SELF CARE
— Surviving the dangers of empathy

by ***Maureen Raymond McKay***

Simon Thomas was a great physician of his time. I remember that I met him one day at the house of a rich old consumptive, and whilst talking with his patient about the method of treatment, he told him that one way was to give him the pleasure of my company, and that so by fixing his eyes on the freshness of my face, and his thought on the overflowing liveliness and vigour of my youth, and filling all his senses with my flourishing youthfulness, his condition might be improved. But he forgot to say that at the same time mine might get worse.

Michel De Montaigne

What that renowned essayist Montaigne recognised, 400 years before their discovery by scientists in 1996 is the existences of 'mirror neurons' or 'empathy neurons', neurons that fire in the brain when we watch another person performing an action or undergoing an experience. It now seems we have the biological basis of empathy. In other words we have schema or templates laid down in the neuronal pathways of the brain which we refer to in interactions with other people. When we see someone touched in a painful way our own pain areas are activated. Thus therapists can use their own mirror system to understand a client's problems and to generate empathy, and they can help clients understand that many of their experiences stem from what people have said or done to them in the past.

Dr Giacomo Rizzolatti, a neuroscientist at the University of Parma observed mirror neurons in action in monkeys. These mirror neurons fired when the monkey watched humans or other monkeys bring peanuts to their mouths and when the monkey itself brought peanuts to its mouth. These mirror neurons were later observed in action in humans. In an interview with Sandra Blakeslee of the New York Times published on the 10th January 2006 Dr Rizzolatti stated that "we are exquisitely social creatures, our survival depends on understanding the actions, intentions and emotions of others".

In the same article Blakeslee quotes Dr. Marco Iacoboni a neuroscientist at UCLA "mirror neurons" allow us to grasp the minds of others not through conceptual reasoning but through direct simulation – by *feeling* not by *thinking*" (my italics). He cites the following example 'if you see me choke up, in emotional distress from striking out at home base, mirror neurons in your brain simulate my distress'.

Don't we counsellors deem ourselves to rank highly on the empathy scale? If we did not our clients would find us out very quickly. But what are the dangers of high grade empathy for the health of the counsellor?

Over a hundred years after Montaigne wrote the words cited at the top of this article Melanie Klein 1882-1960 one of the early proponents of Object Relations the British-based development of classic Freudian theory, pre-empted these later scientists with her recognition of the phenomenon of *projective identification (P.I.)* a form of nonverbal communication in which one person picks up feelings or experiences from another. In a counselling relationship the client can project into the counsellor feelings/emotions which are usually out of the conscious awareness of the client. In other words if the client's anxiety is particularly intense s/he rids herself or himself of that part of themselves that feels painful and unmanageable.

The client may effectively force into the therapist feelings which would otherwise eat away at him such as anger, hatred including self-hatred and despair. On the plus side the client may project into the therapist feelings of a powerful saviour. Although as we shall see later this has its inherent dangers for the therapist. A mild and benign form of P.I. enables one to put oneself across to others and empathise with them. When I was doing my initial training in psychotherapy and the concept of P.I. was discussed I remember thinking to myself "what a load of mumbo jumbo". I had previously been trained in the rigours of scientific method and I needed evidence. But it would not be too long before I realised how naive I was. Thankfully I had a supervisor who believed fully in the phenomenon. As already stated evidence was to come through the discovery by scientists of 'mirror neurons' believed to be the neural basis of empathy, the ability to share the emotions of others.

Projective identification has been taken up as a particularly useful concept by many schools of psychotherapy. It can work both ways i.e. it can be negative or positive. Gomez (1998) tells us: that it is when the therapist is pressured to take on the unbearable feelings of the client that the therapist is in trouble. She states that:

> *"It is this kind of situation that normally competent and well-bounded practitioners can find themselves giving way, extending the time, disclosing too much personal information or spending inordinate time between sessions worrying about the client: all signs of malignant regression". P180*

I will put my hands up, I have done all of the above. How did it come about that I became lax about minding my own health? The obvious answer might be that I was overtired and therefore not mindful of my own process. But William Grosch and David C. Olsen authors of the book, *When Helping Starts to Hurt*, tells us that counsellors can too readily forget that they are the wounded healers and this in their view is what may lead to lack of self care and ultimately to burnout.

> *Grosch reminds us of the myth of Asclepius, the son of the god Apollo and the mortal woman Koronis who was wounded before birth. While Koronis was on her funeral pyre, Apollo snatched his son Asclepius from her womb, saved him from the flames, and gave him to the healer Chiron to raise and instruct in the art of healing. The myth describes Asclepius's entry into the world as a miraculous birth in death. Chiron to whom Asclepius was entrusted was half human and half divine, and inflicted with an incurable wound by the poisoned arrows of Hercules. Thus, Chiron , a healer who needed healing himself, passed on to Asclepius the art of healing, the capacity to be at home in the darkness of suffering and there to find seeds of light and recover (p151)*

So the healer heals and at the same time remains wounded. Carl Jung in interpreting the myth of the wounded healer emphasised that only the wounded doctor can heal whether that doctor be physician or priest (Guggenbuhl-Craig, C.A 1971). Cushway (1996:177) supports the concept of the wounded healer. She states 'An important determinant for becoming a therapist may be a conscious or unconscious wish to make good the unresolved difficulties of early childhood'. Guy (1987) also writes about the hidden motives of psychotherapists being a source of stress. The problems arise not from the motive themselves but from their denial.

The important message to be gleaned from this for those of us in the healing and helping professions is that we see ourselves not only as helpers but as persons who need to be helped. The counsellor is not separated from the patient, for the counsellor too is in search of healing. By reminding ourselves of this and accepting and integrating our woundedness we are much less likely to hold onto elaborate grandiose defences (Grosch, 1994:152). I manage a smile as I mull over that last sentence. If you have like me been the object of a hospital consultant's gaze you will most likely, not have seen any evidence of the wounded healer. Grandiosity? Yes in bucketfuls!

To sum up, what Grosch; Cushway; Guy and others are warning us about is the dangers of forgetting that we are the wounded healers and as a consequence stray to its polar opposite-omnipotence. By so doing we are then much less likely to make an early diagnosis of burnout. Pines & Maslack quoted in Dryden (1995:23) defined burnout as "physical and emotional exhaustion, involving the development of negative self-concept, negative job attitude and loss of concern and feeling for clients".

Faber (1990) refers to a study conducted by Wood et al (1995) in which psychotherapists estimated that 26% of their colleagues were suffering from symptoms related to burnout and depression, while 32% of those that responded admitted experiencing burnout and depression to a degree serious enough to interfere with their work. I became cognisant of these very worrying statistics

while reading research undertaken by Susan (O'Dwyer) Keating (1999) as part of her master's degree in counselling psychology at Dublin University Trinity College.

However it is important to bear in mind, as hopefully we do in the case of our clients that the problems are not always located in the individual and there are circumstantial factors at play. For example the culture of an organisation wherein the counsellors work or train may have a detrimental effect on an employee's or trainee's health.

Environmental stressors will vary depending on whether the counsellor is working for an organisation or is self employed. For example Carroll (1996) concluded that counsellors in organisational settings had a number of characteristics different from counsellors who are self-employed. His research was carried out on counsellors who were employed to counsel other employees. He found that all interviewees reported that they considered themselves to have multiple roles within their organisations. They were "consultants, trainers, agents of change, welfare officers" (Carroll 1996 p119). It emerged very strongly that the counsellor often took on the role of mediator between the organisation and the individual client. How simple or difficult this task is will depend to a great extent on the culture of the organisation in which the counsellor works in particular its philosophy of counselling.

Feltrim, Colin (1995) writing on the stresses of counsellors who work in private practice tells us that counsellors who fall into this category can be particularly at risk. He refers us to Guy (1987), who holds that isolation is one of the main sources of stress for private practitioners. The higher the caseload the longer you spend shut away with one person at a time. Also in choosing to work in private practice our incomes are no longer predictable and therefore the temptation is to overstretch ourselves by taking on too many clients and seeing them back-to-back. The minimum period between sessions in my view should be no less than 15 minutes. From a financial perspective this might seem like poor time management but I have learned the hard way that it is a key function of good stress management. Whilst I am in private practice I work alongside other health care practitioners. I do at times have feelings of professional isolation but not so much as I did when for a very short time I worked from home. It is amazing how therapeutic it can be to be able to drop down to the tea room if only for a few minutes between sessions and have a chat about the weather and the other evils of the day!

There seems to be general agreement in the literature that trainees experience the highest levels of stress. Having managed to survive my own training, and now in the happy position of being a supervisor/peer consultant it is not surprising to me that the vast majority of those who complete their initial training do not go on to seek accreditation. There are lots of reasons of course why this occurs but I suspect that many of the students are burned out before they get off the starting blocks. Cushway 1996:29 posits the following:

> "*On the one hand, trainees are expected to become more self aware and to expose their frailties as a step towards greater client sensitivity. On the other hand, they are selected because of their personal as well as academic qualities and they therefore have to live up to this training and display no weakness*"

When the pressure is on with assignments etc. the first thing to slip is supervision and this in my view is because the trainees are not aware of the benefits of supervision to themselves in addition to their clients. Supervision is not therapy but it can be very therapeutic.

I said earlier that projective identification used interchangeably with counsellor counter-transference, has been taken up by many schools of psychotherapy as a useful concept. However in my experience as a supervisor many newly trained counsellors and some not so new to the profession have very little knowledge of how it impinges on them. As a rule of thumb I find that there is a negative correlation between perceived levels of stress and the understanding of the mechanisms of counter-transference or projective identification. However more controlled research is needed to be carried out on this.

So knowing about the dangers of empathy and the other stressors inherent in the role why do we therapists bother doing what we do? Keating (1999:8) quotes Thorne (1989) in Dryden (1995) who doesn't beat about the bush when he says the counsellor who denies that counselling is difficult and demanding is "mendacious and deluded and incompetent". On the other hand he goes on to say that the therapist that claims not to have personally gained from this work is also likely to be "mendacious deluded and incompetent".

So how do we maintain our equilibrium? There are innumerable suggestions and opinions as to what we can do to attenuate our stress levels. I agree with Guy (1987), that good and regular supervision is one of the most helpful ways of ensuring that job satisfaction scores higher than our stress levels. Good supervision apart from being a protection for the client helps us monitor our own overall stress levels and coping resources. It is often when we are most in need of supervision i.e. when we are training, that we avoid it, often due to financial restraints. Unfortunately there is research evidence that one of the most frequently cited sources of stress for trainee psychologists is poor supervision (Cushway, 1996). She goes on to say:

> *"It is possible to say with relative confidence that the coping strategy which is cited by therapists as most effective for them is talking to a partner or friend or a colleague at work… thus the most frequently reported coping methods are active behavioural including talking to loved ones colleagues or friends, or engaging in sporting, social, or leisure activities" (1995:181).*

For me any activity that takes me out of my head and into my body such as dancing and playing a music instrument, are the sine qua non of stress attenuators.

As well as using supervision as a way of monitoring both our stress levels and job satisfaction, in my view counsellors would benefit from a self-evaluation instrument to measure their levels of job satisfaction and stress on an ongoing basis. One such instrument which I came across on my research for this article is the Professional Quality of Life Scale: Compassion Satisfaction and Fatigue (ProQOL) Version 5. The ProQOL is a measure of the negative and positive effects of helping others who experience suffering and trauma. This can be downloaded for personal use subject to some straightforward conditions at (www.proqol.org/ProQol_Test.html)

To sum up, the discovery of "mirror neurons" - the biological basis for empathy - in humans by scientists in the 1990's is an exciting finding for counsellors and psychotherapists in so far as the phenomena of transference and counter-transference are concerned. These neurons, it seems, allow us to grasp the minds of others by *feeling* not by *thinking*. The downside of course is that those who score highly on the empathy scale, such as counsellors or psychotherapists are in danger of emotional depletion which may lead to burnout. Counsellors are not immune to life's tragedies and the stresses of the job may combine with difficult life events to fuel their distress. Trainees experience the highest levels of stress, and age and experience as well as lighter case loads attenuate stress.

Some of the most important strategies cited as being helpful in coping with the stresses of counselling are active behavioural e.g. good and regular supervision, talking to a partner, colleague or good friend or engaging in sporting, social or leisure activities.

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