accordance with her ways. To put it another way: The events, words, and actions

> the patient described were now permitted to permeate the working model. The model reacted with feelings, ideas, memories, associations, etc… By shifting the working model of the patient into the foreground, the rest of me was relatively de-emphasized and isolated. Only those personal experiences and reactions of mine similar to the patient's remained near the model or might be used to fill out the working model. All that is peculiarly or uniquely me was shifted into the background. (p. 421)

Greenson felt that this listening process enabled the clinician to access material filtered through the patient, as if he were the patient. Furthermore, it appears that by placing himself in the background, there is a small protective space of separation from the patient, though this was not emphasized.

Tansey and Burke (1989), however, did explore the process through more of an interactional model, which provided recognition of the experience of the clinician in terms of subjective experience over the course of treatment. The interactional model relies heavily on Winnicott's (1987) observation of the infant as being inherent to the mother-infant dyad rather than an isolated individual. Therefore, the therapist's reactions and subjective experience can be better understood in the contextual experience, in interaction with and as influenced by the other.

Lastly, internal processing encompasses an examination of the empathy between self and other. The clinician can determine whether there is what Racker (1957/2007) termed a *concordant identification*, in which the shared experience is similar. This process would be clear and direct, as exemplified by the patient who describes the loss of a dear pet, and this evokes feelings of sadness in the clinician. While this form of

concordant identification is traditionally viewed as empathic, it also reflects a reception on the part of the therapist to the projective identification of the patient. The therapist, though, is perhaps more receptive and open to such clear congruent projections as they are a self-representation that emerged from personal and congruent experiences.

Internal processing of empathic response is also relative to the clinician's complementary identification (Racker, 1957/2007). Tansey and Burke (1989) offered the following example of a patient who experiences a psychologically impoverished life and relationships eliciting in the therapist the same feeling and behavior in which there is withholding. In such complementary identifications, the clinician experiences the internalized object representation of the patient as opposed to the self-representation in the concordant identification. Further, this can be experienced viscerally through projective identification.

Through a process of oscillation between inner subjective and outer objective, and interactional pressures in the intersubjective space between self and other, the therapist as well as the patient can experience the stormy vicissitudes of experience. This point is particularly relevant when considering the interaction in which there are elements that are both complementary and concordant identifications. Tansey and Burke (1989) suggested that in the interaction the clinician first determine a correspondence between his or her emotional state and that of the patient. The next check in would include identifying the patient's influence on the therapist:

> the internalized object representation of the patient's…. The often stormy consequences of [such] complementary role enactments…are usually associated with projective identification…The patient, for example, who experiences life and

> relationships as barren and ungiving may well elicit, through interactional pressure, an impulse within the therapist to deprive or withhold from the patient in some way. (p. 94)

The third evaluation of intersubjective fit involves elements of both of the first two evaluations noted above. Tansey and Burke illustrated this combination of complementary and concordant countertransference as follows:

> the masochistic patient who transiently assumes the sadistic role in the therapeutic interaction. The therapist's temporary masochistic identification awakened by the pressure of the interaction is both complementary with the patient's immediate sadistic self-representation, and concordant with the patient's prevailing, longstanding experience of self-as-victim. (pp. 94-95)

In this case, the therapist reviewed and re-experienced what transpired in the context of the interaction with the patient, including access to feelings that arrive internally and tracking the emergent material between as well as recognition of the patient's cues as well as tracking shifts in the emergent material to understand self and other, and the prevailing interaction between the two. The clinician then would analyze the implicit, psychodynamic, and underlying meanings of the particular interaction.

On yet another layer, the interaction may represent a means by which the patient can evoke in the clinician how he is feeling and subsequent fear of what that means to evoke a response or feeling in the clinician. Tansey and Burke (1989) illustrated this multilayered perspective through a patient who evoked victimization in the therapist, with simultaneous fears of retaliation, which may be conscious or unconscious or a combination of the two. Though the therapist works through this process by means of

self-reflection and through exploration of implicit meaning in the interaction, it is a challenge particularly with multiple or severe and complex patients.

3. Closure phase: Emergence and release.

A fracture in the ability of the therapist to move through this experience may be due to a number of reasons. There may be difficulty in determining the type of identifications, the elements of the interaction, the feelings and behavioral roles invoked, and the dynamic meaning for the patient. Lastly, as it is important in opening the session, and tracking the interaction, it is vital that the closure is given its due diligence. Gabbard (1982) discussed the importance of the "exit line" (p. 579) of the analytic couple at the end of the session as being the most potent part of the interaction. It is at this time, also that Chessick (1989) thought it important to study one's countertransference.

In this phase, there may be various levels of empathic disruptions, some of which may be congruent to the type of countertransference. At this phase, the clinician may experience, for example, a feeling of being irritable and perceiving the patient as increasingly dependent. The therapist who then examines these feelings in the context of underlying dynamic forces may see the genetic roles assumed in the fragile time of separation for the patient. Providing feedback to the patient through interpretive moments, and assuming more of a tolerant stance on disclosure of countertransference can be helpful to both the patient and the therapist in arriving at a moment of rest if not completion. As Winnicott (1949) radically asserted, the appropriate and judicious use of countertransference disclosure can serve the patient's needs and the therapist's need to release feelings evoked in the experience with patients. The release of countertransference reactions, though on behalf of the therapist, is better served through

attaining his or her own psychodynamic therapy and also a well-organized clinical supervision. The clinician's internal processing continues through the closure phase.

The Self and Other in the Field

Altman (2010), in his work, *The Analyst in the Inner City*, extolled both the relevance of psychoanalytic theory in thought and action in the polarization of society and the perpetuation of negative images of self and other are influenced by psychic splits within and between individuals. He discussed the importance of object relations in the inner and intersubjective world of the analyst, patients, and society. Altman's hermeneutic writing considered the ways in which patients attempt to engage with the clinician, which emulate personal past experiences. These experiences included primarily important attachment relationships with those who ran the spectrum of response from rejecting, unreliable, and unforgiving, or embracing, consistent, and loving. This basic object relations theoretical foundation informs the clinician and also informs all of us in renewed understanding of the influence on all relations, from the intersubjective experience with the clinician, to families, communities, and globally.

The world of other, the inner world of the clinician, and the intersubjective experience, are multidimensional. As Schweder (1991), a cultural psychologist, posited, the clinician has the need to understand the intent and meaning in the inner world of the patient, and it is as if he or she is stepping into the world view of other, whether that is a new individual or culture. Schweder recognized that there was no neutral stance from which to delve into the world of another, as we utilize our inner world, both conscious and unconscious to access other. Furthermore, entering the life of other can be multilayered, thinly and thickly, as British philosopher Ryle (1949/2002) offered the

description of other through the lenses of either thin or thick descriptions (i.e. superficial observation or deep meaning). A movement of the eyes exemplified thin description, whereas thick description excavated layers of meaning in the movement. Schweder explained that "the process of representing the other goes hand in hand with a process of portraying one's own self as part of the process of representing the other, thereby encouraging an open-ended self reflexive dialogic turn of mind" (p. 110), which is reminiscent of both psychoanalysis and hermeneutics.

Within the aforementioned hermeneutic process, Schweder (1991) described another way of considering understanding others in a way that goes just outside the thought, a place of accessing that that has been hidden away. This perspective is a reminder of the access to the unconscious and the process of movement in the clinical moment, and the means of access at times through reverie, association, dreams, images, and the transferential moment. Schweder encouraged the clinician to consider that the clinical process is one of engagement of self, in a way that the clinician can gain better access to self-awareness. Geertz (1977), an anthropologist, posited that "data are really our own constructions of other people's constructions" (p. 9) and hence are filtered through constructions of experiences by individuals.

Classical psychoanalytic theory as introduced by Freud (1912/1945) held that countertransference was the primary nemesis of the analyst. Such classical countertransference, as elaborated by Greenson (1967) and Reich (1951, 1960), was viewed as a hindrance to helping the patient and solely emerged from the therapist's own complexes, resistances, and unconscious genetic relationship patterns. The therapist was admonished to expunge countertransference through a longstanding psychoanalysis. This

classical view did not take into consideration the relational component of the interaction between self and other, but did emphasize the important construct of considering the clinician's inner world and how that affects how we listen to and in particular how we experience the other. This aspect of the Freudian view has been essentially thrown out in favor of exclusive focus on other, the patient, to the exclusion of self, clinician, which thereby diminishes the experience, understanding, and interpretation for both.

Another aspect of the classical theory is that it fosters interest in countertransference as a communicative mechanism. Because of this, Freud (1912/1945) was interested in the receptivity of the analyst as an organ of reception of the patient's unconscious. This aspect of Freud's analysis is particularly relevant to skills for the clinician today. The receptivity to countertransference as a communicative act facilitates understanding at deeper levels of the patient's world. Furthermore, the classical turning of the therapist's ear to the patient, Isakower's (Balter, Lothane, & Spencer, 1980) "analyzing instrument" or as Reik (1948/1983) called listening with the third ear, is facilitative to understanding the therapist's unconscious processes.

Perceptions of the construct of countertransference have gone through a number of metamorphoses, including, as noted above, Freud's admonition to hide the notion from all other than a few fellow analysts. One focus of countertransference reactions is that they are indicative of patients' longstanding developmental patterns (Winnicott, 1949). Contemporary psychoanalytic theory includes that countertransference may be indicative of the patient's or the clinician's internal struggles, or the struggles that ensue "betwixt and between" the clinical session or therapeutic relationship. Conceptualizations of countertransference as an interference (Reich, 1951) gave way to more contemporary

views, which emphasize its centrality to understanding in an effective practice (Ehrenberg, 1997; Levine, 1997). Still others consider that countertransference both hinders and facilitates the process of therapy (Smith, 1999).

Another question is whether or not countertransference is enacted or even accessed by the clinician, and Renik (1993) maintains that responses cannot be ascertained prior to their eruption. As psychoanalytically informed psychiatrist Silver (1993) argued, countertransference can refer to a variety of frustrations clinicians experience while tending to patients, such the impulse or inhibition to act. These affective responses would need to be brought into consciousness to access understanding of the patient's concerns. It would also be important to interpret one's own historical and current life experiences that are evoked. Silver suggested, however, that the clinician differentiate responses to patients.

> Our job requires that we bring that affective response into clear consciousness, to connect it to the patient's needs and fears, and with our own personal history and current dilemmas. However, our parallel and coincidental feelings of helplessness exemplify a parallel experience; …If we are edgy, depressed, disempowered and bitter, we may find our moods resonating in harmonic vibration with those of a particular patient. Defensive reaction whether verbalized or silent) to confrontation by the patient constitutes counteridentification, not countertransference. (p. 639)

Psychoanalyst Searles (1967) suggested that a therapist may respond to the traumatized or otherwise complex and challenging patient who hurls projections by attempting to avert or mitigate the intense experience through premature interpretations. Giovacchini

(1979) further suggested that therapists who defend against intolerable countertransference do so by being convinced that the patient is untreatable, though the treatability of a patient appears to depend more on the stable integration of the analyst's psyche than that of the patient. The projections met with such premature interpretations "amount to a forced feeding of self-determination (of the therapist) which can feel as foreign to the patient as the tarantulas would to the cactus" (Silver, 1993, p. 640). This suggests the parallel and matched aggressive response of the therapist to that of the patient as colorfully embellished by Silver:

> Meanwhile, when we maintain a guarded prickly veneer, this mutual internal tension mounts. We must acknowledge our own rigid prickly immovable aspects. These derive, first, from our need to serve as container for the tarantula eggs of our patients' projected oral aggression, and reciprocally, our experiencing our patients as cacti into which we deposit our own eggs of unconscious, countertransference-derived…(aggression)…and second, from our independently personal anxiety regarding impoverishment, helplessness, loneliness, and dying. (p. 641)

Therefore, the inner world of the clinician thus recognized with moveable and immoveable parts serves residence for the patient's projections. The otherwise immoveable parts are then shaken up, out of their slumber in the unconscious, and surface as countertransference. It is at that point where the therapist is obliged, through a spirit of curiosity, to explore the awoken giant of countertransference, thus managing the corrupted tensions to gain new data for informing interpretations of self and other.

Friedman (1988), in his description of psychotherapy considers this in terms of the following:

> Considering that the one thing a therapist knows with assurance is that he is constantly managing tensions between himself and his patient while about everything else he is never sure…. Therapists function in a sea of trouble and they talk as though they don't. Respect and attention abound, to be sure, but the identifying truth about psychotherapy is that it is an uncivil, threatening, even brutal struggle. (pp. 5-6)

Fromm-Reichmann (1950), a German psychoanalyst and contemporary of Freud, commonly worked with patients in primitive states. She provided a clinical example in which she was able to ascertain that two aspects of countertransference, including the classical internal and more contemporary communicative perspective as previously outlined. Her patient was particularly aggressive, not unlike many of others she had treated. However, she began to experience an overwhelming sense of anxiety and so took it to her clinical supervisor because she considered it a part of the unconscious. Once she was able to recognize it as a negative transference, through the supervisory consultation, the anxiety abated and the analytic dyad resumed their work. She worked in the knowledge that the experience with the patient involved both the patient's and her psychodynamic processes. Further, she touched on the implications in the field between, the intersubjective or analytic space, when she was able to return to the work with the analysand once the transferential anxiety was interpreted and dissipated.

The implications for compassion fatigue from this clinical example suggest the clinician who is open enough flexibility to be moved by the patient, can open up the

possibility of more thorough work with the patient. Furthermore, the clinician can gain greater understanding of the unconscious forces in the intersubjective experience, even for those clinicians with a wealth of training and experience. This understanding through interpretation that often happens with other in consultation with a clinical supervisor, as is the case with Fromm-Reichmann. Lastly, the interpretive moment for the therapist can release some of the rigid interior part, through the countertransference, as exemplified in the case above when the anxiety was relieved.

As British object relationist Winnicott (1949) emphasized, countertransference is key in understanding psyche of other. Therefore the work of prevention of compassion fatigue entails a process of acknowledging the intrapsychic influence on the experience of other. Furthermore, work with other, particularly the intense psychotherapeutic work with those traumatized or in severe and complex primitive states is, as Shur (1994) described, "an amalgam, deriving potentially from the patient's and the therapist's unconscious processes" (p. 4).

Bettelheim (1974) suggested that the work with challenging patients stimulates the clinician's disruptive impulses, which if met openly can lead to healthier psychological integration for the clinician. The healthy integrated psyche is better able to match the broad spectrum of challenging patients, and less likely to engage in defensive maneuvers. In compassion fatigue, the avoidance symptoms may in some cases be representative of such disruptive impulses that are acted upon through avoidance. However, the struggle with intense, frightening, and dystonic states of other can enlarge the therapist's capacity. Furthermore, Giovacchini (1979) expounded that through such work, we as clinicians "receive treatment ourselves so that our therapeutic

armamentarium and our knowledge of early developmental phases is enriched sufficiently to diminish the list of conditions that are considered to be contraindications to analysis" (p. 236). This receiving process therefore only is derived from leaning in toward the other, rather than avoidance. Therefore, with compassion fatigue there is a sense of aversion to taking this analytic stance of leaning in, as a misconceived way to self-protect. Exploration of the nature of trauma work is worthwhile at this juncture to further understand the psychodynamic processes.

Davies and Frawley's (1994) description of the impact of working with trauma in terms of countertransference was resourceful. They suggested that there are at least four complications with the transferential experience related to survivors of sexual trauma. These theorists addressed the situation that the clinician is readily and repeatedly confronted with, namely the complicated patient who presents in a frightened and yet disorganized way in which experiences have been concretized rather that symbolized along the way. The patient attempts to symbolize by borrowing the response from the therapist, thereby giving a name to their disintegrative traumatic memories. Consequently, the ensuing dissociation is used defensively, and then the clinician may get a taste for his or her more primitive defensive structures such as acting out, splitting, projective identification and omnipotence. This can result in ongoing perceptions and generalizations about all patients who are in primitive states by the therapist who becomes inflicted with and carries the primitive energies for other.

From a classical psychoanalytic view, the therapist managed this through encouraging the patient to free associate, lying on the couch without direct eye contact with the clinician, and the clinician maintained "abstinent or benevolent neutrality"

(Urribarri, 2009, p. 168). The clinician self-protected through creating distance, and suspending thought and gaze. The antithesis to this stance is, as noted above, being open to the countertransference, in favor of broadening in a healthy way one's psyche. Herman (1992) however, offered a middle ground. She determined through her work in trauma, the vital importance of a "moral neutrality" (p. 135), which supports the respectful caring of self and other. Neutrality in this sense ensures recognition of the inherent injustice in traumatic experience, protection empowerment of the patient, and resistance of the therapist to disempower. The power of responsibility conferred on the therapist is to foster the patient's recovery, partly through bearing witness to a crime against the individual or against humanity. The clinician positions herself, according to Herman, in a pose of:

> solidarity with the victim, which…involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice. This affirmation expresses itself in the therapist's daily practice, in her language, and above all in her moral commitment to *truth-telling* without evasion or disguise. (p. 135)

Truth-telling involves a thorough examination of verbiage and patterns of thought and belief about experiences, shift of the perspective toward more authenticity on behalf of all parties, but especially in terms of the clinician as otherwise there is likely collusion in maintaining status quo.

Authenticity, or truth telling, in clinical trauma care was exemplified by the work of psychologist Danieli (1984), who emphasized the use of descriptive terms in the trauma narrative of Holocaust survivors as a means to diminish the tendency for

clinicians to participate in a "conspiracy of silence" (p. 23), that is rather than speaking of family "deaths," she affirmed they were "murdered" (Herman, 1992, p. 135). The authenticity in moral neutrality can stand as a guard for the therapist as well to no longer sequester in silence that which had been silenced in the patient, and rather to bring to light the vicarious experience through words and in particular through sharing one's own narrative within clinical supervision, personal depth therapy, and within an organization that supports a sanctuary or trauma informed model of care.

Truth telling both holds implications for the clinician and impacts profoundly on the patient. As survivor, professor, and political activist Wiesel (1968) described, Western countries created a vacuum of silence about Germany in 1944, which he considered proof of the world's guilt. From the victims' perspective, Wiesel (1968) admonished that they

> suffered more, and more profoundly, from the indifference of the onlookers than from the brutality of the executioner. The cruelty of the enemy would have been incapable of breaking the prisoner; it was the silence of those he believed to be his friends—cruelty more cowardly, more subtle—which broke his heart. There was no longer anyone on whom to count: even in the camps this became evident. "*From now on we shall live in the wilderness, in the void: blotted out of history*." It was this conviction, which poisoned the desire to live. If this is the world we were born into, why cling to it? If this is the human society we come from—and are now abandoned by—why seek to return? (p. 189)

The therapist who bears witness in an actively empathic way helps to facilitate breaking the silence and thereby enhances the healing experience for the patient. Similarly, the

clinician who suppresses and does not lean into other, but falls back into self, is not "truth telling," and more likely suffers from the traces of fearsome multiple vestiges of primitive states. As Neff (2011) suggested in her work on self compassion, the clinician who is kind to self and suspends self judgment likely experiences less isolation and over-identification with the troubles of her patient. The good enough clinician, who is able to be actively connected to both perceived error and self-kindness, both challenging and soothing, is better equipped to be mindful of other in the clinical situation. As the author and meditation teacher Salzberg (2005) explains, "Loving ourselves points us to capacities of resilience, compassion, and understanding within that are simply part of being alive" (p. 19). The next section of this chapter addresses further this notion of self and other, and the connection we share psychodynamically in a relational field.

The Relational Matrix and Intersubjectivity

Psychoanalytic theorists have increasingly conceptualized human experience within a contextual and relational matrix rather than in a classic intrapsychic psychoanalytic perspective (Aron, 2000; Atwood & Stolorow, 1984; Fonagy & Target, 1996). The term *intersubjectivity* can refer broadly to the experience of perception and interaction as discussed by Coburn (2002), in which there is a "seamless intertwining of multiple worlds (or layers) of subjective experience" (p. 656), what is termed in this inquiry as layers. Through the layers experienced by the clinician, there is a tension among phenomena of the clinician's internal subjective, of other (patient), and between self and other. This tension is related to the multiple phenomena involved in the clinician's experience, such as the stance in the intersubjective field, mutual empathy, transferential experience, and self and object/relational representations, to name a few.

The subjective experience may be considered to be increasingly discovered via listening through this multilayered, contextual and relational matrix, in a way that embraces the affective embodied experience of intersubjectivity and has a deeply felt unconscious component, such as through dynamic relatively unstructured formulations.

Coburn (2002), for example, described the multiple subjective worlds "that seamlessly and relentlessly ebb and flow in relation to one another" in an ever evolving organizing process. The clinician, or researcher, selects out of a number of layers, which can be arbitrary, and extracts from the full context in order to perceive, analyze, and interpret. By so doing, the clinician relegates a large portion of the data aside, which can be taken up in the future. This similarly mirrors the research process, in which the researcher needs to let go of much in the process of honing in on the research. As Romanyshyn (2007) clearly described in his book on the soul in research, this can be a process of mourning for that which is not engaged into the theoretical or clinical construct.

Aron (1996) credited Stolorow, Atwood, and Ross in their 1978 article, which introduced to the American psychoanalytic community the construct of intersubjectivity. However, the work of others such as Winnicott and other relational analysts predated those of Stolorow and colleagues. Self psychologist Stolorow (2011b) described his developing conceptualization of intersubjectivity as the dynamic interplay between the mutual transference and countertransference between clinician and patient. In particular, Stolorow examined the impact of the interaction of the clinician and patient's subjective worlds on the "correspondences and disparities—intersubjective conjunctions and disjunctions—between the patient's and analyst's respective worlds of experience" (p.

23). Psychologist Benjamin (1988, 1990), child psychoanalyst Stern (2000), and psychoanalyst Ogden (1994) advanced the notion of mutual relatedness in their emphases on the unconscious nonverbal communication.

An investigation of primitive borderline states suggested that such states are shaped within "an intersubjective field, co-constituted by the patient's psychological structures and the way these are understood and responded to by the therapist" (Stolorow, 2011a, p. 23). Stolorow, Brandchaft, and Atwood (1987) further broadened the perspective of intersubjectivity to other clinical phenomena, such as transference, enactments, dreams, and neuroses. Stolorow (2011b) claimed that the focus on intersubjectivity advanced conceptualization of clinical problems and care. In particular, there was a transition in thought of motivation from isolated intrapsychic drives to the primacy of affect in interaction with other.

Sletvold (2014) posited that intersubjectivity refers to a process of imitation and identification, and what Benjamin (1990) denoted as a mutual recognition of the other. The ego psychologist Stolorow (2011b) added that intersubjectivity is a "contextual precondition for having any experience at all" (p. 23). Slochower (2014) characterized the clinical encounter as it has both an open "timeless quality" (p. 13) and a finite container of the treatment process. This dialectic between the dynamic timelessness and finite container, is a characteristic of the psychodynamic processes incurred in the field between self and other.

> The person with understanding does not know and judge as one who stands apart and unaffected; but rather, as one united by a specific bond with the other, he

> thinks with the other and undergoes the situation with him. (Gadamer, 1975/1989, p. 288)

Empathy has been considered throughout this study. However, recently psychoanalyst Stolorow (2014) addressed the Cartesian split imposed by contemporary thought on the pervasive view of the isolated mind. In this paper he declared that this Cartesian doctrine that separates the person into, two, an outer an dinner region, which

> reifies and absolutizes the resulting separation…and pictures the mind as an objective entity that takes its place among other objects, a "thinking thing" that has an inside with contents and looks out on an external world from which it is essentially estranged. (Stolorow, 2014, p. 80)

The doctrine of immaculate perception, which Stolorow drew from Nietzsche, involves a denial of the analyst as a connected human being. She or he does not enter the world of other with a vacuous gaze sans previous and current live experiences or preconceptions. He argued that there is no need to bridge between the separated minds as they are already connected because of our common humanity, including our common existential vulnerability and mortality. Stolorow implored clinicians to consider the fallibility of the belief that our empathy can be neutral, in a way whereby the therapist leaves oneself outside the door of the therapy room in order to be with and view together with patients their lives. Rather, Stolorow felt that the nature of human beings is dwelling, which is one aligned with that of philosopher Heidegger.

From a contextual sensibility, all thought is interpretive and based on horizons and as Gadamer termed, prejudice. Therefore, there are no purely objective stances or absolutes. Thus, understanding evolves through an interactive dialogical reflective

process of self, other, and the dynamic in between the two. Stolorow explained that each participant draws from experiential worlds which form a home base from which he or she searches for analogues for the possible meanings from those governing the experiences of others. Introspective understanding is thus grasped through and a property of dialogue. Therefore understanding is not a privileged possession of the few nor of a mind, which is isolated.

The leaning in toward other in a visceral, psychological, and emotional way, a primary thesis of this inquiry, confers a protective shield for the therapist rather than a resistance against the other, which Stolorow articulated as a process energetically participative and engaging in an emotional way. Stolorow (2013) illustrated this as a means by which the individual can meet the trauma directly, and being able to speak to the unbearable, and "saying the unsayable, unmitigated by any efforts to soothe, comfort, encourage, or reassure—such efforts invariably being experienced by the other as a shunning or turning away from his or her traumatized state" (para. 6). This consideration reifies the importance of creating a space in which healing can occur. Stolorow also considered:

> If we are to be an understanding relational home for a traumatized person, we must tolerate, even draw upon, our own existential vulnerabilities so that we can dwell unflinchingly with his or her unbearable and recurring emotional pain. When we dwell with others' unendurable pain, their shattered emotional worlds are enabled to shine with a kind of sacredness that calls forth an understanding and caring engagement within which traumatized states can be gradually transformed into bearable painful feelings. Emotional pain and existential

> vulnerability that find a hospitable relational home can be seamlessly and constitutively integrated into whom one experiences oneself as being. (para. 10)

The finding of such "a hospitable relational home," as described by Stolorow above, also has implications for the clinician. As the clinician dwells, leans in toward the experience of other, he or she is not fathoming the entire experience of other. Rather, it is a process of dwelling, moving through, and feeling the deep sorrow of the story. The experience of getting stuck, whether by leaning out away, fleeing the patient, or imploding in the trauma of it, adversely impacts on the healing for the patient and eventual compassion fatigue for the clinician.

The role of the therapist therefore involves both being a good enough mother relationally and an interpreter of experience, as considered by a number of psychoanalysts, including Kernberg (1965) and Winnicott (1953). The clinician in the maternal role leans in to gain an empathic sensibility, and in the interpretive mode leans out to gain perspective. I have an image of justice, with her holding in her hands the scale between the two, in a field between called by various names.

In this inquiry, I suggest that there is a field in which the "I and Thou" (Bragen (2001) meet (as previously described). This field has been considered by a number of philosophers, religious leaders, neuroscientists, physicists, and psychologists by various names. Jung, in his work on transference, postulated the analytic relationship is found within a bi-personal interactive field, for which he provided a helpful diagram (Jung, 1946/1983, para. 422). Langs (1979) offered a description of the "bipersonal field" (p. 51), which he derived through extensive investigation of the listening process. An interpersonal, bipersonal or analytic field, hereafter termed "field," represents the

temporal-spatial setting that guides the interaction between self (therapist) and other (patient) and represents the unconscious space where dreams, thoughts, and images reside.

Similar to Stolorow's (2014) emphasis on the fallacy of the Cartesian doctrine of the isolated mind, a view of the field is unconstrained spatially. When I considered the mutual influence, for example, in the clinical moment, the therapist may "dwell" with the patient long after the session is over. Dreams, memories, visions, reflections, and thoughts permeate the psyche and are not confined into impermeable psychological frames of the therapy hour. Langs (1979) considered the field as a place where the patient's and therapist's communications and experiences form what he considered vectors of varying proportions. Within a session, for example, the analyst may experience other through distant memories that become connected through transferential experience into the present moment in the intersubjective field of the present. The field is a place to start to explore what Winborn (2014) termed "shared realities" which are undergirded below the transferential chimera, the borders of consciousness, the negative coniunctio, reverie, interactive field, and the "participation mystique" (pp. 1-29).

The term *analytic field* first emerged in South America and has been considered as such on the European continent, though is beginning to show up in the United States. Though the intersubjective field has recognized the mutual conscious and unconscious of the individuals as noted by Morgan (2010), Bollas (2007) emphasized that Freud was "unequivocal in stating that the work of psychoanalysis is *unconscious to unconscious"* (p 87). Freud early wrote of the analyst's dynamic process in psychoanalysis as the ability to "surrender himself to his own unconscious mental activity, in a state of evenly

suspended attention…and by these means to catch the drift of the patient's unconscious with his own unconscious" (Freud, 1923/1950, p. 239). Even earlier, Freud (1912/1945) admonished the analyst to become a finely tuned instrument to skillfully "turn his own unconscious like a receptive organ towards the transmitting unconscious" (p. 115), as previously discussed in this chapter. The contemporary of Freud, Jung in his alchemical perspective, insisted that the genuine encounter entailed reciprocity:

> For two personalities to meet is like mixing two different substances: if there is any combination at all both are transformed. In any effective psychological treatment the doctor is bound to influence the patient: but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence. (Jung, 1946/1954, para. 163)

As Solomon (2007) pointed out, the reciprocity is now considered a psycho-neurological reality (though this perspective is beyond the scope in this inquiry). Solomon further discussed the theory of emergent properties which are a

> tool in understanding how, across all matter, a deep structural dynamic at the edge of chaos, is at work in which order, patter, and, psychologically speaking, systems of meaning threaten to break down into chaos. Under the right conditions, a structural transformation into a more complex pattern or meaning may occur. If a high level of relatedness pertains amongst the components of a system…then genuinely novel properties and processes may emerge that could not have been predicted or explained simply by adding up the properties of the original components. In psychological terms, this is a field theory view…when a solution to a conflict or a problem is achieved that is of a higher order than the sum of its

> constituent parts—when, for example, after a difficult period of analysis, a patient begins to perceive …their own humanness and that of the analyst emerges in the patient. (Soloman, 2007, pp. 284-285)

Consideration of the field includes that dynamic systems can either is dissipative or expanding, closed or open. According to Davies (2006), a physicist, cosmologist, and professor, field can be a pulsing space. This pulsation is not only experienced through a mind, but is embodied. The next section will review several of the implications of the somatic experience, and will pay attention considerations in the intersubjective field.

Embodied Psychodynamics

Clinicians and theorists have speculated about how countertransference operates (Tansey & Burke, 1989), such as in concordant identification whereby the clinician feels what the client feels; or by complementary identification whereby the clinician's response is as a reaction to the clients feeling, such has feeling hurt when the client angrily attacks the clinician. Through concordant identification, the patient elicits in the therapist a shared experience, whereas with the complementary identification, the therapist becomes, for example, the role found commonly in the patient's past. Wilhelm Reich (1945/1972), the Austrian psychoanalyst, considered that the clinician gains access to and understanding of the patient through careful sensing and observation of the patient. Reich stated that "the patient's expressive movements involuntarily bring about an imitation in our own organism. By imitating these movements, we 'sense' and understand the expression in ourselves and, consequently, in the patient." (p. 362). Reich added that the bodily response connotes certain patterns that could be analyzed by the clinician to read the character and conflicts of the patient. Stone (2006) referred to the analyst's body

as a somatic "tuning fork" (p. 109) to the experiences of other. As Freud (1915/1957) stated, "It is a very remarkable thing that the Ucs. of one human being can react upon that of another, without passing through the Cs" (p. 194).

The clinician may analyze himself or herself in terms of the somatic language to interpret response to patients. The somatic interpretation then can transform understanding of self in response to other and may guide the clinician in terms of steps to take to ameliorate symptoms of compassion fatigue. This was illustrated by Reich's (1945/1972) description of what he termed armoring, as follows.

> The armoring, its nature, the degree of its rigidity, and the inhibition of the body's emotional language can be easily assessed once the analyst has mastered the language of biological expression. The expression of the armored organism is one of "holding back." The meaning of this expression is quite literal: the body is expressing that it is holding back. Pulled-back shoulders, thrust out chest, rigid chin, superficial, suppressed breathing, hollowed-out loins, retracted, immobile pelvis, "expressionless" or rigidly stretched-out legs are the essential attitudes and mechanisms of total restraint. (p. 363)

The rigid armoring thus described by Reich, prevents sensitivity to feeling, including internal sensations and feeling emotionally from and with others. This likely engenders a diminished capacity for empathy. The process of armoring experienced in an embodied way, parallels the dissociation, withdrawal, emotional numbing, and avoidance symptoms, which characterize compassion fatigue. Furthermore, this understanding establishes the clinician directly within the embodied self to access awareness of the progressive development of troubling responses that form into compassion fatigue.

Hatfield et al. (1994) discussed the delicate balance of emotion as it hovers over the approach toward and withdrawal from, or what I term in this study, leaning in and leaning out. They identified primitive emotional contagion as a contributing factor in such hovering movement in response to behavioral, psychophysiological and social phenomena. The primitive emotional contagion, was characterized by a tendency toward mimicry of facial expressions, which led to synchronization of body movements and vocalizations of the other person. This then transformed emotionality whereby the embodied movements allowed for convergence of mutually synchronistic emotionality. Such rudimentary contagion is characterized by its automatic, unintentional, and uncontrollable nature and therefore in usual conversation, awareness of its occurrence would be largely inaccessible. However, the embodied clinician who is more likely to seek to understand the complexities inherent in psychodynamic ways of listening, and the implications of the unconscious, would be in a position to both access and utilize understanding of what transpires in a clinically and personally effective way.

Early, the Scottish moral philosopher, A. Smith (1759/2013), proposed that when we are aware of another's plight, we not only see their emotional and behavioral response, but we imagine a situation in which we would be aroused similarly. Similar feelings are induced in the observer, which are on a smaller scale than the person having the immediate feeling. Smith described this as "fellow-feeling" (p. 2), which arises in a variety of circumstances, not exclusively only those of pain or sorrow. Smith stated that: "the passion which arises from any object in the person principally concerned, an analogous emotion springs up, at the thought of his situation, in the breast of every attentive spectator" (p. 2).

The contemporary psychoanalyst, Trevarthan (1979), suggested other terms used to connote this empathic connection, when he theorized the intersubjective nature of infants. He noted the "innate rhythmic" (p. 509) nature of the maternal child interaction and the ensuing self regulation in engaging with (m)other. Bråten's (2007) postulate of the innate virtual other provided for an altercentric participation or felt sense of the other person. Furthermore, the emotional responses that the therapist has can be both feeling with other and feeling another emotion, which is incongruent with the situation.

Sletvold (2014) described embodied intersubjectivity implies that emotions by nature are generated and developed through relational experience. He elaborated:

> An emotional body state is not only an intrinsic psychological property of a subject, but a relational property of subjects in a given social context….We not only feel our own emotions, we also sense each other's emotions, are moved by them, make them our own, and in this process transform our selves, for better or worse, through identifications with each other. (p. 87)

This focus brings into consideration the unfolding of the clinician's relational experience of other in an embodied way. According to a number of authors (e.g., Ronnestad & Skovholt, 2013; Wampold & Brown, 2005), understanding embodiment from the perspective of the therapist yields a wealth of ways to access and analyze inner resources to sustain themselves in clinical practice in a field wrought with challenges. Furthermore, the researcher and psychologist Anderson (2002) considered that "the finely textured experience of the human body" (p. 40) enriches research, writing, empathy, and compassion. Anderson suggested distinctive features of embodied writing, which can mirror effective work with other, including

> living close to the palpable experience of other and valuing both internal (perceptual, kinesthetic, visceral and imaginal) and external data (sensory-motor reactions). Embodied writing allows for release of the superego witnessing, which conventionally prevents exploration of unknown or not fully formed concepts. The locus of the voice of the words is situated inside the body, thereby providing a space in which perceptions may cultivate an experience in a host of sensual enactments past and present. (p. 44)

Embodiment connotes presence in the moment, which influences a process of slowing the momentum of thought and action, similar to the state of reverie, which Ogden (1997) described for clinical work. As Merleau-Ponty (1945/1962, 1969) suggested, the body inhabits the world and the world inhabits the body. Therefore, the slowed momentum allows for mindful presence in which the clinician tends to seemingly minor details of the worlds of self and other and the in-between field. Ogden's (1997) noticed:

> It has increasingly seemed to me that the sense of aliveness and deadness of a given moment of an analytic hour is perhaps the most important gauge of the analytic process. The attempt to use language to capture/convey a sense of this delicate interplay of aliveness and deadness of human experience in the analytic setting represents a major challenge to contemporary psychoanalysis. (p. 4)

The sense of deadness or aliveness emerges also in compassion fatigue as exemplified when the individual experiences emotional numbing or hypervigilance and anxiety. The notion of aliveness will also be addressed further in Stern's (2010) perspective on vitality. The process of embodied presencing, a term revived through Senge and Scharmer (2004), in reverie connotes a sense of aliveness in the therapy hour. This enriched aliveness

connotes movement, perhaps in that leaning in and leaning out process, forming a rhythmic dance in between self and other which restricts the enactment of the story, particularly by those traumatized as previously discussed. The movement engages clinician presence, which is considered preventative from being ensnared in fragments of other.

Sletvold (2014) posited a resurgence of interest in embodiment because of both enhanced research in infancy (see for example the psychiatrist and psychologist Stern's, 2000) and the evolution of the relational tradition in psychoanalysis toward intersubjectivity. Sletvold further encouraged extending attention to what Stern (2010) identified as "something more" (p. 178) beyond the verbal-symbolic source of the unconscious and conscious material, which is often "hidden in plain view" (p. 178) but minimally recognized. The clinician's attention to the embodied experience of the interaction (i.e. bodily sensation, emotional feelings while tending and bearing witness to the other) may provide salient data on what is occurring in the internal world of the patient, and the clinician. Such attention could include rhythm of speech, gaze, posture, and overt muscular activity, in addition to visceral sensations.

The eminent child psychiatrist and psychoanalytic theorist Stern (2010), in his last book *Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy, and Development*, suggested that the human interactive and clinical process of understanding others is concerned with an emergent principle of vitality. The clinician's assessment of movement vitality is considered an intuitive process that accesses states of mind, thoughts, meaning, patterns, and emotions, which can impact on healthy vs. illness states. Stern posited that vitality permeates daily life, and throughout

psychology and psychotherapy. He considered our innate alertness to vitality, to feeling within and sensing it in other. However, he admitted that the emphasis on vitality was abandoned in favor of attention to a scientific mechanistic view of separation of mind and body. In the 18th and 19th centuries, the doctrine of "vitalism" held that life was sustained by a vital element (élan vital) distinct from then known mental, physical, or chemical, forces. Stern encouraged redemption of vitality, but with the added dimension of mental processes and action. The fundamental perspective on vitalism is manifested in movement due to its integration with a number of other events. Stern (2010) claimed:

> A movement unfolds in a certain stretch of time, even it that is very short. There is a temporal contour or time profile of the movement as it begins, flows through, and ends. Therefore a sense of time, its shape and duration is created in the mind, along with the movement….Movement also brings with it the perception or attribution of force(s) "behind" or "within" the movement. In addition, movement has to happen in space, so the movement defines a sense of a space. Finally, a movement has directionality. It seems to be going somewhere. A sense of intentionality is also inevitably added. In a sense force, time, space, and directionality could be called the four daughters of movement. (p. 4)

The five processes of vitality, a "fundamental dynamic pentad" (pp. 4-5), including movement, force, time, directionality, and space, can be considered in the embodied intersubjective interaction experienced by the clinician. The intention is to explore the gestalt of these processes, as they reveal the dynamics behind or underneath the intersubjectivity and in particular how the clinician might hold (in Winnicottian terms) within that space between and on an ongoing basis after the discrete clinical interaction.

It is at this point in the process of delving into the dynamics of the space between self and other that Winnicott addressed. The inspiring volume about Winnicott by Abram (2007) emphasized the sensitivity that Winnicott had toward the fundamentally vital human need of relationship. Winnicott (1988) conveyed the importance of therapeutic relationship as follows:

> A correct and well-timed interpretation in an analytic treatment gives a sense of being held physically that is more real (to the non-psychotic) than if a real holding or nursing had taken place. Understanding goes deeper and by understanding, shown by the use of language, the analyst holds physically in the past, that is, at the time of the need to be held, when love meant physical care and adaptation. (pp. 61-62)

Furthermore, Winnicott (1956) postulated in his work on mutual states between mother and infant, that the mother is characterized by a mental state of intense concentration and mild withdrawal, named primary maternal preoccupation. Likewise, the therapist employs a state of concentration, which moves from intensely acute focus to a mild withdrawal in reverie or self-reflection. The therapist who at once restores an evenly suspended focus of attention can more flexibly move through the various layers.

Winnicott (1987) took into account the mother's subjective states of mind in approach to her infant, rather than just the response of the infant. This was revolutionary at the time. In a parallel way, there has been so little emphasis on the clinician's subjective states, and specifically in terms of the work on compassion fatigue. From Winnicott's perspective, the exquisite mutuality of the relationship was viewed as a means for sustenance and development for both mother and infant within a miniature

environment of care. The good enough mother provided such an environment and was also influenced in the entrainment to sustain herself in the process. A parallel to the good enough clinician is suggested here: Might the clinician similarly experience of entrainment to sustain self through rather than avoidant of the interaction with other? Winnicott's description of the mother who desires provision for her baby is via an identification with the infant's dependence. She identifies the dependence from her own internal relation to dependence and has good enough compassion address her own eruptive concerns of dependence. In the case of the mother, she tends to the baby and assures the baby of her presence, albeit differently than the clinician would do for the patient, but nonetheless a similar transferential process.

The conceptual model of emotional holding has traditionally been understood in terms of children or emotionally disturbed individuals. However, there is applicability to all of us, including clinicians. Greenhalgh (1994) described emotional holding as a way in which one can tend to those difficult or disturbing feelings, which inhibit relationship, growth, or learning. Holding helps to demonstrate that difficult emotional feelings are tolerable, manageable, and meaningful, though as Greenhalgh admitted, it is at times the most difficult of work:

> In a holding environment the adults have the capacities to hold the anxieties aroused in themselves. There is a reliable provision of trust and affirmation, and stability of emotional climate….In providing a holding environment the adult strives to be reliable, to be attentive and sympathetically responsive to the child's explorations, and to see and feel the world through the child's eyes-to be empathic. (p. 108)

Similarly, though, the clinician who discovers a holding environment or field for oneself, may find that it provides a similar secure, and soothing place to rest psychologically. Stapley (1996) differentiated between the external holding environment including imposed socio-environmental rules and structure vs. the internalized holding environment which is a milieu developed under early primitive and developmental experiences. Further, this concept of a holding field for clinicians can be applied to the organizations in which the clinician practices. These systems fields often replicate the primitive defenses that the clinician is often managing in the work, as described more thoroughly in Shur's (1994) examination of how systems of care enact the primitive internal world. As Stamm (1985) outlined, "The holding environment is not a therapeutic technique or process done to the patients by the staff. Rather it is an ambience or climate that the unit seeks to maintain. It contains a balance of qualities" (p. 222).

The exploration of systems back to the interaction between self and other, and back further to the intrapsychic phenomena of the individual is similar to thinking in terms of a zoom lens focusing from macro to micro. Stern stated that Einstein's thinking was related to "forces and volumes moving in time and space" rather than words or pictures. Stern stated that:

> Now zoom in to describe the "dynamics" of the very small events, lasting seconds, that make up the interpersonal, psychological moments of our lives: the force, speed, and flow of a gesture; the timing and stress of a spoken phrase or even a word; the way one breaks into a smile or the time course of decomposing the smile; the manner of shifting position in a chair; the time course of lifting the eyebrows when interested and the duration of their lift; the shift and flight of a

> gaze; and the rush or tumble of thoughts. These are examples of the dynamic forms and dynamic experiences of everyday life. The scale is small, but that is where we live, and it makes up the matrix of experiencing other people and feeling their vitality. (2010, p. 6)

Stern utilized the term *vitality* to emphasize that movement and proprioception are qualities of aliveness. Movement can be physical and mental: visible or invisible. Therefore when a therapist is working with the patient, reflection on shifts in the chair or how many or few thoughts are tumbling forward can be helpful to access the gestalt of the phenomenological experience with other. As Varela, Thompson and Rosch (1991) described, this reflection can be embodied, mindful, and open-ended.

The clinician can engage in a process that will not only be helpful for the patient and the success of the therapeutic relationship, but one which is deeply supportive of the clinician in a way that honors both his or her inner world and the strategies incorporated in the clinical work. The following is based in the concept that the intersubjective experience is co-constructed. This foundation provides an understanding that there is the potential for shaping experience through interpretive moments, even amidst some ambiguity. There remains an open analytic space for the ambiguous, unknown, implicit unconscious to reveal itself, at times through what the psychoanalyst and writer Stern (1989) termed unformulated. As Stern (2010) advised, "there is always some ambiguity to be resolved in experience, some formulation of the unformulated that remains to take place, some emergent quality in the creation of whatever is to come next" (p. 1).

Stern (2003) importantly added that unformulated experience is not necessarily unconstrained. Rather, as Sass (1989) suggested, there is unlikely to be a single meaning

involved in the experience with the other. Similar to hermeneutics, there is a middle way between self and other, objectivism and relativism, past and present, and inner and outer. It is notable that Gadamer's (1975/1989) hermeneutics considers all experience as interpretive, as was elaborated in the chapter on methodology in this inquiry.

The application of the dynamic Stern's (2010) pentad of movement, time, directionality, and space, is useful in considering compassion fatigue. Within the clinical moment, the clinician's close consideration of the dynamics of small present experiences, contribute to understanding the evolving development of compassion fatigue. Stern described examples of this practice such as the flow of gestures, the timing of a phrase or word, a smile, shifting in the seat, eyebrows lifted, and the rushes of thoughts. Further examples may include visceral responses, daydreams, associations, making lists, thinking of past experiences, and daydreams which are rich with symbolism, all of which may provide clues to the clinician's countertransference. Listening in an analytic way can be helpful in this process.

Exploration of the person of the clinician has not been exhaustive and there are notable exceptions related to those clinicians courageous enough to bring forth the personal. These have included Little (1951) in her work on countertransference and her background with depression as an analysand of Winnicott. Isay (1996) in his work as a psychiatrist who came out of hiding in his sexual orientation, Harris (1998) in her autobiographical material used in theoretical work, Casement (2006) on the work of learning through personal life, Richman (2006) on subjective experience of trauma, and Gerson (1996) on the person of the therapist. Aron (1996) noted that individuals are drawn into the clinical field through complexes around desire to be known and challenges

with intimacy. Aron posited, and I concur, that it is a rather unusual experience of learning in detail about another and yet personally being rather visible to the patient. Aron suggested that this alone elevates anxiety with one's own longing to be recognized and known in contrast to unconscious attempts to consolidate by hiding, which I pose is the crux of the difficulty in compassion fatigue.

The organization in which one works supports the hiding which then spirals into dysfunction with the individual and perpetuates a sick organization. Subjective awareness of holding the dialectic between subjectively acknowledging one's own humanity and inclinations toward the relational is the beginning of recognition which can relief the impulse to disclose and to work through the evocation of material through other means. As with patients who are traumatized and sequester their experiences in a secretive world, the clinician who hides from revealing his or her true self is worn down. The focus here is not to diminish the importance of clinical therapeutic discretion, but rather to illustrate that total secrecy is wearing and that it behooves clinicians to engage in clinical supervision or their own psychological work to disconfirm the need to hold the myriad of the patients with whom they have born witness alone. I posit that the lack of awareness and attempt at holding the material at bay, perhaps rigidly, influences boundary violations. The focus on the patient and adherence to absolute analytic neutrality, without conscious access to underlying psychodynamic influences of what transpires between self and other, plausibly influences eruptions of boundary violations, and intrusive vicarious stress reactions.

As Winnicott emphasized the good enough mother, the "good enough" clinician engages in the raw experience of tending to other as a human experience influenced by

psychodynamic factors, contextual considerations, and subjective reactions. Therapeia means caring for, and in this perspective, is inclusive of caring for the caregiver. Acknowledgement of the humanity in the presence of other, weds the psychodynamic influences to a greater understanding of how we affect one another, and mirrors the range of intersubjective influence from trauma to compassion, and shame to acceptance.

Deep Listening: Leaning In, Leaning Out

Listening is considered an essential skill in clinical work, and in particular the work of psychodynamic inquiry. The therapist listens as the basis for empathizing, interpreting, confirming, formulating, associating, and validating experience. It was Freud (1912/1945) who recommended that the therapist employ an "evenly-hovering attention" (pp. 111-112) that is nondiscriminatory in the process of listening, and further suggested that the clinician's state of mind is reflected in the ability to engage in this manner (Bion 1967a; Chrzanowski, 1980; Ferenczi, 1928,1930; Khan, 1977).

Although it is unfortunate that neither Freud nor other psychoanalysts have described the specific steps of the process to attain and sustain optimal listening, Rubin (1985) suggested a thousand-year history of description of listening as exemplified in Eastern systems. Goleman (2006) and Kornfield (1977) have fostered a Western contemporary understanding and interest in mindfulness meditation through studies that support the value of meditation. The application of this work in terms of analytic listening could be to increase attentional ability, openness to associations and the transference, and the ability to better sculpture time and space dwelling in psychic material. Khan's (1977) cryptic description of meditation as a mode of "lying fallow" (p. 397.) supports the concept of openness to listening to other. The inherent openness to

lying fallow is commensurate with the notion of getting out of the way of self and other in order to examine what is occurring while simultaneously and mysteriously using self to access the very material to analyze what is occurring. Thus, this supports the dialectic of being open to receiving what the other is presenting in an amalgam in-between the self-other dyad.

The clinician's optimum preparation for listening was suggested by Freud (1912/1945), in his recommendations to therapists to tend to one's "own psychical perceptions" (p. 101). Freud advised that the best way to do so is in an unfiltered and open way, through both reflection and observation. The process of reflecting took account of the discriminating way of perceiving in which feelings and thoughts are edited and suppressed. The counterpoint to this is observation, in which the clinician dwells in a state of impartiality and listens without censorship. Freud described the cultivation of this state in his recommendations to clinicians:

> It consists simply in not directing one's notice to anything in particular and in maintaining the same "evenly-suspended attention" (as I have called it) in the face of all that one hears. In this way we spare ourselves a strain on our attention which could not in any case be kept up for several hours daily, and we avoid a danger which is inseparable from the exercise of deliberate attention. For as soon as anyone deliberately concentrates his attention to a certain degree, he begins to select from the material before him; one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations.… In making the selection, if he follows his expectations he is in danger of never

> finding anything but what he already knows; and if he follow his inclinations he will certainly falsify what he may perceive. It must not be forgotten that the things one hears are for the most part things whose meaning is only recognized later on….The rule for the doctor may be expressed: "He should withhold all conscious influences from his capacity to attend, and give himself over completely to his unconscious memory." Or, to put it purely in terms of technique: "He should simply listen, and not bother about whether he is keeping anything in mind." (paras. 4–5)

This is similar to a lens in which the focus is on one aspect of what is visualized, and the other parts of the picture are blurred, depending on the focal point. For the therapist, listening involves the creation of a safe landing place and then the openness to listening emerges.

Bion (1967a) supplemented Freud's perspective on listening and extended into the relevance of relinquishing desire and memory to serve an opening to the emotional experience within the analytic session. Bion (1970) claimed that memory, understanding, and desire was deleterious to the process and the analyst. Bion felt that the capacity to lay aside desire, to allow the letting go even of understanding, and enhance the power of observation are essential disciplines for the psychoanalyst. Bion stated that a "vigilant submission to such discipline will by degrees strengthen the analyst's mental powers just in proportion as lapses in this discipline will debilitate them" (pp. 51-52). To sustain this state of mind, Bion recommended suppression, disciplined denial, and suspension. These skills suggest the importance of a therapeutic frame, boundaries, vigilance and a sentinel-like figure at the portal between self and other. The flaw in the Bionian perspective lies in

the fact that there can never be total control and emptying the mind as even the desire to attempt to empty, fills one with more mental activity, and thereby counters the evenly suspended attention that Freud described. Furthermore, it does not account for the ever elusive unconscious and the intersubjective experience. Rubin (1985) offered a case example from a report of a therapist, Brown, who managed feeling drowsy in session as follows:

> an emerging trust in the understandability of what was happening reduced my anxiety and let me go along with it. Thus I stopped interfering with it by fighting it … priority was given to Freud's recommendation to aim at 'evenly-hovering attention'…. At times the aim became to remain capable of attention by attending to what seemed to prevent it. (pp. 481-482)

The foregoing has focused on the external world, and now a shift to the internal world of the listener, which refers to the clinician's state of mind in the process of deepening the listening or tending to other. Meditative processes have been suggested as a way to manage psychoanalytic listening (Rubin, 1985, 2006). Phases of listening may include single-pointed attention, which has the capacity to penetrate into the present moment (Kornfield, 1977). This phase fabricates a container to increase perceptual acuity and attentiveness. Similar to a meditative process, the therapeutic situation offers a capacity to move inwardly, both within the therapist and in the intersubjective space. A slowing process of decreased motility and sensorium contributes to setting the optimal stage for observation and a concentrated effort of attention. This concentrated attention fosters an expansive tranquility, which leads to more acute and deeper listening. The next phase works on calming the inner mental state of the clinician to finely tune the attention and

perception, and this can be accomplished in a number of ways, including as outlined by Rubin (1985) through meditation training.

In the listening process, the clinician enlivens a therapeutic relational field. Fenichel (1939) spoke of the therapeutic relationship and interaction as follows: "The analyst should always create an analytic atmosphere of tolerance… [The analyst] must be aware that even when he says nothing he may be considered as a forgiver or a punisher" (para. 3) Further, Fenichel addressed the passive as compared to active engagement of the therapist as influential on the unconscious of the patient. Activity vs. passivity in itself connotes a rhythm. Fenichel suggested that the therapist can be either too active or too passive, particularly if there is resistance on the part of the patient. He described the caricature of the psychoanalyst falling asleep, or dissociating by not heeding attention. He suggested that this can happen to any therapist who is in a repetitive state of free floating states of mind, and appeared to implicate the patient's resistance, which compels the analyst to be careless. However, from a different perspective than a classical one, perhaps the analyst is resisting, in this case his own primitive mind.

Through a detailed reading of Reik's (1983) work *Listening with the Third Ear*, and Ogden's work, *Reverie and Interpretation: Sensing Something Human*, deep listening is found helpful. The clinician who has access to definitive modalities of listening and being in the moment through reverie provides a catalyst for engaging with other within a frame that is at once definitive and malleable-forgiving. Through an analysis of Reik's constructs, I am able to provide a psychoanalytic framework for considerations of ways of bearing witness to traumatic stories and suffering of other. Reik provided a foundational means of accessing listening patterns through natural sequencing, which

begin with preliminary access to unconscious or intuitive conjectures about the psychodynamics of the patient, and ends with how these dynamics inform the understanding involved in case conceptualizations, and impact on self.

Akhtar (2012) considered psychoanalytic listening through multiple processes. He considered listening through dimensions as objective (evenly suspended receptivity), subjective (an embodied felt sense or inspiration), empathic (seeking to resonate with other) and intersubjective (co-construction of meaning in the interpersonal space between self and other). The work of deep listening represents a confluence of countertransference, intersubjectivity, and the analytic field between self and other. A therapeutic or deep listening could be described as follows: I sit with the patient, and listen on so many levels…. I'm listening to her words and what they say in the present; I listen for she says it and the options she takes with me in the moment. I question in my mind what the content is at this particularly moment, why the selection of these out of a myriad of thought, pictures, and words. I contemplate the meaning, perhaps the inclinations relative to longstanding patterns that evolved in childhood. I simultaneously consider my response to the patient's verbal and nonverbal language, and wonder what parts of me she is hitting, stimulating or repulsing. Are there any parts of me that feel the yearning to avoid, to run away, self protect or get closer to, to emphasize and encourage vs. to dissuade and avoid? Does this have to do with me or the patient or a little of each in the transference? Temporally I wonder the influence of time, time of the session, the amount of time, the seasons or time of day, how was the night before, and what has occurred during the interval between sessions, what is the impact on memory and what is and has been shared. What is the in-between field, is the analytic third space animated

perhaps drawing you in toward digging more deeply in a certain content area? What is omitted, silenced? What is felt somatically and what is sensed affectively and in the connection between? What might that say about attachment and early memories?

These are simply a few items that the clinician may consider in the clinical moment, as the patient presents both conscious and unconscious material, the clinician initially conjectures about the material. The mode of conjecture varies with the nature of the patient, and primitive states. Furthermore, it entails a free associative and digressive process of reverie, which Reik considered essential to psychoanalysis. It is later when the clinician formulates through a more comprehensive and systematic review with the patient, after listening with the third ear. However, Reik warned that mechanistic rigid reductionism would too abruptly and prematurely disrupt the hidden meanings. Thus the systematic thinking or framing the listening was to be applied flexibly and with appropriate timing, a timing that is subjective and psychological rather than objective chronology.

Reik (1983) borrowed the term "third ear" from Nietzsche to signify the musicality in language. The rhythmic nature of language and listening reflected the interaction between self and other, a feeling of the social experience. Listening and the timing of interpretation follow this social sensitivity, which can be accessed through being attuned with listening. Unlike objective time, which is measured in equally divided units, interpretive moments are unequal and have an endless range of possible unfolding intervals. Reik elaborated: "the analyst becomes aware of the rhythm of his patient's instinctual impulses, and this unconscious knowledge will tell him when to make his communications" (1983, p. 328).

Reik (1983) incorporated several modes of listening, an intuitive phase of conjecture in which thoughts are provisional. There is a sense of uncertainty and doubt (pp. 222-223). There is a pursuit of freely open and often contradictory trains of thought, even into the absurd. The therapist, according to Reik,

> does not concern himself first and foremost with the logical proof of his idea, and often pursues contradictory trains of thought. He has an open mind and does not shrink from yielding himself, by way of experiment, to a train of thought that seems senseless and absurd. (p. 223)

Reik considered the use of logic too early indicates that there is a resistance on the part of the therapist to yield to one's own unconscious and its emergent thoughts about the mind of other.

The second is the comprehension phase. This is often the phase where the clinician may prematurely corrupt the spontaneity of the patient and at times do so to subvert the process as a defense against personal anguish. This perhaps hinders the value of the intuitive phase, the clinician's perception of other, and misappropriation of vestiges of the patient's unformulated experience. Reik quickly stated that comprehension phase is similar to that of other sciences, but what makes psychoanalysis unique is the conjecture phase, a phase where there can be surprises rather than obligate perceived control over psyche. It's what makes it interesting. There conjecture phase offers the possibility to self and other that there may be another consideration, and by so doing this phase honors the unconscious and what has remained otherwise silent. It is a phase of curiosity and discovery, one which is suppressed in compassion fatigue. As Arnold (2006) stated, "the therapist lets go of preconceived, systematic ideas, on the other hand, the "emotional

undertones" of the patient's associations "become clearly audible and distinct as if amplified by a microphone" (p. 116) and the patient's unique personality emerges.

The three phases of conjecture that Reik discussed include the following description: "This is a holistic process which is delineated in discrete phases, through the detection of understanding psychodynamic meanings as it occurs through preconscious, unconscious, and conscious engagement with the patient" (1983, p. 471). The clinician listens to and observes both verbal and nonverbal signals, including movements, from the patient, taking into account the silences and what is left vacuous. The patient speaks or silently includes what Reik noted as "speaking gestures" (p. 132). As the clinician allows for space both physically and temporally, the patient's discourse will manifest a uniquely stylistic unfolding of associations through which the underlying emotional rhythm is brought into awareness. The key, as Reik suggested, is that this process is unconscious and yet the clinician can begin to detect the emotional notes underlying the words, gestures, and movements. The clinician taps into the intersubjective analytic field and gains access to clues in the rhythmic nuance of other.

This perspective was reflected in Kaplan's (2014) research on trauma, where her approach was best reflected by a form of psychoanalytic listening that creates space in the field between in order to provide for deeper understanding. She listened during her research for the cues of countertransference, which then offered the opportunity to access nonverbal, subtle and largely unconscious expressions. With her research with survivors of the Holocaust, she found that such a psychic space was overcrowded with phenomena, which pushed and shoved to try to gain consciousness. Therefore, the process of the clinician is to recognize in the countertransference what is uncharacteristic for the self,

and unexpectedly evoked. This process would give a clue that it is from the other. Furthermore, Kaplan recommended a variety of actions to take to manage the deep listening and resulting influences on the clinician, several of which that highlight what transpires between self and other psychodynamically. Examples included limiting the exposure to multiple clients who have been traumatized, managing identification and mirroring of behaviors during clinical encounters, and boundary setting.

Relative to compassion fatigue, analytic listening establishes a preliminary process of detection of response, which is largely processed unconsciously. Observation for clues for unconscious processes involves the realization they have been hitherto unexamined, unclear, hidden, and elusive. The means of access include awareness of and engagement in associations, visioning, memories, dreams, and an embodied intuitive sensibility. The clinician may have a sense for the patient and his or her concerns, but may not identify this as part of an interpretive process and hence this material remains largely unheeded in the unconscious. The psychic material may work to erupt then in the clinician as it pushes forward, engaging and impinging the clinician through affect, mood, dreams, and meaning.

Greatrex (2002) offered yet another perspective that has relevance to deep listening. Greatrex pointed out that projective identification, which reflects a clinical enactment in psychotherapy, occurs "around the difficult nodal points at the deepest levels of our psychic organization that seem resistant to change" (p. 187). As suggested through neurophysiological and infant studies, the access to these "difficult nodal points" mirrors that of the classic mother-infant dyad. As such, the intersubjective experience of therapist and patient mirrors the elemental psychic states, which are instrumental to the

development of psychic organization. Finally, Greatrex offered that the "capacity for self-reflective thought, embedded in feeling and language, offers the potential for consolidating change" (p.190). The clinical work, which is rich with feeling and conversation, is best followed by self-reflection and the intellectual work of interpretation. This momentum for change serves the prevention of compassion fatigue.

The Generative Hermeneutic Turn

The emergence of themes in this inquiry suggest that the work with those suffering includes the probability of working within the context of trauma, developmental physical, emotional, or sexual trauma in childhood as well as acute or chronic traumatic experiences of young, middle, and older adults. As has been seen in this study, this can evoke for the therapist inner stirrings of past history of feelings of abandonment, fear for safety, anxieties, guilt, remorse, fears to terror, and depressive feelings, that can emerge in the countertransference. In addition, through the intersubjective empathic process that occurs when tending to the patient, the clinician "catches," partially or more fully, at times in exquisite detail, what the experience of other might be like. The clinician steps into the shoes of other and for a few moments may experience the other. The therapist learns, in this empathic dance, to keep one foot on the ground while stepping into the world of the patient with the other foot. Lastly, he or she may experience a kind of fusion through the unconscious, much as Jung illustrated, also as noted above, where the "dance" persists, through dreams, intrusive thoughts, sensations, images, and the way the world is perceived in terms of safety, others, intimacy, and relationship.

The emergent themes herein coalesce into a way of viewing the work with the suffering and what the clinician is trying to create in the therapeutic relationship, termed

sanctuary at the edge. The therapist or clinician will likely engage in at least two processes in the field, that of leaning in toward and that of leaning back. Both are required to both provide for an experience for self and other that engages empathy and provides a frame for reverie and interpretation. This is a pulsating movement psychically. Leaning in addresses the tendency when unsure or resisting to pull away. It also represents the antithesis of vicarious trauma of avoidance, numbing of feelings, and isolative behaviors. Leaning in allows the therapist to work more closely with the patient and situates the empathic response in the immediate. Casement (1991) drew from the work of Sterba (1934), who suggested that transference interpretation was best engaged by both the "observing ego" and the "experiencing ego," within "an island of intellectual contemplation" (Casement, 1991, p. 31).

The leaning in process parallels a Buddhist meditative process described by Chodron (1994) as Tonglen, a practice developed in the 1st century by a Buddhist master, Atisha (Glaser, 2001). Chodron stated that Tonglen is a process to use when you experience situations that are "painful or undesirable, to breathe it in" (p. 36). As Glaser (2001) succinctly described the process, Tonglen "combines giving and taking with the breath. The in-breath becomes a vehicle for breathing in the suffering of ourselves and others, and the out-breath for giving away the goodness we cling-to and hoard" (p. 15) Tonglen is an exchange thrown into the darkness (or the unconscious) and returns transformed. This action goes against the natural inclination, which Moore (1992) described as an "opus contra naturam" (p. 18), as it goes against long-held habitual defenses against troubling circumstances. Tonglen can be considered similar to Bly's

(1988) recommendation to move into the shadow and consume it as a transformational process.

Bloom (2000) claimed that it is vital to consider the worry we may have with being around suffering or taking it in, but also recognized the struggles of engaging with such suffering. She discussed at some length the importance of exploring these concerns in light of understanding that "to take on the suffering of others with no sense of martyrdom or resentment is a great affront to one's ego" (p. 20). Bloom's chapter, aptly entitled "Directing the Mind, Defrosting the Heart: Meditations for Developing Compassion," emphasized that clinical practice

> works on the resistant, frozen self and uses it as the repository, the vehicle of contact to receive other peoples' suffering…asks us to exchange ourselves, our suffering, for the suffering of others. And in the act of exchanging, we discover that not only is our suffering lessened but the suffering of others also begins to be dispelled. (2000, p. 159)

As Casey (1998) claimed, this process is as if the "metaphorical lead of impure selfish desire turns into the gold of purified desire" (p. 44). Tonglen is a transformative process that can be practiced in the moment, even in the moment of deep listening with the patient. In this process, the practitioner, rather than holding the breath when hearing of someone's pain, actually breathes in, breathing and taking their pain inwardly, and exhaling the transformation of relaxation and joy. Tonglen is a process of having compassion for ourselves so that we can generate compassion toward others. It also connotes investigating one's inner world to simultaneously discover, with the patient, his or her world of fear, jealousy, addictions, anger, pride, arrogance, and other feelings of

impoverishment. The practice of Tonglen allows for an empathic connection with the other and his or her suffering while also allowing for compassion to enter in the midst of the intersubjective experience.

In the above discussion, the leaning in process was discussed; next, the leaning out psychodynamic processes helpful for the clinical work and prevention of compassion fatigue will be discussed. Leaning out addresses the need to provide a frame for the engagement with other to attach to or resist. The leaning out of the clinician psychically provides a secure base for the experience and situates the psychic exchange. Leaning out allows the therapist to reflect and draw on analysis to draw interpretations in service to both the patient as well as the clinician. Several of the means of leaning out include the provision of an analytic frame, which encourages fundamental aspects of the meeting such as time, interval, space, and expectation for appointment follow through. Further modalities that promote internal frame for the therapist include engaging in personal therapy, a clinical supervisor, and as outlined below, accessing an internal supervisor.

British psychoanalyst, Casement (1991) described the relevance of accessing what he termed an "Internal Supervisor" (p. 24). He claimed that the internal supervisor provides a ready means to remain disposed enough to treat the patient who relates to the clinician as a transferential object. He stated that clinicians need to be both accessible and not overly intrusive with the patient, where intrusiveness was viewed as a defense of falling too far forward into or too far backward from the patient's experience. Casement considered the therapist holding a stance as follows:

> As far as possible, the therapist's presence therefore has to remain transitional or potential presence (like that of a mother who is nonintrusive yet present with her

> playing child). The therapist can then be invoked by the patient as a presence, or can be used by the patient as representing an absence. (Casement, 1991, p. 25)

Casement's transitional potential presence is similar to Winnicott's (1971/2005) potential space. This process calls for the clinician to be just close enough, but to have sufficient space between self and other to be a good enough clinician. Casement described the need for the clinician to have adequate enough distance to function, while remaining close enough psychically to help the other to be used essentially as an alternate ego in service to the patient. Essentially, the clinician is obligated to discover the best positioning in which to be available and intimate psychologically and yet separate simultaneously. Furthermore, he encouraged clinical supervision, and also personal therapy to come to discover within themselves this island of contemplation. The clinician leans away enough so as to maintain presence, through the processes of tracing insight in the moment to moment dynamics of the session. This involves the levels of listening, accessing vicarious somatic felt sense, empathizing and gaining insight into other. Through interpretive moments in the leaning out process, the clinician gains a sense for the intersubjective field, and the permutations of the unconscious that leave a trail beyond the confines of the session.

To review what Casement offered regarding this important aspect of self-monitoring, there is a space of potentiality between self and other, between the observing and experiencing ego, between the materiality of the session and the space for reverie, and also between the indwelling experience and the island of contemplation. This experience of in-between offers a way to have a frame, and boundaries that are not too

rigid and impermeable, and it allows for less defensive maneuvering of leaning back away from empathic processes.

The internal supervisor connotes that the individual also has the capacity to reflect on self and other spontaneously, thereby being able to monitor, encourage, and to be present. The importance of a clinician having an internal supervisor is also relevant to the patient. As Casement (1991) rightfully acknowledged, the patient follows what the therapist does in, "monitoring their moods, noticing their timing, wondering about the unconscious implications of their comments" (p. 33). Money-Kyrle (1956) described the relevance of this awareness of the need of the clinician to "know thyself," and to be familiar with unconscious potentialities in the therapist's understanding.

> Empathy and insight, as distinct from his theoretical knowledge, depend on this kind of partial identification (with early self). Identification can take two forms—introjected and projective. We may therefore expect to find both forms in the analyst's partial identification with his patient. As the patient speaks, the analyst will as it were become introjectively identified with him, and having understood him inside, will reproject him and interpret. But what I think the analyst is most aware of is the projective phase—that is to say, the phase in which the patient is the representative of a former immature or ill part of himself, including his damaged objects, which he can now understand and therefore treat by interpretation, in the external world. (pp. 360-361)

Therefore the clinician would need to maintain the split within himself so that he can fluidly move between the dialectic of experiencing and observing ego, and between thinking and accessing a felt visceral sense, between self and other. Casement (1991)

suggested adhering to Freud's familiar notion of maintaining an "evenly suspended attention" formerly elaborated above, through what he named "unfocused listening" (p. 37). Unfocused listening is a process of being provisional with preconceived thoughts regarding what the patient is relaying. This provides some time and open space such as the "island of intellectual contemplation" to allow for emergent themes, connections, and alternative meanings to arise. The ability to spontaneously reflect and also experience states of reverie can be considered nourishing substrates for the internal supervisor and counters vulnerability to compassion fatigue. Lewis, Amini, and Lannon (2001) added:

> The person of the therapist is the converting catalyst, not his order or credo, not his spatial location in the room, nor his exquisitely chosen words or denominational silences. So long as the roles of a therapeutic system do not hinder limbic transmission—a critical caveat—they remain inconsequential, neocortical distractions. The dispensable trappings of dogma may determine what the therapist thinks he is doing, what he talks about when he talks about therapy, but the agent of change is who he is. (p. 187)

Jung (1937/1958) further emphasized the process and the person of the clinician who

> must decide in every single case whether or not he is willing to stand by a human being … on what may be a daring misadventure. He must have no fixed ideas about what is right, nor must he pretend to know what is right… If something which seems to me an error shows itself to be more effective than a truth, then I must follow up the error, for in it lie power and life which I lose if I hold to what seems to be true. (para. 53)

Kuchuck (2013) considered the unique subjective signature of the therapist in influencing both the clinician-patient fit and the trajectory of the treatment. The therapeutic relationship forms a carrier for the emerging work between self and other, which is considered a valuable and sacred work.

This inquiry has explored the influence of self and other as experienced in the field. Interest in this intersubjective analytic and tangible embodied field between self and other has been noted to provide a complex data set from which to determine its influence on clinician vicarious traumatization and compassion fatigue. The psychoanalytic perspectives of the dynamics of empathy and its constructs of compassion, transference, projective identification, intersubjectivity, and therapeutic presence, have been superimposed hermeneutically through the connections to compassion fatigue. The hermeneutic twists and turns have been the hallmark of the development of the conversation between compassion fatigue and psychodynamic thought. As noted, there are few works that have been devoted to this particular integral approach to the subject of compassion fatigue.

The following chapter will provide a summary and discussion of the emergent themes, as reflected in a hermeneutic turn toward the research guiding questions. In the spirit of Hermes, a return to the identified gaps in the scholarly literature will provide a basis for the implications for further research on psychodynamics of compassion fatigue, methodological considerations, and recommendations for clinical practice and professional education. Further implications of this study will be discussed including study or methodological limitations, and implications for the broad context for the application of the study, will be elaborated.

Chapter 5
Insight into Action: Implications and Recommendations

The person with understanding does not know and judge as one who stands apart and unaffected, but rather, as one united by a specific bond with the other, he thinks with the other and undergoes the situation with him. (Gadamer,1975/1989, p. 288)

The aim of this inquiry has been to engage in a hermeneutic dialogue with the vast horizons of psychodynamic epistemology to inform a depth psychological understanding of clinician compassion fatigue. This concluding chapter provides a very brief summation of select psychodynamic processes and illustrates the extension of the findings to the organizational field. The chapter concludes with recommendations for research including methodological considerations.

The hermeneutic methodological process, through which the inquiry was approached, infused each step along the way: from the emergent lines of inquiry, to the initial questions, through ever-evolving series of thematic eruptions in the hermeneutic spiral, and in these final thoughts on the study's implications. The hermeneutic circle provided a way for me to hold a psychodynamic stance not dissimilar from that of a psychoanalytically informed therapist. Through the process, I was receptive to the unconscious, and to the heuristic emphasis on exploring what transpires between self and other. The self and other could be viewed through multiple dimensions: self as researcher and other as what is researched, self as clinician and other as patient, or self as clinician and other as the organization which provides context. The study provided an extensive array of interpretive data, which enriched support for the psychodynamics of clinician

compassion fatigue. Both the focused textual content and process of the inquiry embodied the psychodynamic stance, which allowed for the distillation of otherwise latent dimensions of the analysis in the textual interpretation. As researcher, I became aware of the importance of providing psychological spaciousness to invite discovery into the investigation that explored self and other in terms of compassion fatigue.

Clinical Import: Self-Other, Empathy, Relationship, Field

The classical through contemporary psychoanalytic and psychodynamic textual interpretation constituted a focus on reflective function, self-other matrix, empathy, transference, therapeutic relationship, and the analytic field. Throughout the inquiry, implications for the therapist's use of self through a quality of reflectivity have been highlighted. The reflective function enables the clinician to monitor internal states and to disengage from the momentum of reenactments. The reflective clinician attends to self and becomes more cognizant of countertransference concerns, which then fosters a sense of ability to be authentic and compassionate in relationship with other. The reflective component also connotes the provision of an internal mental space through which the therapist resources comfort and protects nonlinear associations and reverie.

An array of psychodynamic thought on empathy as a means by which to understand the experiences of the other grounded the inquiry initially. Distancing through special and temporal means and the frame of the interaction tempered the clinician's empathic resonance with the other's experience. Empathic response was considered an aspect of interaction with the other that underlies a spectrum of psychodynamic responses, such as countertransference. Projective identification and in particular reference to the embodied sense of the transference provided a basis for conceptualizing

the clinician's visceral and psychological reactions that occur particularly with the difficult, complex or severely traumatized patients. Furthermore, the clinician's absorption of emotional contagion, especially when compounded by large caseloads of traumatized individuals, was elaborated. An inquiry into primitive states naturally emerged in this process as these states influence self, the clinician, and other, the patient and the organizational system.

Therapeutic relationship was found to be a crucial consideration in addressing the construct of psychodynamics in compassion fatigue. This emphasis was due to relationship being a vehicle for what transpires between self and other, in particular with patients who suffer from trauma, this is often inflicted through a difficult and impairing relationship. Moreover it has been argued that we are relational beings. Therefore, therapeutic relationship has implications for modeling a type of healthy relationship beginning with the direct care with patients, and circulating through the organizational system at large. The inquiry delved into the meaning of therapeutic relationship first through empathy, which culminated in a distinction of therapeutic presence. Therapeutic presence was found to evolve through deep listening, reverie, holding a frame, and interpretation. The cultivation and maintenance of a therapeutic presence was found to inform what transpires between self and other in the therapeutic moment, and to engage the clinician in a way that he or she senses compassion for self and other.

Lastly, the intersubjective, psychic, or analytic field emerged as a dimension for both situating the interpretive inquiry and conceptualizing compassion fatigue. The perspective of a field extends the understanding of experiences between self and other to the broader context. The notion of the field provided a holistic conceptualization of self,

other, and the research, within the contextual environment, including the home base of self and other, the family or system of care, the government, and natural world. An application of findings to the contextual field will be elaborated further.

Applications in the Field: A Systems Illustration

The emergent data from the study on clinical field viewed intersubjectively between self and other, the clinician and patient, can be extended and applied to the health care organization. This process is particularly relevant in examining the influences of systems on the clinician's development of compassion fatigue. The psychodynamics of the organization are particularly well illustrated in systems, which provide care for the severely traumatized or otherwise complex and seriously mentally ill. Systems that care for combat veterans, such as the Department of Veterans Affairs, and community state agencies that care for the chronically mentally ill are two such examples. In such systems, they work with those who are particularly suffering and vulnerable to primitive states. The following illustrates relevant considerations of the psychodynamics engaged in such organizations, which infers preventive measures against compassion fatigue for the system at large.

Organizations characteristically function through a structured chain of command in which leaders are at the top, patients at the bottom, and clinicians are sandwiched in the middle. Stratified power-oriented systems that classically are anxiety driven and may avert responsibility emulate the patients served who are seeking help for suffering. The system, similar to an individual, may seek to avoid self-blame, and avert their responsibility, often to the clinician sandwiched between administration and the patient. In a primitive state, the organization reflects the psychodynamic processes similar to an

individual who is severely traumatized. Several of those processes include primitive reenactments, splitting, avoidance, and aggressive power differentials. Those severely traumatized or otherwise seriously mentally ill tend to unconsciously exert a tremendous amount of pressure on system and therapist to secure a stage for their enactments. When this occurs and the system at large parallels this process, the pressure on the clinicians and clinical team may be overwhelming.

Whereas the system should be a nesting space for the clinician to do the work of tending to those suffering, it becomes instead a battlefield of procedural measures that are set up to attain some control. The organization, though initially established to meet the mission of caring for those in need, becomes embroiled in primitive mind, which then obstructs the clinical practice. Organizations such as this may suffer from a type of vicarious compassion fatigue. Boundaries and functions may be blurred, or aggression or avoidant behavior may ensue in a form an institutional countertransference. Organizations that mismanage these powerful psychodynamics often do so through matching the primitive states of mind by blame, shame, avoidance, and exile, which leads to more institutional and clinician vulnerability to compassion fatigue. Furthermore, the clinician overwhelmed in this type of institution, may also experience compassion fatigue and opt to deflect responsibility onto the administration in order to relieve the intensity of the psychodynamic pressures.

Those who are suffering, such as the severely traumatized, may have a fractured sense of self and emit shards of their experience out into the environment, the system, and most directly into the clinician. Patient enactment inductions, if contained directly by the clinicians rather than either subverted by the institution or relegated to administration

by a beleaguered clinical staff, would engender a corrective influence on the experience for the patient and sustain the clinician and clinical team. The suffering patient seeks to heal the enduring split off fragments in a system that can no longer serve him or her, as it is also functioning from the same mind, and is likely vicariously traumatized as well.

The clinical provider has the most direct information about the patient and would be able, with training and adequate clinical supervision, to work through these split off parts that are roughly thrust into the clinician, the team, and the organization. The clinician's and organization's awareness of countertransference psychodynamics, especially with those in primitive state of mind, can facilitate the rightful responsibility and de-escalate substantive use of countering primitive defenses such as blame. The unprocessed primitive fragments in such primitive states may be enacted aggressively through splitting of staff and extensive staff reviews, and therefore may be essentially left unprocessed. The psychodynamic split of staff can solely lead to the demise of interdisciplinary team, as they struggle for a sense of empowerment in a system that was presumably developed to meet the needs of patients who are suffering. The system thus corrupted by compassion fatigue and vicarious traumatization further derails the mission through vigilant tending to maintain status quo in the power structure of the organization.

Alternatively, those organizations that recognize the dynamics underlying the challenges of serving this kind of high need population would more likely recognize the need for Winnicottian holding place, to contain the fractured transferences and split parts of individuals. The organization that can contain and sustain a type of generative holding place, is better equipped to avert compassion fatigue, similar to the clinician.

The application of the emergent psychodynamic considerations of compassion fatigue to the broader contextual field provides an exemplar of the mutual influence of field on psychodynamics. Organizations that engage in a depth psychological understanding of the influence of compelling dynamic forces at work are afforded a similar understanding to that of the clinician. The institution established on such understanding would align processes to support the mission, as exemplified by the Department of Veteran's Affairs, which focuses on caring for veterans who "have born the burden." The instrumentation of the mission would demonstrate value in understanding the complex psychodynamic forces at work with those suffering, through, for example, training, policy development, research, and administrative support in the field. The disengagement from system-wide primitive enactments, would unencumber intra-agency relationships, and, as suggested in the findings of this study, diminish onset of compassion fatigue.

In summary, the population of patients served requires a safe and psychologically robust place in which to heal from wounds, which in many cases are invisible. Those suffering are often in traumatized, primitive states, which are disturbing to the patient and those around them. Severe projections can ensue whereby those suffering unconsciously thrust disrupted internal states into objects, including the therapist and the collective clinicians or system. The system can then have a collective countertransference and compassion fatigue, where it no longer has a heart for the work. Alternatively, the clinicians and system which understands the psychodynamic processes underlying what occurs in the patient served and the system at large are better positioned to implement procedures, training, policies, and clinical support for all participants.

Recommendations for Further Research

Recommendations for further research emerged throughout the qualitative inquiry, and are outlined as follows. The application of the emergent interpretive data to the psychodynamics of organizations, in particular health care systems that manage the care for complex or severely traumatized, is an area in vital need of further research. This body of research could encompass both qualitative phenomenological and action inquiry studies on empathic response, processes of holding and containment, the use of consistent frame, the particular stress of containing trauma and primitive defense, and the means of alignment of psychodynamic understanding with meeting the mission and vision of the organization. Mixed method approaches would facilitate the development of training tools for both clinical and administrative staff, and to determine types of clinical support best meets the needs of clinicians in direct care. Coordination with interdisciplinary research teams would add another dimension to the research.

Further studies are recommended to apply the theoretical data from this study to an existential phenomenological study of clinician's experience of the psychodynamics of compassion fatigue. Specific emphasis on empathic engagement, vulnerability to emotional contagion, and the influence of the extended field on the clinician would further advance understanding of the psychodynamics. Lastly, an exploratory hermeneutic study on compassion in psychodynamic work would yield better understanding of this vital yet rarely underscored component to the prevention of compassion fatigue and the fostering of clinical practice and caring environments that bring into the work compassion and loving care.

Closing

In this concluding chapter, I glanced backward to gather and refine the rich interpretive material into its relevance for clinical practice, systems, and further research. The above outlined select psychodynamic processes, illustrated of application of emergent data onto the broad organizational field, and recommended further research. This last section of the chapter represents a closing to the process, similar to what might occur in the psychodynamic clinical self-other experience. In this case, the self is myself as researcher, and the other is the rich psychodynamic thought of those who have been given voice through textual interpretation.

In summary, this hermeneutic qualitative interpretive inquiry employed a number of lenses, including psychoanalysis, psychodynamic psychotherapy, and philosophy, to gain perspective on the psychodynamics of compassion fatigue. In the exploration of the deeper recesses of psychoanalytic thought, an opening of new vistas was revealed for reconsideration of clinical work, organization systems, and research. The findings of this interpretive study will serve to support those who work with the severely traumatized, whether in small ways as individuals directly caring, as researchers, or on a global scale when managing the myriad psychodynamic forces in villages and countries. This inquiry, through the permutations of both inner work and outer recommendations for action, has resulted in a deep appreciation of the psychodynamic process utilized in the building of effective and sustainable care by clinicians who are held in caring systems.

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