EMPATHIC RESPOND AND SECONDARY TRAUMA:
THE EXPERIENCES OF COMPASSION FATIGUE, RESILIENCE AND
COMPASSION SATISFACTION AMONG RELATIONAL THERAPISTS
AN ABSTRACT

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Abstract

Relational therapy as a contemporary psychoanalytic therapy, is an in-depth therapy that its practical implications influenced by a paradigm shift. The new relational paradigm puts the therapeutic relationships in the middle of the therapy and emphasizes intersubjectivity, which requires high levels of empathy and intense use of the self from therapists. Further, the new relational paradigm shapes the dynamics of trauma treatment while working with dissociation, enactment, and self-states. The main argument is that relational therapy holds high levels of empathic response position. Therefore, relational therapists are a unique and important population that may hold the answers to the questions about the in-depth mechanism of secondary traumatic stress (STS). Empathic response was found to be a major factor in the STS mechanism for developing compassion fatigue (CF) in the compassion fatigue resilience model (CFRM). The literature suggests that compassion fatigue can be a negative outcome for therapists treating trauma, but they are also resilience and can experience compassion satisfaction (CS) and a sense of meaning. This study investigated the experiences of relational therapists treating trauma that requires empathic attunement. The research questions focus on the relationships between the empathic response and CF, resilience, and CS. The questions also ask about the risk and protective factors of relational therapists to develop STS and how they maintain their well-being. The population of relational therapists can provide a deep understanding about the empathy mechanism, which in the heart of STS mechanism. The literature does not suggest evidence for the factors influencing therapists who hold a relational position. These
psychotherapists who create a safe place for traumatized people to revisit frightening and horrific events, may have figured out how best to contain the secondary stress from clients. Therefore, this study investigated 12 relational therapists from all around the world in the English and Hebrew languages. The research was a qualitative inquiry, using Interpretative Phenomenological Analysis (IPA) method and included two phases. The first phase included 12 semi-structured in-depth interviews with relational therapists from different countries. The interviews explored relational therapist’s experiences and how they maintain their well-being. The second phase included online survey as a member-checking method to validate the interpretations of results from the interviews conducted in the first phase. The results indicate that relational therapists are treating patients who have experienced a wide range of traumas, in most cases, patients who experienced sexual abuse or childhood traumas. The participants acknowledged the concept of complex trauma and the needs of their patients with complex trauma-going through a relational trauma, and the need to heal in relationships. The study suggests that intersubjectivity, use of the self, and authenticity were seen by the therapists as part of their empathic response. The empathic response was found to be a double-edged sword and connected to CF, resilience, and growth. Relational therapists experience compassion fatigue symptoms and retain this empathic response position when treating traumatized clients. The negative effects were reported in addition to the positive effects of both compassion satisfaction, and personal growth. However, despite the compassion fatigue experiences, most participants reported compassion satisfaction is stronger than compassion fatigue
and they expressed their resiliency despite the difficulties of treating trauma. Further, the experience of being an open and an authentic therapist is a dialectical experience, on the one hand, the use of the self, leave therapists vulnerable and exposed but on the other hand it gives them freedom to be themselves and express their subjectivity. Therefore, intersubjectivity and authenticity considered as protective factors. Finally, participants report on the importance of self-care methods and boundaries. This research contributed to understand the well-being of trauma practitioners and service providers by studying the mechanism of empathic response, to improve the therapist's therapeutic abilities by suggesting in-depth understating of the empathic response of therapists and how to be aware to the empathic response in-session, regarding CF, resilience, and CS. This will help supervisors, educators, and trainers to enhance understanding and predicting the presence of and treatment for compassion fatigue, resilience, and compassion satisfaction.
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DEDICATION

To the love of my life, my husband, and my best friend, Pinhas.
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To my husband, Pinhas Toporek, for all his emotional, moral, and financial support in this journey and unconditional love. For sacrificing to make my dream come true and doing this difficult and challenging transition from our home country to US and back, along with our four children. Thank you for being such an involved father while I was working on completing my PhD. For being my best friend and the main supporter who always there when I needed him, I could not have done this without you. I dedicate this study to you.

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Biography
CHAPTER 1: INTRODUCTION

This study focuses on exploring the question: How do relational psychotherapists experience treating traumatized patients? Because it has been demonstrated among service providers and professionals across many social and medical service sections of the trauma field that the use of empathy is a risk factor for experiencing secondary traumatic stress reactions, how do empathy-focused relational psychotherapists do it? These psychotherapists who create a safe place for traumatized people to revisit frightening and horrific events, may have figured out how best to contain the secondary stress from clients. This study focuses on finding out.

The purpose of this study is to explore (a) how relational therapists experience working with traumatized individuals and (b) the identifiable wanted and unwanted consequences of working with traumatized individuals. The knowledge generated from this research may suggest new insights about the empathic response mechanism in treating trauma and may inform trauma therapy practice and education. Participants will include a purposeful sampling of relational therapists who have been treating trauma in a highly empathic approach.

The goal of this chapter is to introduce the main theoretical ideas to address the rational and research questions. Therefore, this chapter starts with an overview of the context and background of this study, including main theories, concepts, and definitions of key terminology. The chapter will also include the statement of the problem and the statement of the purpose, followed by the research questions. Later, the chapter also includes the research approach and the researcher’ assumptions and perspectives. Finally, this chapter addresses the rationale and significance of this study.
Background and Context

This section will introduce the main theories, concepts and terminology that will be used along this study. The main concepts refer to trauma and secondary trauma, the terminology of secondary trauma and the relevant concepts from relational psychoanalysis and trauma treatment (See Appendix G: Glossary)

Psychological Trauma

The source of the word Trauma is in the Greek language, meaning *wound* and originally refers to a physical injury in the medical field. Today, we use the trauma term for psychological trauma as well. There are many definitions to psychological trauma, but it is agreed that it is defined by the experiences of certain event and the cognitive and emotional reactions to this event (Dalenberg et al., 2017). Usually, psychological trauma occurs when the human self-defense system becomes overwhelmed and disorganized following a traumatic event. Traumatic events usually include intense fear, helplessness and loss of control which can result in emotional, cognitive, and biological changes (Dalenberg et al., 2017; Valent, 2012). It is important to distinguish between trauma events and reactions to trauma.

Psychological Reactions to Trauma

Whereas the reactions to trauma vary widely and depend on objective and subjective factors as well as personal, social, and cultural factors. Responses to trauma can be in a spectrum between spontaneous recoveries to post traumatic stress disorder (PTSD) and Complex PTSD (Dalenberg et al., 2017; Gordon & Alpert, 2012). These reactions will be reviewed next.
Spontaneous Recovery. The literature suggests there are different pathways of adaptation after an event with traumatic potential (Bonanno & Mancini, 2012). In fact, most people return to a certain level of normalcy even after potentially traumatic events, which considered as spontaneous recovery. Meaning, most of the survivors of events with traumatic potential will not reach a state of chronic dysfunction. The clear path of recovery has received surprisingly little attention, this pathway in which dysfunctional symptoms occurs for a temporary period, usually several months, but then gradually returns to the pre-event state (Bonanno, 2004; Bonanno & Mancini, 2012).

Posttraumatic Stress Disorder. The current criteria of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), states what makes an event traumatic and explains that during a traumatic event, a person must have experienced or witnessed an event that involved actual or threatened death or serious injury, or a threat to the physical or mental integrity of self or others, and which involved fear, helplessness, or horror. The symptoms of PTSD fall into four categories: Intrusive thoughts; Avoiding reminders; Negative thoughts and feelings; Arousal and reactive symptoms. Overall, PTSD symptoms can cause a significant distress and problems functioning (APA, 2013).

Complex trauma. In addition to PTSD, complex trauma goes beyond post traumatic symptoms and include dissociation and a significant impact on the victim personality and identity (Courtois, 2004; Davis & Frawley, 1994) because of prolonged and repeated psychological traumas and usually refers to an interpersonal traumatic experience (Courtois, 2004; Herman, 1992). Specifically, complex trauma is usually related to childhood trauma and involves three components of symptoms among adults: relational impairment, affect dysregulation, and identity alterations (van Dijke et al.,
These components were found to be very challenging to treat for trauma practitioners and need very close attention (Su & Stone, 2020; van Dijke et al., 2018).

**Trauma Treatment**

Although many people exposed to trauma demonstrate few or no chronic symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to suffer from symptoms and consequences, including substance abuse, mental illness, and health problems. Additionally, trauma can significantly affect how an individual engages in major life areas as well as with treatment (Dalenberg et al., 2017). Therefore, many trauma survivors need help and are being supported by family members, friends, or trauma trained professionals.

Since the 1960s and the awareness to trauma adversity (Figley, 1985), there was an intensive growing body of knowledge about therapeutic approaches and interventions methods for treating trauma. These approaches include clinical interventions to address the symptoms of PTSD and complex trauma, as well as psychosocial education and empowerment models to trauma. In addition, in the last 30 years, there was an emphasis on Trauma-informed care. Trauma-informed care is a model that applied in a wide range of settings and which weaves trauma knowledge and sensitivity into existing models in a way that decreases the negative side-effects of intervention and increases the chances for meaningful interventions (Treatment (US), 2014; Wilson et al., 2013).

Trauma treatment is challenging and therefore, this study will focus on professionals who are practicing and implementing these approaches and interventions. Specifically, this study will focus on psychotherapists who treat trauma victims and the effects of their work on their well-being.
Secondary Trauma

While treating trauma, trauma professionals and care providers are required to be compassionate and empathically attuned to their patients, but that requirement can damage their physical and mental health and overall well-being (Figley, 1995; 2002; Figley & Ludick, 2017; Pearlman & Sakkvitne, 1995). Secondary traumatic stress (STS), Compassion fatigue (CF) and Vicarious Trauma (VT) are concepts that describe this phenomenon (Figley, 1995; 2002; Pearlman & Sakkvitne, 1995). Secondary traumatic stress (STS) is defined as “the natural consequent behavior and emotions resulting from knowing about traumatizing event experiencing by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1993b in: Figley, 1995, p. 7). STS, therefore, is when people are traumatized from experiencing indirectly traumatic event.

Compassion fatigue (CF) is a buildup of secondary traumatic stress over time and has a cumulative effect of exposure to suffering. It is a more common term for secondary traumatic stress, which is nearly identical to PTSD, except it applies to those emotionally affected by the trauma of another (usually a client or family member). This concept refers to the physical and mental exhaustion that usually affect helpers and caregivers over time. (Figley, 1995; 2002). Vicarious trauma (VT) refers more to the accumulative changes in the cognitive schemas and belief systems because of exposure to trauma victim’s experiences. The changes include mainly higher awareness to fragility of life and feelings of helplessness (McCann & Pearlman, 1990; Pearlman, 1995; Pearlman & Sakkvitne, 1995).
The phenomenon of secondary trauma can occur in different contexts, such as family, work, and even the media. For example, secondary trauma among family members (Catherall, 2004; Figley, 2013; Galovski & Lyons, 2004), among health professionals (Figley et al., 2013; Sorenson et al., 2016) and secondary trauma due to the exposure to representations of trauma (Kaplan, 2008). This study focuses on secondary trauma among therapists treating trauma. These three terms (STS; CF; VT) are used interchangeably in this study, but the focus in this study is on the compassion fatigue term, which was developed to the Compassion Fatigue Resilience Model (CFRM). The CFRM includes the risk and protective factors to determine CF and level of resilience among helpers (Figley & Figley, 2017; Ludick & Figley, 2017) and will be addressed in the next section.

**Compassion Fatigue, Resilience and Compassion Satisfaction among Therapists**

One of the most important populations, and therefore more studied, with respect to secondary trauma, is the therapist’s population. Therapists, also named clinicians, psychotherapists, analysts, or counselors, are in risk to develop CF because of their therapeutic work (Bride, 2007; Ivicic & Motta, 2017). A sample of 282 social workers from the US was found to be in risk to develop STS symptoms (Bride, 2007). Furthermore, trauma therapists are even in greater risk to experience CF (Elwood et al., 2011). A study with a sample of 532 self-identified trauma specialists found that they are in risk to develop compassion fatigue or burnout (Craig & Sprang, 2010).

The negative effects of CF can occur on the emotional, cognitive, and physical levels and can damage many dimensions of the well-being. The symptoms can include similar PTSD symptoms such as arousal of the nervous system and sleep disturbances,
the emotional intensity can increase and the cognitive ability can decrease, and overall exhaustion of the mind and body. CF symptoms can also include damage to identity, world-view perceptions, values, and spirituality as well as damage to the ability to provide services, maintain personal and professional relationships, loss of productivity and even leaving the profession (Figley, 1995; 2002; Mathieu, 2012; Mor Barak et al., 2001; Showalter, 2010).

However, the effects of treating trauma can be also positive effects. To address the positive effects, it is important to first present the concepts of resilience and post traumatic growth (PTG) regarding trauma. Resilience is the ability to maintain relatively stable, healthy levels of psychological and physical functioning after being exposed and experiencing traumatic event (Bonanno, 2004; 2005). Furthermore, humans can adapt following a traumatic event and to grow and gain benefits from it. The official concept for growth after a traumatic experience is Post Traumatic Growth (PTG) (Linley & Joseph, 2004; Bonanno, 2004; 2005; Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006).

This ability to adapt and even grow after a disturbing experience can be seen not only among trauma victims but also among professionals who treat the trauma victims. The concepts that address this are vicarious resilience (VR), vicarious post traumatic growth (VPTG) and compassion satisfaction (CS). Vicarious resilience is a concept that helps understand the ways which mental health workers can be positively impacted by treating traumatized populations by being exposed to their patients’ resilience (Hernández et al., 2007; Hernández et al., 2010; Hernandez-Wolfe et al., 2015). Vicarious post traumatic growth is a process of growth following treating traumatized individuals and
(Arnold et al., 2005) and it is like Compassion Satisfaction which is a positive outcome from caring and it refers to the sense of fulfillment a therapist can feel from doing a job well and from helping others, particularly to those who are traumatized (Stamm, 2002). The negative and positive effects of treating trauma depends heavily on risk and protective factors.

**Compassion Fatigue Resilience Model**

This study relies on the compassion fatigue resilience model theoretical model. The CFRM is a comprehensive model because first, it functions as a road map and applies to all service providers of service providers and professionals who work with trauma survivors. Second, it includes risk factors to compassion fatigue and protective factors to elevate resilience (Ludick & Figley, 2017). Further, this model added the term of Compassion Fatigue Resilience (CFR), which is “the spectrum of resources available to the human service worker, varying from low resilience to very high resilience” (Figley & Figley, 2017, p.7). Therefore, this model emphasizes the positive pathways regarding secondary trauma, when higher resilience results in lower compassion fatigue. The idea is to move from the pathology and focus also on the positive transformation and empowerment that trauma therapists (Figley & Figley, 2017; Ludick and Figley, 2017).

**Protective Factors**

The protective factors regarding STS and CF usually refer to resilience, growth, and compassion satisfaction (Hensel et al., 2017; Ludick & Figley, 2017) as well as social support (Hensel et al., 2017; Ludick & Figley, 2017; Stamm, 1999). However, one of the most important factors which incorporates few methods and factors, is self-care,
**Self-Care.** Self-care is an essential factor in CF among therapists because lack of self-care increases level of CF among therapists significantly (Figley, 2002). Professional self-care is an application of strategies and methods by professionals to maintain their own personal, familial, emotional, and spiritual needs while still answering to the needs of their clients (Figley, 2002; Stamm, 1999). The purpose of self-care is to maintain health and balance while practicing and treating trauma (Glennon et al., 2019). Self-care methods should be implemented by professionals on both, the individual and organization levels. At the individual level, methods of self-care involve maintaining positive health behaviors such as a balanced and nutritious diet, sleep well, and sport and exercise. Additional methods such as spiritual, meditation or mindfulness are also individual methods (Glennon et al., 2019; Newell & Nelson-Gardell, 2014).

At the organizational level self-care strategies should include setting proper boundaries and rules regarding workload and client care, actively encouraging the use of breaks, rest and relaxation (Glennon et al., 2019; Maslach, 2003; Newell & Nelson-Gardell, 2014). Social support from professional colleagues can include concrete and emotional support, formally and informally. Thus, supervision and the quality of supervision is a very important factor which need to have priority (Hensel et al., 2017). Further, therapists and especially trauma therapists should include in-sessions self-care methods and not just outside the session’s methods. This include awareness to the dynamics within the clinical work that can affect the clinician (Glennon et al., 2019) and will be discussed more in depth later. In any sense, self-care is a mandatory factor for therapists to prevent compassion fatigue and enhance compassion satisfaction (Abendroth & Figley, 2014; Figley, 2002).
Risk Factors

There are many risk factors to develop secondary traumatic stress (Hensel et al., 2015), important risk factors that addressed in the literature are: 1. Age and experience when younger and less experienced professionals such as students are in higher risk to develop STS (Hensel et al., 2017); 2. Gender, when women are in higher risk to develop STS (Baum & Moyal, 2020; Hensel et al., 2017). 3. Personal previous trauma and traumatic memories are also an important risk factors that increases the risk for CF (Ludick & Figley, 2017); 4. Work environment factors such as caseload, less work support, no supervision etc. are also discussed and significantly can impact the well-being of professionals (Hensel et al, 2017; Stamm, 1999). However, the main factor for developing secondary trauma is empathy (Figley, 1995; Ludick & Figley, 2017).

Empathy. However, the main risk factor- the empathy, is an in-session factor and therefore more complicated factor and need more attention. Empathy is the comprehension of another’s experience from that person’s perspective when the idea is to get a sense of how it feels to be in the other person’s shoes (Kohut, 1981). Therapists usually have high empathic ability, which leads to empathic concern and empathic response. Empathic response is the precise response to help the client effectively and establish a positive, safe, and compassionate relationship with the client. Nevertheless, empathic response is also a central factor in the process of developing compassion fatigue over time (Figley, 1995; Figley & Figley, 2017).

Clinical Dynamics of Empathy. Additional in-session elements in trauma therapy that are pathways in the mechanism of secondary trauma are bearing witness and transference and counter-transference. Bearing witness in therapy is a therapeutic
position of witnessing of helpers and practitioners. This position recognizes and acknowledge the external realities of evil and sufferings of trauma victims (Amir, 2018; Ullman, 2006; van der Hart & Nijenhuis, 1999). Therefore, witnessing inherently involves a state of crisis, when assumptions and categories of the existing world start to crack and when therapists’ identities are threatened because of encountering the otherness of patients (van der Hart & Nijenhuis, 1999; Ullman, 2006).

Transference is an unconscious process of displacement of emotions to the therapist and countertransference is the opposite direction. The classical view has been understood by Freud as the way patients “transfer” feelings from important persons in their early lives, onto the therapist. Countertransference is the therapist’s response to a patient’s transference (Dalenberg, 2000). In the treatment of trauma, transference has unique characteristics in the therapeutic relationship, which include an intense sense of fear, shame, terror, helplessness and even aggression (Herman, 1992). This dynamic can contribute to the process of secondary traumatic stress because of working intensively with the traumatized (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Rothschild, 2006).

Since empathy is a central risk factor to develop CF, this study will examine relational therapists who hold high empathic response levels. Next, the relational psychoanalysis theories and terms will be presented.

Relational Trauma Treatment

Relational therapy represents a “paradigm shift” in psychoanalysis from a one-person drive theory approach to a two-person psychology approach. This approach puts the therapeutic relationship in the middle of the therapeutic action and emphasizes the use
of the self of therapists (Beebe & Lachmann, 2003; Benjamin, 2004; Harris, 2017; Malone, 2018; Mitchell & Aron, 1999). Furthermore, the relational turn in psychoanalysis has influenced understating, studying, and treating trauma (Bohleber, 2010; Boulanger, 2007; Harris, 2018; Gartner, 2017). The idea that talking about a traumatic experience with an empathic listener could help heal the sense of betrayal of trauma was an idea that grew from the relational movement in psychology (Herman, 1992; Robb, 2006).

The main theoretical concepts that are the foundations stone of relational psychoanalysis approach include: two-person psychology and mutuality in therapeutic relationships (Aron, 1996; Mitchell, 1993); intersubjectivity and the idea of the third (Aron, 2006; Benjamin, 2004; Ogden, 1994; Stern, 2004); relational transference – countertransference (Stern, 2004); enactment and dissociation (Davis & Frawely, 1994; Howell & Itzkowitz, 2016). These theoretical concepts will be discussed further under two main factors which influence trauma therapists: the use of the self and trauma treatment dynamics.

**The Use of The Self**

The paradigm shift in the relational approach turned the use of the self of the therapist as the main therapeutic tool. The main concepts that reflect the use of the self are the high empathic response and focus on the therapeutic relationships as well as and the idea of intersubjectivity and the third. This highly empathic position includes deep affective, generous involvement and working in the here and now with the therapist’s own self. Further, the center of the therapy is the relationships between the patient and the therapist (Aron, 2006; Barsness, 2017; Mitchell, 1993). This requires authenticity,
being present, apply deep listening and affective attunement, while paying deep attention to affective states, follow affects as well as recognize and stay with negative emotions, etc. (Barsness, 2017; Barsness & Sorenson, 2017; Benjamin, 2018; Herman, 1992).

The theory behind *Intersubjectivity* argues that all parts of the psyche are created solely in the interpersonal context (Stolorow et al., 1983; Stolorow and Atwood, 1992). Therefore, therapy should be focused on the interpersonal context and created by the mutual interaction in the subjective world created between the therapist and the patient. Therefore, the psychoanalytic techniques in the relational turn moved from a position of anonymity, neutrality and abstinence to position of self-expression, self-disclosure and spontaneous in therapy (Mitchell, 1995; Stolorow and Atwood, 1992; Stolorow, 2013; Stolorow et al., 1983). Further, the fuller concept of intersubjectivity also include the ‘third’ concept (Benjamin, 2004; 2018; Ogden, 1994). The third “entity” is created in therapy, based on the unique interaction between the subjectivity of the therapist and that of the patient. Of course, the third analytic term did not mean that subjectivity or a third actual and concrete entity was created: the third analytic term emphasizes the intensity of the effect of the interplay between the subjectivity of the therapist and that of the patient (Benjamin, 2004; 2018; Ogden, 1994).

*Trauma Treatment Dynamics*

The main dynamic concepts in treating trauma refer to transference and countertransference (Dalenberg, 2004; Stern, 2004) and dissociation, enactment, and self-sates (Davis & Frawley, 1994; Howell & Itzkowitz, 2016). Those concepts are dominant in the theoretical and practical levels and essential to understanding what is going on in relational trauma treatment.
Unlike the classical psychoanalysis views transference and countertransference as not happen in “real” relationship, the relational see all interactions in therapy as transference and countertransference. The countertransference is an intersubjective experience and helps to understand deeper the patient’s internal and interpersonal world (Barsness & Strawn, 2017). Further, relational transference and counter-transference is a feeling emerging from a two-person system, co-constructed process together in the therapeutic relationships. Therefore, Gartner (2017) suggests a new term: *Countertrauma* as the dynamic between patient and therapist. This approach allows accounting for emotions that emerge during trauma therapy and can overwhelming and intense (Gartner, 2017; Itzkowitz, 2017).

Furthermore, working with dissociation, self-sates and enactment can be intense and terrifying. *Dissociation* is in the center of the trauma discourse which emerged in psychoanalysis after the horrors of World War II and the Holocaust and child abuse damages (Bloom, 2013). Originally, Freud, together with Pierre Janet introduced the dissociation model as a psychological defense mechanism of split and separation when the trauma victim is unable to fight or flight and integrate the traumatic experience and therefore uses detachment to protect himself (Freud, 1894). Unlike repression, dissociation is a desperate attempt of an overwhelmed ego to maintain a mental function (Bloom, 2013; Davis & Frawely, 1994).

From a relational point of view, dissociation will always be on the interpersonal relationships level and will appear within a specific transference-countertransference dynamic (Bloom, 2013; Ferenczi, 1949). It does not mean that the connection with a
certain therapist creates the dissociation, but rather allows it (Bromberg, 2006; 2011; Davis & Frawley, 1994; Howell & Itzkowitz, 2016; Itzkowitz, 2017).

Many survivors of sexual abuse trauma adopt dissociative *Self-States* that enable them to function daily and at the same time protect the self that is still thriving for recognition and validation, the price is a split of the personality (Davis & Frawley, 1994; Howell & Itzkowitz, 2016). The dissociated, unprocessed traumatic experience and the effects and emotions behind them, can be manifested in the therapeutic relationship between therapists and patient, in a dissociative process called *Enactment* (Bromberg, 2006; 2011). The dissociate self-states can emerge during a therapy, part of them are the terrified abused child or other victim, reliving the trauma in the inter-personal space that become flooded with extreme emotions of anxiety, horror and anger (Bromberg, 2006; 2011; Howell & Itzkowitz, 2016; Itzkowitz, 2017). In that sense, trauma therapy includes working with dissociation, self-states and enactment can be emotionally intense for relational therapists.

**Secondary trauma, Resilience and Growth among Relational Therapists**

The main argument of this study is that relational therapy inherently holds high levels of empathic response when working with traumatized individuals and therefore puts the therapist in a vulnerable position (Saakvitne, 2017). The high level of empathic response is due to the use of the self, intersubjectivity and high relatedness as well as working with countertransference and dissociation in this relational space. High levels of empathic response may lead to STS or CF over time (Figley, 1995; Figley & Figley, 2017), or from a relational point of view to countertrauma (Gartner, 2017).

Countertrauma is more fluid, intersubjective, two-person system, whereas secondary
trauma implies a one-person model, with trauma residing first in the patient and then in the therapists (Gartner, 2017).

The use of self of relational therapists (Benjamin, 2004; Mitchell, 1995; 2000; Ogden, 1994) reflect the deep involvement and engagement of relational therapists in the trauma treatment. Moreover, the relational position validates the patient’s narrative by understating and working with dissociation, enactment and self-sates (Itzkowitz, 2017; Harris, 2018). Further, working with enactment and self-states can be very intense and terrifying (Itzkowitz, 2017). Meaning, relational therapists acknowledge the truth of traumatic reality and fragility of life, which can promote CF (Itzkowitz, 2017; Pearlman & Saksvitne, 1995). Thus, the relational therapeutic position of intersubjectivity and use of the self, essentially effects relational therapists since it is probably not possible to stay in this intensity of engagement and be emotionally protected at the same time (Gartner, 2017; Harris, 2018; Saakvitne, 2017). Therefore, it is argued that relational therapists are in high risk to develop CF.

At the same time, high levels of empathic response can enhance also positive outcomes (Bartoskova, 2015). From a relational point of view, the positive outcomes are usually demonstrated in the patient and therapist experiences of meaningful therapeutic process that reflect resilience and can lead to compassion satisfaction (Stamm, 2002) or vicarious posttraumatic growth among therapists (Arnold et al., 2005). Meaning, empathy can be a positive factor for relational therapists, by promoting resilience and growth (Gartner, 2017; Gold, 2017).

Therapists with high ability to empathy have more flexible schemas and therefore are more prone to be assimilated by the traumatic experience. However, flexible schemas
enable also to develop a deep process of meaning making. Therefore, highly empathic therapists can find a sense of meaning in their work helping others (Neimeyer, 2005; Park et al., 2017). From a relational point of view, Gartner (2017) suggested the term counterresilience and Gold (2017) expanded and suggested the term countergrowth; both terms assume a two-person psychology model that reflects give and take in the therapeutic dyad (Gartner, 2017; Gold, 2017).

In the relational context, when the therapist engages and participates, they can also experience personal growth from the mutuality and intersubjectivity space in the therapeutic relationship (Gartner, 2017). Further, it can be a mutual affective involvement and can be healing for both the patient and therapist Boulanger (2007) claims that vicarious trauma is inevitable but also that working with vicarious trauma is a necessary therapeutic tool. Vicarious trauma must become a dynamic, intersubjective process where therapists need to work through their own experiences of their patients’ experiences (Boulanger, 2007; 2016).

**Statement of the Problem**

Treating trauma is challenging, when one of the most essential challenges is how to balance the empathic response. Empathic response is an important factor for effective trauma therapy, when high levels of empathic response predict higher therapy effectiveness (Elliott et al., 2018; Wilson & Thomas, 2004). Empathic attunement enables accurate transmission of information in therapy but at the same time, it enables the transmission of traumatic information. Meaning, the more empathic therapists are toward clients with trauma, the more they are prone to identifying with the negative
emotions and feelings of traumatized clients and therefore to be at a high risk of being secondarily traumatized (Figley, 1995; Wilson & Thomas, 2004).

As mentioned, this study relies on the compassion fatigue resilience theoretical model, which can help predict the vulnerability of compassion fatigue, when the empathic response is the key factor in the model (Figley & Figley, 2017; Ludick & Figley, 2017). The model is highly comprehensive, but it does not suggest how empathic response, as a key factor, affects practitioners and how practitioners, knowing it can be harmful, should approach empathic response. It offers detachment as a protective factor (Ludick & Figley, 2017) but it is hard to understand how we can be empathic and detached at the same time.

Abendroth and Figley (2013, 2014) suggest to avoid over-personalization in the therapeutic setting and be empathic. In other words, they suggested empathic discernment—the ability to respond empathically—but in a way that serves the best benefit of the patient and the therapist (Abendroth & Figley, 2013, 2014). The desired balance in the empathic response, also called being an exquisite empathic (Figley and Figley, 2017), occurs when clinicians set clear interpersonal boundaries and when they maintain a close relationship without fusing or confusing patient and clinician stories. However, the theoretical concepts of empathic discernment and exquisite empathic should be studied and addressed practically because they are still blurry and we still do not know much about the empathic response and how therapists can remain empathetic but not be hurt.

The gap in the knowledge is understating how therapists deal with the tension in which empathy is a necessary tool in treatment but can also hurt them and that empathy
can serve as a risk but also as a protective factor for them. The literature does not address this part of the phenomenon of secondary trauma among therapists and mainly offers out of sessions self-care methods but less in-sessions protections methods (Glennon et al., 2019). If the empathic response is the major factor in the process of compassion fatigue, we need to address it. Therefore, the population chosen to participate in this study is relational therapists, given their high empathic response in their therapeutic approach.

The argument is that relational therapy holds high empathic response levels due to two main factors: the use of the self and trauma treatment dynamics. First, the relational approach changed the therapist’ position and turned the use of the self of the therapist as the main therapeutic tool (Harris, 2018). Second, working with dissociation, enactment and self-sates in relational trauma treatment is emotionally intensive (Itzkowitz, 2017). Therefore, relational therapy challenges the suggestions for balanced empathic response or exquisite empathy, as well as the suggestions of detachment and avoiding over personalization in the therapeutic relationships.

It appears that relational therapy, which holds the interpersonal-relational paradigm shift, can open a new understanding of the empathic response in the process of compassion fatigue and secondary traumatic stress but also in the process of growth and compassion satisfaction. High levels of empathic response can be seen as a double edge sword, where on the one hand, the therapist can be overwhelmed, disturbed and traumatized but on the other hand, the therapist can experience meaningful psychological resilience and growth. Investigating this complicated field can help us learn about the desired empathic response and to point out where the healthy empathic response ends and where the toxic empathic response begins and what are the factors that can promote
resilience and growth and reduce distress and pain. The hope of this research is to gain knowledge about how to reduce the cost of caring to trauma victims and to enhance growth and resilience among helpers.

**Purpose of the Study**

The purpose of this study is to explore a sample of relational therapists treating trauma and their experiences to learn how they maintain their well-being giving their high empathic response approach. It is anticipated investigating relational therapists, challenges they face and ways they deal with those challenges, will help understand better the mechanism of empathic response and how therapists should apply their empathic response in adaptive ways. Learning about how relational therapists respond empathically and their experiences, emotions and thoughts can expand the current knowledge about risk and protective factors while treating trauma.

This research goal is to reduce the gap in the knowledge about empathic response by investigating relational therapists who experts in treating trauma with high empathic response. The study will learn from relational therapists’ experiences of negative and positive outcomes of treating trauma and the role of empathic response in those experiences. This will allow to learn about the empathic response factor in the CFRM and how empathy operates in trauma treatment. Specifically, the goal is to learn how therapists should use their empathic response in the healthiest way for their well-being and for the benefit of the treatment.

**Research Questions**

Trauma therapists need to respond empathically to patients for the benefit of the treatment effectiveness, to build good relationships with patients, to be compassionate
and helpful. However, the empathic response is a major factor in the mechanism that triggers compassion fatigue. At the same time, empathy can protect therapists, because without empathy there is no sense of connection, meaning and satisfaction that can protect against compassion fatigue. In other words, the empathic response of therapists is complex and elusive and raises questions about how therapists should respond empathically. It is important to distinguish between a healthy empathic response and a harmful empathic response of therapists and what kind of empathic response protects therapists and what kind of empathic response can harm them.

Therefore, the following questions are addressed:

1. How relational therapists experience working with patients which have gone through a psychological trauma?
2. What is the connection between empathic response and compassion fatigue?
3. What is the relationship between empathic response and resilience?
4. What is the relationship between empathic response and compassion satisfaction?
5. What are the risk and protective factors of compassion fatigue among relational therapists?
6. How do they maintain their well-being while treating trauma?

**Research Approach**

The current study investigated experiences and interpretations of 12 relational therapists from all over the world. Participants are educated and experienced therapists who identify themselves as relational therapists treating patients with traumatic stress reactions, among other complaints. The study was approved by Tulane’s Institutional
Review board (IRB) and the PhD dissertation committee of the author. The research was conducted online. The first phase included online interviews and the second included an online survey. In-depth interviews in the first were the primary method using qualitative research method and are the basis for the overall data in his research. The interpretive phenomenological analysis (IPA) was found to be the most suitable to answer the research questions. This analysis included getting descriptions and interpretations of relational therapists while answering interview questions and open-ended questions from the survey. Interviews were recorded online and transcribed.

The study conducted in two languages: in English with U.S. participants and in Hebrew with participants from Israel. The research approach with regard to the cross-culture aspect include referring the population as one population of therapists and to learn during the research process if the cultural aspects emerge. The research methodology is described in more detail in the third chapter.

**Assumptions and the Researcher**

Based on the researcher professional experience as trauma therapist, it is important to address the assumptions behind the research questions. The personal experience in social work practice informs this study and here it will be clarified here. The main assumption is the relational approach requires high levels of empathic response and therefore higher risk for compassion fatigue but at the same time to increase resilience and compassion satisfaction. The second assumption is therapists with high empathic response are dealing with challenges during treating trauma that affects them but have their ways to cope with these challenges.
The researcher is a therapist has been practicing psychotherapy that include a relational approach for 6 years prior to returning to graduate school. The researcher brings to the inquiry a process of clinical and professional experience and have the understating about the context of the study. Thus, the researcher had a short experience with the relational practice and wanted to explore in depth her questions with well trained and experienced relational therapists. The researcher is aware professional experience has advantages but is can also can bias choices in research design and interpretations of results. The researcher is committed to self-reflection and an ongoing dialogue with faculty advisors.

**Rationale and Significance**

The goal of this research is to develop knowledge that will help understand the role of mechanism of empathic response, the importance of this research is to deepen the knowledge about the risk and protector factors about empathic response in treating trauma and the in-session self-care methods to balance the empathic response. This knowledge has significant practical meanings for treating trauma to protect professionals, and their patients and their personal environment. This knowledge can be used by clinicians, educators, supervisors and by different agencies and organizations who provide service for the traumatized.

One of the most important implications of this study is to provide useful insights about the empathic response for supervisors, trainers, and scholars. Supervisory support and guidance received by students or professionals are important factors to prevent compassion fatigue (Jordan, 2018; Knight, 2013). Trainers and supervisors need to be familiar with the evidence on how therapists should respond empathically to patients in a
way that is effective but not harmful. This research provides knowledge and practical tools for educators of therapists that can help prevent compassion fatigue and to encourage self-care, resilience, and satisfaction.

Although this research focus is the broad mechanism of STS, this research can contribute to the understanding of relational therapy specifically. Studying and naming relational therapists’ experiences will provide validation for therapists to their experiences and tools to reflect what they can do about it and what do institutions can do about it for their stuff (Gartner, 2017). Relational therapists can gain specific knowledge about secondary trauma, resilience and growth from the lens of the relational trauma treatment approach but that can be also spread to other clinicians treating trauma using different methods.

Another goal of this research is to develop knowledge for better treatment for traumatized individuals. The more service providers will be familiar with their experiences; they can reflect on the therapy, provide better treatment and increase their patient’s satisfaction. Moreover, there is an ethical importance to be familiar with outcomes of treating trauma to provide better treatment and professional help without being overcome by the pain (Saakvitne, 2017). Further, when therapists are familiar with positive outcomes of also growing from therapy, they enhance mutuality by showing their patients how they are receiving from the therapy and not just providing help. That can empower and increase patients’ sense of meaning and growth as well (Gold, 2017).

In addition, this research can help reduce therapists leaving their profession and to retain them. Therapists, in this sense, are like wine that gets better over time, with practice—especially relational therapists who are trained in the psychoanalytic approach
for many years. Therefore, helping helpers and caring for their well-being is important to prevent attrition among well-trained therapists (Rothschild, 2006). Furthermore, helping helpers increase the responsibly also for the therapists’ friends and family members. Because therapists can bring their experiences home, the more they become familiar with the outcomes of trauma treatment, the more they will know how to prevent negative influence and promote a positive influence on their personal environment (Rothschild, 2006).

In this chapter the main problem and research questions were presented. The main problem refers to the empathic response trauma therapists apply and the outcome of compassion fatigue. However, empathic response can elevate resilience and compassion satisfaction. The main questions are about the risk and protective factors considering the duality of the empathic response in trauma treatment. These questions will be explored with relational therapists who hold high levels of empathic response. In the next chapter the literature on compassion fatigue, resilience, and compassion satisfaction and about relational therapy and empathic response, will be reviewed lengthily to learn deeply the theoretical and research findings in the background of this study.
CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this study is to explore experiences of relational therapists as a group of therapists in positions of high empathic response. The goal is to learn about the empathic response and the ways compassion fatigue, resilience, and compassion satisfaction affect therapists. Therefore, the goal of this critical literature review is to explore two main fields: first, the mechanism of transmission of trauma and, specifically, the compassion fatigue resilience model, when empathic response is a major factor. The second field includes relational therapy, its core concepts, and theoretical frameworks. Last and most important is the connection between both fields to learn about empathic response effects among relational therapists who treat trauma.

Trauma

The source of the word trauma is in the Greek language, meaning ‘wound’ and originally the term refers to a physical injury in the medical field. The medical term of trauma was adopted to the field of psychology (Dalenberg et al., 2017). The definition of psychological trauma has developed and changed over the years; today there are many definitions and one of them is trauma as “a state of disruption in which one or more life-enhancing processes are irretrievably lost” (Valent, 2012, p. 5). In general, the definitions of psychological trauma based on the experiences of certain events and on the emotional, cognitive, and behavioral psychological reactions to these certain events (Dalenberg et al., 2017).

Trauma Events

Traumatic events range from one single overwhelming event to a more ongoing and repeated events. Traum events are diverse can be acute, chronic, or complex, or can
be non-interpersonal events such as natural disaster or interpersonal trauma such as sexual abuse. Acute trauma usually results by single distressing event. The chronic trauma happens when a person is exposed to multiple, long-term, distressing, traumatic events over an extended period. Complex trauma is chronic trauma but also interpersonal trauma (Dalenberg et al., 2017; Green et al., 2000) and will be addressed more later.

Additional concept refers to trauma in the macro level is the concept of collective trauma. Collective trauma defined as the psychological reactions to traumatic events happened to entire society. This includes the historical traumatic events that happened to specific group but also to the collective memory of this group that define this trauma and the ongoing reconstruction of the trauma to make sense of the trauma (Hirschberger, 2018).

**Trauma Reactions**

In general, psychological trauma occurs when the human self-defense system becomes overwhelmed and disorganized (Dalenberg et al., 2017; Gordon & Alpert, 2012). But when learning about psychological trauma, it is important to distinguish between a traumatic event and a traumatic reaction. Traumatic events usually include intense fear, helplessness and loss of control and can result in emotional; cognitive; and biological changes. Reactions to traumatic events vary widely and depend on objective and subjective factors as well as on personal, social, cultural, and political factors. Therefore, responses to trauma can be in a spectrum between spontaneous recovery, delayed responses, and to chronic dysfunction such as: post-traumatic stress disorder (PTSD) and complex traumatic disorder (Bonanno & Mancini, 2012; Dalenberg et al., 2017; Gordon & Alpert, 2012; Weinberg & Gil, 2016; Yehuda et al., 1998).
Spontaneous Recovery

In recent years, the heterogeneity of the human stress response has become increasingly apparent. The literature suggests there are multiple and unique pathways of adaptation after an event with traumatic potential (Bonanno & Mancini, 2012). In fact, most people return to a certain level of normalcy even after potentially traumatic events, which considered as spontaneous recovery. The clear path of recovery has received surprisingly little attention in research and therefore Bonanno (2004) suggested a pathway in which normal functioning gives way to symptoms for a temporary period, usually several months, but then gradually returns to the pre-event state (Bonanno, 2004; Bonanno & Mancini, 2012).

Bonanno & Mancini (2012) described that based on the professional literature, most of the survivors of events with traumatic potential will not reach a state of chronic dysfunction. The focus on the pathological aspects of trauma has led to the fact that only in recent years research on resilience has been developed. The literature suggests that people's resilience is not unusual or expresses pathology but rather the opposite - trauma resilience is the most common response to events with traumatic potential (Bonanno, 2004; 2005; Bonanno & Mancini, 2012; Linley & Joseph, 2004). The concept of resilience will be discussed broadly later but the states of chronic dysfunction will be addressed next.

Posttraumatic Stress Disorder

The current criteria of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies what makes an event traumatic. Moreover, DSM-5 explains that during a traumatic event, a person must have experienced or witnessed an event that
involved actual or threatened death or serious injury. Or the person has experienced a threat to the physical or mental integrity of self or others which involved fear, helplessness, or horror. Symptoms of PTSD fall into four categories: (1) Intrusive thoughts, (2) avoiding reminders, (3) negative thoughts and feelings, and (4) arousal and reactive symptoms. Overall, PTSD symptoms can cause a significant distress and problems functioning (APA, 2013).

However, there are diverse critiques about the current DSM. The main critiques usually refer that the DSM definition reduces and simplifies trauma (Burstow, 2005; Thompson & Walsh, 2010); ignore some of the subjective elements of trauma, the interpretations, and experiences of trauma (Hoge et al., 2016; Thompson & Walsh, 2010); medicalize trauma, and even pathologizes functional and valuable coping strategies used by trauma victims (Burstow, 2005). Further, the emphasize on PTSD created a split between pathology versus non-pathology reaction to trauma, which led to ignoring the broad spectrum of adjustments and reactions to trauma (Bonanno & Mancini, 2012).

**Complex Posttraumatic Stress Disorder**

Several events of acute trauma as well as untreated acute trauma may progress into chronic trauma. Usually, the prolonged and repeated psychological traumas are beyond post traumatic symptoms and include dissociation and a significant impact on the victim personality and identity (Courtois, 2004; Dalenberg et al., 2017; Davis & Frawley, 1994). The more complicated reaction to trauma defined as complex posttraumatic stress disorder (CPTSD) trauma coined by Herman (1992) and usually refers to an interpersonal traumatic experience and include complex reactions as well (Courtois, 2004; Herman, 1992).
The complex trauma syndrome usually connected to the concept of *cumulative trauma* which is the tendency for children or adults to have experienced multiple, different forms interpersonal traumas (Briere et al., 2008). Specifically, complex trauma is usually related to childhood trauma and involves three components of symptoms among adults: relational impairment, affect dysregulation, and identity alterations (van Dijke et al., 2018). Adults who have had childhood abuse and need treatment are considered a challenge for treatment to trauma practitioners. The challenges include the complicated diagnosis process of their medical and psychiatric adversity; the gentle therapeutic relationship; and the different interventions that are less accessible (Su & Stone, 2020).

The challenges of working with humans who have had trauma are not only for practitioners who work with complex trauma victims but with all traumatized groups and individuals. Humans who have had trauma, whether they suffer from posttraumatic stress disorder or complex trauma, struggle with disturbing symptoms and functions problems. These difficulties can also be transmitted to the environment. The phenomenon and mechanism of transmission of trauma and the challenges for practitioners working with trauma victims is addressed next.

**Secondary Trauma**

Secondary trauma is a broad concept that reflects the idea of the transmission of trauma from exposure to trauma materials (Figley, 1995; Motta, 2008). Secondary trauma can come in different forms, sometimes it is obvious but other times the change is invisible. For many years, individuals, researchers, and practitioners did not pay attention to those in the second line of trauma. Only in the 1990s did researchers start to examine
and find evidence showing helping practitioners and service providers in the trauma field resulted in fewer stress symptoms that are more complex than regular burnout (Figley, 1995). Figley (1988), introduced the field of traumatic stress among professionals and service providers in 1988 as a new field of study and initiated a rich area of research on secondary trauma (Figley, 1988). From this point and for the past 30 years there has been extensive research done on secondary trauma among helpers (Mathieu, 2012; Newell et al., 2016). The official acknowledgment for secondary trauma can be seen in the last revision to the posttraumatic stress disorder (PTSD) diagnostic criteria in the DSM-5, which clarifies that secondary exposure can also lead to the development of stressful symptoms that requires treatment (APA, 2013). Further, this rich area of research led to diverse terminology (Newell et al., 2016).

**Secondary Traumatic Stress, Compassion Fatigue, and Vicarious Trauma**

The terminology of secondary trauma includes using interchangeably the terms of secondary traumatic stress, compassion fatigue and vicarious trauma, but still there are differences and nuances in the different terms (Branson, 2019; Newell et al., 2016).

**Secondary Traumatic Stress.** Secondary traumatic stress (STS) defined by Figley as “the natural consequent behavior and emotions resulting from knowing about traumatizing event experiencing by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1993 as cited in Figley, 1995, p. 7). STS, therefore, is when people are traumatized from experiencing indirectly traumatic event, because stressful event are not isolated from the person who lives in them (Figley, 1995; 2002). Meaning, part of the context of traumatic events is STS when caregivers of trauma victims can experience self-changing because of caregiving (Stamm,
Symptoms of STS are sometimes similar to symptoms of PTSD, such as arousal, avoidance, negative thoughts and feelings, dysfunction and overall clinical distress. However, there can be a wide range of responses of stress such as: drug abuse, high vulnerability, lack of confidence, emotional numbness, fatigue, and psychosomatic diseases, etc. (Bride, 2012; Figley, 1995; Galovski & Lyons, 2004).

**Compassion Fatigue.** The *Compassion fatigue* (CF) concept was first used by Joinson (1992) in an article in a nursing magazine to describe a common reality for busy nurses. Figley (1995) applied the term to individuals that suffer as a result of helping others, or, in other words, the cost for caring. This concept refers to the physical and mental exhaustion that usually affect helper and service providers over time and can include wide range of signs and symptoms (Figley, 1995; Mathieu, 2012), such as:

- Psychological problems and symptoms (e.g., emotional exhaustion; negative self-image; depression; reduced ability to feel sympathy and empathy; depersonalization; disruption of world view/heightened anxiety or irrational fears; hypervigilance; intrusive imagery; hypersensitivity to emotionally charged stimuli; insensitivity to emotional material; loss of hope; difficulty separating personal and professional lives; failure to nurture and develop non-work-related aspects of life);
- Physical problems and symptoms (e.g., physical exhaustion; insomnia or hypersomnia; headaches and migraines; increased susceptibility to illness; somatization and hypochondria)
- Behavioral and professional problems and symptoms (e.g., increased use of alcohol and drugs and other addictions; absenteeism; anger and irritability;
exaggerated sense of responsibility; avoidance of clients; impaired ability to make decisions; forgetfulness; problems in personal relationships; attrition; compromised care for clients (Mathieu, 2012).

**Vicarious Trauma.** Another concept describing secondary trauma is *Vicarious trauma* (VT). Vicarious trauma refers more to the accumulative changes in the cognitive schemas and belief systems because of exposure to trauma victim’s experiences. The changes include mainly higher awareness to fragility of life and feelings of helplessness. Those changes happen as a result from the clinician’s engagement in an empathic relationship with clients (McCann & Pearlman, 1990; Pearlman, 1995; Pearlman & Sakkvitne, 1995). VT symptomology is diverse and can appear in a clinician’s professional and/or personal life, and falls into four categories: intrusive imagery, arousal, avoidance behaviors, and negative changes to cognitions (Branson, 2019).

**Burnout.** Additional term that used as relative to compassion fatigue is burnout. *Burnout* defined as a psychological syndrome that occurs because of prolonged reactions to ongoing stressor in the work environment. Three main dimensions are an overwhelming exhaustion, feelings of cynicism and detachment from the work, and a sense of ineffectiveness and lack of accomplishment (Maslach, 2003; Maslach & Leiter, 2016). CF exists when symptoms of burnout and STS occur together and negatively affect a provider’s work (Craig & Sprang, 2010; Newell & Nelson-Gardell, 2014). Further, STS and job burnout tend to overlap, however, STS is not the same as job burnout, and each seems to have a unique effect on well-being (Boscarino et al, 2010). Next the compassion fatigue resilience model will be addressed and will describe the different factors related to secondary trauma.
Secondary Trauma among Different Populations

During the years, many studies investigated the transmission of trauma among diverse populations. Secondary trauma and the family system have been studied intensively (Catherall, 2014; Figley, 2013) in different contexts, such as: Secondary trauma among veterans’ family members. This review suggests that PTSD is mediating the impact of veterans' distress on the family and that especially the symptoms of avoidance and arousal are predictive of family distress and secondary trauma (Galovski & Lyons, 2004). Also, among second generation of Holocaust survivors, the intergenerational transmission of trauma was investigated (Danieli, 1985). Further, the population of wives of ex-prisoners of war was studied intensively and found secondary traumatization and low marital satisfaction. The studies found that the wives’ distress or ST was more related to the husband PTSD and less related to their captivity (Dekel & Solomon, 2006). Children of traumatized individuals were also investigated and found to be in risk for secondary trauma such as children of ex-prisoners of war (Zerach, 2015) and children of Vietnam veterans (Rosenheck, & Nathan, 1985).

Caregiving and Secondary Trauma

A main mechanism in the process of the transmission of trauma and secondary trauma is the caregiving mechanism (Dekel & Monson, 2010). Studies show that military veterans’ caregivers are in high risk for secondary trauma because of the exposure to trauma and the cost of caring (Bride & Figley, 2009; Dekel & Monson, 2010). The caregiver burden has been studied among spouses of the traumatized and indicate that spouses who perceived greater sense of caregiver burden, experienced greater emotional
distress and that caregiving is a mechanism which can explain their secondary traumatic stress (Calhoun et al., 2002; Dekel & Monson, 2010).

The cost of caring is reflected also in many different studies on secondary traumatic stress of various caregivers and service providers such as: healthcare providers (Sorenson et al., 2016); nurses (Beck, 2011); physicians (Nimmo & Huggard, 2013); animal care providers (Rohlf, 2018); attorneys and their administrative staff (Levin et al., 2011) and also very recently, health care workers during the COVID-19 pandemic (Blanco-Donoso et al., 2021; Orrù et al., 2021). The focus of this dissertation is on secondary trauma among service providers and specifically psychotherapists who treat trauma.

**Compassion Fatigue Among Therapists**

One of the most studied populations regarding secondary trauma is the therapists’ population, also named clinicians, psychotherapists, analysts, or counselors. Perhaps the most recently used term about therapists’ distress and psychological impact, is compassion fatigue but also secondary traumatic stress and vicarious trauma (Newell et al., 2016). Therapists were found to be in risk to develop CF because of their therapeutic work (Bride, 2007; Ivicic & Motta, 2017). Furthermore, trauma therapists were found to be even in greater risk to develop CF (Elwood et al., 2011).

The studies in this field present research about therapists from different disciplines or therapists that use different therapeutic methods. For example: a study about social worker found that social workers experience at least some symptoms of secondary trauma if not the full PTSD (Bride, 2007); psychologists were also found to be in risk to develop STS as a result of their therapeutic work (Pellegrini et al., 2022); and even telephone and
online counsellors were found to be at risk to experience vicarious trauma (Taylor & Furlonger, 2011). In general, a review study from Ivicic and Motta (2017) found overall results indicated relatively high levels of secondary trauma among mental health workers, such psychologists, social workers, and creative arts therapists (Ivicic & Motta, 2017).

Moreover, clinicians who treat different populations were investigated. A review study shows that clinicians working in the alcohol and drug field are in risk to develop secondary traumatic stress and compassion fatigue (Huggard et al., 2017). A recent review (Molnar et al., 2020) of studies investigated welfare and child protection professionals found that the traumatic exposure is inevitable (Molnar et al., 2020). Therapists who work with sexual assault victims were also found to be in greater risk for CF (Baird & Jenkins, 2003) as well as male therapists who work with sex offenders (Baum & Moyal, 2020). Overall, secondary traumatic stress has been studied extensively among therapists who work specifically with trauma survivors and provided trauma treatment. These therapists are even in greater risk to experience STS (Elwood et al., 2011). Since therapists from different disciplines, who treat different populations and specifically trauma therapists, are in risk to develop CF, it is important to examine the risk and protective factors.

**Risk and Protective Factors**

In a meta-analysis of 38 studies, Hensel et al. (2015), identified 17 risk factors for STS among professionals who do therapeutic work with trauma victims. There are many risk factors for developing compassion fatigue and secondary traumatic stress, but the main risk factors are exposure to trauma materials (Figley, 1995; Ludick and Figley, 2017). Additional risk factors include: Age and experience- when younger and less
experienced professionals are in higher risk to develop STS (Hensel et al., 2017); Gender- when women are in higher risk to develop STS (Baum & Moyal, 2020; Hensel et al., 2017); and personal previous trauma which is also an important risk factor that increases the risk for CF (Ludick & Figley, 2017). In addition to these factors there are many work environment and organizational factors such as caseload, work support, supervision etc. that are also discussed in the literature (Hensel et al, 2017).

The protective factors usually refer to resilience, growth, and compassion satisfaction (Hensel et al., 2017; Ludick & Figley, 2017) as well as to social support (Hensel et al., 2017; Ludick & Figley, 2017). Additional protective factors refer to detachment (Figley & Figley, 2017; Ludick & Figley, 2017) or balanced/exquisite empathy (Figley & Figley, 2017). Organizational factors such as supportive work environments and good supervision were noted to protect from STS (Boscarino et al., 2004). One of the most important protective factors is self-care and will be addressed next.

**Self-Care**

The most important part of this area of study is the implications for practice part. Figley (2002), in his book, *Treating Compassion Fatigue*, called for assessing, preventing, and treating compassion fatigue among trauma when asking who is more vulnerable and under what conditions as well as how can we help them. The author emphasized helping others effectively begins with helping therapists themselves (Figley, 2002). Stamm (1999), in his book, *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*, discussed how to assess and prevent STS, and
the importance to address it holistically at all levels, such as personal and professional levels, work-related factors, and social support issues (Stamm, 1999).

Self-care is an essential factor in CF among therapists because lack of self-care increases level of CF among therapists significantly (Figley, 2002) and promoting self-care enhance resilience (Figley & Figley, 2017). Professional self-care is an application of strategies and methods to maintain one’s own personal, familial, emotional, and spiritual needs while still answering to the needs of their clients (Figley, 2002; Stamm, 1999). The purpose of self-care is to maintain health and balance while practicing and treating trauma (Glennon et al., 2019) to protect the practitioner and to be a more effective practitioner (Figley, 2002).

It is crucial therapists maintain empathy and compassion and continue to be invested in therapeutic relationships but at the same time, take care of themselves (Figley, 2002). In other words, self-care is an essential factor in secondary trauma among therapists. Sometimes the reason of neglecting the well-being of therapists is lack of time and availability because of an objective burden and sometimes is due to emotional exhaustion (Abendroth & Figley, 2014). In any sense, self-care is a mandatory factor for therapists to prevent compassion fatigue and enhance compassion satisfaction (Abendroth & Figley, 2014; Figley, 2002).

**Self-Care Methods.** Self-care methods should be implemented by professionals on both, the individual and organization levels. At the individual level, methods of self-care involve maintaining positive health behaviors such as a balanced and nutritious diet, sleep well, and sport and exercise. Additional methods such as spiritual, meditation or mindfulness as well as recreational activities and self-expression methods are also
individual methods (Glennon et al., 2019; Newell & Nelson-Gardell, 2014). Essential part of self-care includes supervision and training according to the clinician’s needs (Glennon et al., 2019; Newell & Nelson-Gardell, 2014), while individual psychotherapy in times of need is also a recommended individual method (Newell & Nelson-Gardell, 2014).

At the organizational level, organizations that provide services to trauma victims have the responsibility to raise awareness and educate their staff about the signs and symptoms of compassion fatigue and burnout. It should be communicated, either in staff meetings or in individual supervisions, to monitor signs and symptoms of CF and burnout and apply self-care methods. In addition, the organization can provide materials and written information about CF and self-care methods (Sansbury et al., 2015).

Self-care strategies that organizations should promote include: setting proper boundaries and rules regarding workload, working hours and client care. Also, actively encouraging the use of breaks, rest and relaxation (Glennon et al., 2019; Maslach, 2003; Newell & Nelson-Gardell, 2014). Social support from professional colleagues can include concrete support but also emotionally support. However, supervision is the most important and necessary support as well as the quality of supervision (Hensel et al., 2017). Further, organizations have a responsibility to provide opportunities for the professional growth of their therapists. Professional growth can include special training and education and feel empowered and knowledgeable treating their patients (Sansbury et al., 2015).

However, this study focuses on the dynamics of empathy in relational trauma treatment. So, it is important to address the self-care within the therapy. Glennon et al.,
argue similarly to this study, that there is a gap in the literature regarding in-sessions self-care. Trauma therapists should include also in-sessions self-care methods and not just outside the session’s methods. They suggest a model of self-care practices for clinical use with trauma work. The model includes real-time self-care skills for clinicians in session: dual awareness, countertransference/transference awareness and processing, conscious use of self, and containment (Glennon et al., 2019).

The dual awareness is the awareness of therapist to the patients’ emotional needs and his own emotional responses and needs at the same time. This is an essential skill that needs to be developed to balance two people’s emotions. Likewise, is the countertransference/transference awareness and processing. This requires from therapists to be aware of transference and counter-transference issues and being aware of their triggers during the session. Further, the dual awareness can detect the presence of countertransference and transference. In addition, the conscious use of the self, which is essential in this study, refers to integrating their personal selves with their professional selves. And last is the containment, which is not jumping in and offering solutions, but rather help the patients to maintain the pace of goal setting, disclosures, and healing (Glennon et al., 2019).

**The Mechanism of Empathy**

The focus of this study is the mechanism of the transmission of trauma and the risk pathways to the main risk factor- the empathy. Therefore, I will review the following factors that related to the work of psychotherapists: (1) bearing witness, (2) empathy, and (3) transference and countertransference.
**Bearing Witness.** One of the first risks factor to develop secondary trauma is the exposure to trauma. Bearing witness is exposure to trauma even in a deeper level. Bearing witness is revealing extreme traumatic situations, it informs, declares, testifies, and vouches for an important truth about the trauma (Valent, 2012), and therefore it has an important therapeutic function. The literature on bearing witness to trauma is a theoretical/philosophical framework that refers to witnessing trauma through cultural images and representations, as a moral social function (Felman and Laub, 1995; Tait, 2011) but also bearing witness of helpers and practitioners and the importance of it, as a therapeutic position (Amir, 2018; Ullman, 2006; van der Hart & Nijenhuis, 1999).

Felman and Laub (1995) emphasize the importance of witnessing and testimony, based on the horror of the Holocaust, as a traumatic event which produce no witness. Different scholars such as: Felman and Laub (1995), Herman (1992), and Coady (1994), recognized the psychological aspects of testimony action and witnessing as a meaningful, transformative experience, centered on the recognition, self-establishment, and validation of the subject's reality. By witnessing, the narrative can be told, transmitted and heard, and most important, taking responsibility.

Although trauma victims are the primary persons to bear witness to the trauma, therapists bear witness in a secondary manner, by listen to the trauma narratives and treating traumatized victims. Further, testimony in therapy is an intersubjective action, involving both the patient and the therapist. The patient is a witness to give his testimony and the therapist is a witness to the story of the testimony. Both forms of testimony have great therapeutic value, and both serve the patient (Amir, 2018; Herman, 1992; van der Hart & Nijenhuis, 1999).
Therapists bear witness in different forms, stages, and time points during the therapy such as: In the acute stage of trauma to the immediate psychic wounds, or in a later stage when they bear witness to suppressed wounds, reliving memories, symbolic dreams, fantasies, among others (Valent, 2012). Valent (2012) suggested the therapist’s mind includes two worlds. One world witnesses, identifies, and exercises compassion for the victim’s pain. The second world translates emotions to words and helps build the narrative of traumatic stories to help the victim adapt and make the trauma bearable. From that sense, coordinating these two worlds can be very challenging for therapists.

Meaning, bearing witness is a moral stance that requires from therapists to acknowledge and validate the trauma, be compassionate and adopt a position of solidarity with traumatized victims (Herman, 1992). Therefore, witnessing is an essential part in trauma treatment. Although sometimes witnessing can involve frustration, denial and dissociation response, witnessing includes a struggle against destructive compulsive repetition and against dehumanization. Conversely, being willing to know enables us to exhibit more humanity (Ullman, 2006). Moreover, in trauma treatment, the process of bearing witness in therapy evolves by exposing the missing narrative as well by the act of speech. According to Ullman (2006), the story should be heard and recognized by the other- the therapists and after can be recognized by the trauma. Additionally, bearing witness occurs within the therapeutic relationships and inherently include empathic response. This will be discussed next.

**Empathy and the Therapeutic Relationship.** There are disagreements about definitions of empathy, but most scholars agree it is the foremost tool of all therapists. Empathy is a major factor in therapy because it enables compassion by giving insight to
others’ inner worlds (Rothschild, 2006). According Auchincloss and Samberg (2012) the main ability of empathy is to understand other people, which include a deep cognitive and emotional process of sensing the experience of another. Therefore, empathy is central factor in all relationships and especially therapeutic relationships.

The importance of empathy in relationships, including in the therapeutic relationship was developed by Kohut (1981). Kohut (1981), founded the movement of self-psychology and took a turn from the classical psychoanalysis by suggesting that empathy and verbal reflection can help patients even more than interpretation. He viewed empathy as the comprehension of another’s experience from that person’s perspective when the idea is to get a sense of how it feels to be in the other person’s shoes. Kohut referred to empathy as a vicarious introspection and a therapeutic action in the broadest sense of the word.

Especially when working with traumatized patients, the quality and nature of therapeutic relationship was found to be a substantive factor (Herman, 1992) whereas one of the vital tasks while developing a therapeutic relationship is empathy (Meichenbaum, 2013). Therefore, empathy is a fundamental part of trauma therapy. Herman (1992) emphasized the healing relationship in trauma treatment and claimed the therapist role is both intellectual and relational and suggest that the therapist should enable the patient to gain insights but also to enable empathic relationships. Furthermore, the quality of therapeutic relationship makes a significant contribution to the outcome and effectiveness of therapy with traumatized individuals (Murphy & Joseph, 2013).

One of the main characteristics of therapists is having empathic ability, which lead to empathic response and empathic attunement in therapy. The empathic stance of
service providers was divided by Ludic and Figley (2017) into four subfactors: (1) exposure to suffering, (2) empathic concern, (3) empathic ability, and (4) empathic response, when the empathic response is the key factor in the therapeutic outcomes. Empathic attunement is an important factor for effective trauma therapy, when high levels of empathy predict higher therapy effectiveness (Elliott et al., 2018; Wilson & Thomas, 2004).

A recent meta-analysis supports the importance of empathy and suggests that empathy is a moderately strong predictor of therapy outcome (Elliott et al., 2018). However, in the treatment of trauma, empathy considered to be a risk factor and primary mechanism of the transmission of trauma, by which STS occurs (Figley, 1995; Laverdiere et al., 2019; Wilson & Thomas, 2004). A narrative review study about predictors of CF supports that empathy is a central risk factor for developing CF (Turgoose & Maddox, 2017). The components of empathy include affective sharing, self-awareness, mental flexibility and perspective taking and emotion regulation. When affective sharing and perspective taking are considered as enhancing more vulnerability regarding secondary traumatic stress. (Figley, 1995; Wilson & Thomas, 2004).

Empathic attunement enables accurate transmission of an information in therapy (Elliott et al., 2018; Wilson & Thomas, 2004) but at the same time it enables the transmission of traumatic information. Meaning, the more empathic therapists are toward trauma victims, the more they are prone to identify with the negative emotions and feelings of the trauma victims and therefore to be in higher risk to be secondarily traumatized (Figley, 1995; Turgoose & Maddox, 2017; Wilson & Thomas, 2004).
Addiontaly, empathic identification leads to empathic strain along with repeated exposure to traumatized patients, which can lead to STS reaction (Wilson & Thomas, 2004).

Therefore, therapists who treat trauma are held between two forces, on the one hand they adopt empathy to effectively treat their patients but on the other hand this empathy put them in risk to develop STS. Wilson and Thomas (2004) presented the matrix of empathy in trauma treatment and the concept of balance beam which reflects the struggle of therapists to maintain a balance in empathic attunement/strain. Abendroth and Figley (2013; 2014), discuss vicarious trauma and the therapeutic relationships and explained why it is important to avoid over-personalization in the therapeutic setting but at the same time to stay empathic. In other words, they suggest empathic discernment which is the ability to response empathically but in a way that serve the best benefit of the patient and the therapist.

In relational empathy, transference, and counter-transference are major factors related to STS. This will be reviewed in the next section of this review.

**Transference–Countertransference.** Transference and countertransference concepts have been redefined and developed during the years. The classical view has been understood by Freud as the way patients “transfer” feelings from important persons in their early lives, onto the therapist. Countertransference is simply the therapist’s response to a patient’s transference (Dalenberg, 2000). In the treatment of trauma, transference has unique characteristics in the therapeutic relationship, which include an intense sense of fear, shame, terror and helplessness. It also includes aggression, when the patient transference toward the therapist can easily changes from idealization to devaluation (Herman, 1992).
Dalenberg (2000) suggested new ways to view transference and countertransference in the treatment of trauma from a humanistic point of view. This humanistic point of view suggests that the countertransference in trauma treatment is subjective and unique to each therapist; but despite that, this point of view suggests viewing the common therapists’ responses in the treatment of trauma. The traumatic countertransference includes the attachment that the therapist feels and display; the emotional reaction to trauma dynamics; the actions taken by therapist with emotional significant to the therapeutic relationship and the unique and conflict-based reactions to trauma materials (Dalenberg, 2000). Hence, the therapeutic process involves psychodynamic processes such transference and countertransference can contribute to the process of secondary traumatic stress (Rothschild, 2006).

Those dynamic processes of transference and countertransference that occur during therapy, can affects therapists and lead to vicarious traumatization because of working intensively with the traumatized (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The transference and specifically the countertransference, and vicarious trauma affects one another in a cycle where the therapist’s psychological self, that can be changed as a result of vicarious traumatization and at the same time, those changes in the therapist’s self, change the countertransference responses (Dalenberg, 2000; Pearlman & Saakvitne, 1995).

Hence, the therapeutic dynamics in trauma treatment is complicated and intense. As reviewed above, under the combination of bearing witness to the trauma, empathic response and processes of transference and counter-transference, therapists can experience the distress which leads to STS. However, trauma treatment has not only
negative influences on therapists, but therapists can draw positive influences and grow, as it will be described in the following section.

**Resilience and Growth**

Psychological resilience has been studied broadly in the contexts of stress and trauma and refers to the adaptation after a stressful and traumatic experience and the capability of individuals and groups to recover after a significant trauma (Bonanno, 2004; 2005; 2015; Masten, 2007). The ability of humans to adapt following a traumatic event and even to grow and gain benefits from it, was studied broadly in the last two decades. The official concept for growth after a traumatic experience is Post Traumatic Growth (PTG) (Linley & Joseph, 2004; Bonanno, 2004; Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). The phenomenon of PTG was studied among different populations that have had traumas such as among combat veterans (Saltzman et al., 2018); ex-prisoners of war (Solomon and Dekel, 2007); cancer survivors (Occhipinti et al., 2015); people diagnosed with HIV/AIDS (Amos, 2015); refugees (Chan, et al., 2016) and more.

**Vicarious Resilience**

Like the primary trauma victims, also populations that were impacted by the trauma in a second manner, such as helpers and practitioners, can experience resilience and growth (Bartoskova, 2015; Bybee, 2018). Hernández et al. (2007) proposed the concept of vicarious resilience (VR). They based this proposal on an exploratory study, which examined how therapists of traumatized populations can learn something about overcoming adversity from their clients. Vicarious resilience, therefore, is a construct that helps understand the ways which mental health workers can be positively impact by
treating traumatized populations by being exposed to their patients’ resilience (Hernández et al., 2007; Hernández et al., 2010; Hernandez-Wolfe et al., 2015).

Studies about vicarious resilience and growth among trauma therapists, show that vicarious trauma and vicarious resilience can coexist, and that treating trauma can involve positive and negative emotions and reactions together (Hernandez-Wolfe et al., 2015; Michalchuk & Martin, 2018; McNeillie & Rose, 2020). The factors relate to the process of vicarious resilience refer to: revealed that participants-maintained resiliency by privileging a shared journey; developing purpose and personal growth; deriving positive meaning and serving humanity (Michalchuk & Martin, 2018).

**Vicarious Growth and Compassion Satisfaction**

The theoretical frameworks about growth following secondary trauma refer to compassion satisfaction (CS) and vicarious growth (VG). Compassion satisfaction is a positive outcome from caring and it refers to the sense of fulfillment a therapist can feel from doing a job well and from helping others, particularly to those that are traumatized (Stamm, 2002). Vicarious posttraumatic growth (VPTG) is a process of growth following treating traumatized individuals and the benefits can include: improving relationship skills, observing and appreciating the resilience of the human spirit and the satisfaction from noticing a positive change in patient’s life (Arnold et al., 2005).

These first studies (Arnold et al., 2005; Linley et al., 2005; Linley & Joseph, 2007) showed the possibilities for positive outcomes and growth for therapists treating trauma. Linley et al. (2005) found higher sense of coherence was associated with positive changes among trauma therapists. Later, Linley and Joseph (2007) found the therapeutic dyad was the best predictor for positive outcome for therapists when empathy is also here
the pathway to vicariously growth. In fact, Pearlman and Saakvitne (1995) pointed out earlier that despite the negative tone of research, sequelae of trauma work are not just negative. They claimed a therapist’s conscious and unconscious affective responses to the trauma narratives of his patients can also facilitate healing (Pearlman & Saakvitne, 1995).

The possibility of secondary growth has been supported by various studies (Bartoskova, 2015; Laverdiere et al., 2019; Manning et al., 2015; McNeillie & Rose, 2020). A study among therapists treating complex trauma offers that those therapists can redefine their vicarious exposure to trauma as a personal and psychological growth (McCormack & Adams, 2016). A critical review by Bartoskova (2015) presented empirical support for the phenomenon of growth among therapists and claimed that we need to move away from the stereotype of only negative results from working with traumatized individuals. This review offers evidence about positive changes among therapists as valuable findings that require further investigation. This reviewer (Bartoskova, 2015) suggests three factors that play a role in the growth and positive experiences of therapists: (1) Empathy (Laverdiere et al., 2019) (2) sense of coherence, and (3) social support (Ludick & Figley, 2017). However, it is still less clear which factors enable it due to the mixed findings (Bartoskova, 2015).

The focus on resilience and growth, at the same time while studying secondary trauma and compassion fatigue is systematically addressed at the Compassion Fatigue Resilience Model (CFRM) (Figley & Figley, 2017; Ludick and Figley, 2017).

**The Compassion Fatigue Resilience Model**

The CFRM and specifically the empathic response in it, is in the center of this research (Figley & Figley, 2017; Ludick and Figley, 2017). The compassion fatigue term
developed to the CFRM during the years (Figley & Figley, 2017; Ludick and Figley, 2017). The development of this model includes adding the term of Compassion Fatigue Resilience (CFR), which is “the spectrum of resources available to the human service worker, varying from low resilience to very high resilience” (Figley & Figley, 2017, p.7). Therefore, this model emphasizes the positive pathways regarding secondary trauma, when higher resilience results in lower compassion fatigue (Figley & Figley, 2017; Ludick and Figley, 2017).

The CFRM applies to all kind of service providers and professionals who work with traumatized victim and include the risk and protective factors for developing CF. The main risk factor is the empathic response, when prolong exposure to suffering, traumatic memories and other life demands are also risk factors. The protective factors include self-care, detachment, sense of satisfaction and social support. This resilience model offers adaptation, coping with resistance to secondary traumatic stress by embracing resilience and growth. This model presents the risk factors for compassion fatigue but also the factors preventing compassion fatigue and by that suggesting a comprehensive approach for the mechanism for STS (Ludick & Figley, 2017).

In sum, there is growing literature about the positive process following indirect exposure to trauma, which emphasizes resilience and growth, and not just focus on the pathology (Manning et al., 2015). The idea is to move from the pathology and focus also on the positive transformation and empowerment that trauma therapists could experience through their empathy for and interaction with patients, from a strengths-based approach (Hernandez-Wolfe et al., 2015; Ludick & Figley, 2017). This approach suggests preventing negative outcomes of trauma treatment such as compassion fatigue and
secondary traumatic stress and at the same time increasing resilience and compassion satisfaction among trauma therapists.

After reviewing the transmission of trauma and the negative and positive experiences of indirect trauma, next will be reviewed the relational therapy approach, the paradigm behind this approach and the therapeutic factors that can influence therapists. Specifically, the below section will present the empathic response from a relational point of view and how it relates to CF, resilience, and growth.

**Relational Psychoanalysis and Trauma**

The relational psychoanalysis considered a framework and not a theory led by one-man theory such as Freud or Yung. The relational psychoanalysis is a collection of ideas which several theorists and psychologists contribute a certain approach or concept to the relational model without a leader who determines the central direction (Harris, 2017; Malone, 2018). The accumulation of these ideas and concepts has significant implications for practice, known as contemporary relational psychoanalysis (Barsness, 2017; Malone, 2018). This relational model has also significant implications for social work education and practice (Barsness, 2017; Ornstein & Ganzer, 2005; Tosone, 2004).

**The Relational Turn in Psychoanalysis**

Relational psychoanalysis is the most recent development of the postmodern psychoanalytic theory, which has taken a clear direction of reference in the last three decades. The relational turn in psychoanalytic thinking includes moving from modern theory of searching for an objective true and rational such as Freud derive theory and ego psychology developed to a postmodern thinking (Beebe & Lachmann, 2003; Malone, 2018). The relational model, based on therapeutic intersubjectivity, has been well
integrated into the therapeutic work of the 21st century, emphasizing the importance of the actual real relationship between therapist and patient and on the psychological connection between subject and subject rather than connection between subject and object (Beebe & Lachmann, 2003; Harris, 2017; Malone, 2018; Mitchell, 1993).

The relational turn ideas were influenced from global social movements such as: civil rights, against Vietnam war and for women rights. The ideas about psychological development and mental health became democratic and questioned authority, difference, and relationship (Harris, 2018). The relational turn in trauma psychology, therefore, is part of the feminist movement, which hold the idea that the personal is political and the political is psychological. In a relational space, all the voices can be heard and be listened (Benjamin, 1988; Robb, 2006). For example, Herman (1992) and her colleagues suggested psychological trauma of rape can be compared to post trauma of veterans (Herman, 1992; Robb, 2006).

The relational paradigm also based on earlier social psychology theories that have argued about the development of the self in a social context (Harris, 2017; Layton, 2008). Herbert Mead argues that the appearance of the “self” happens and developed within a social process. Meaning, the self is a social phenomenon that appears within a social process. This sociological theory of the self assumes that we are the products of a social experience rather than a precondition (logical or biological) for the social experience. This theory attacks the classic psychology and individualistic theories of the self that assumes the self as an isolated phenomenon and leads the social process (Mead, 1964). The basic assumption of relational paradigm is that psychological development
influenced mainly by relationships, not by drives (Layton, 2008), therefore it is called ‘relational psychoanalysis’.

**Relational Trauma Treatment**

The relational turn in psychoanalysis has influenced studying, understating, and treating trauma (Bohleber, 2010; Boulanger, 2007; Harris, 2018; Gartner, 2017). The idea that talking about a traumatic experience with an empathic listener could help heal the sense of betrayal of trauma was an idea that grew from the relational movement in psychology (Herman, 1992; Robb, 2006). Additionally, relational psychoanalytic approach emphasizes dialectical construction and multiple meanings (Boulanger, 2007; Herman, 1992) and focuses on transference and counter-transference, dissociation, self-states and enactment while working with trauma victims (Harris, 2018; Howell & Itzkowitz, 2016).

In general, the relational turn and new paradigm produced new concepts, terms and therapeutic approach. The main theoretical concepts that are the foundations stone of relational psychoanalysis approach include: two-person psychology and mutuality in therapeutic relationships (Aron, 1996; Mitchell, 1993); intersubjectivity and the idea of the third (Aron, 2006; Benjamin, 2004; Ogden, 1994; Stern, 2004); Transference – countertransference (Stern, 2004), Enactment and dissociation (Davis & Frawely, 1994; Howell & Itzkowitz, 2016). These theoretical concepts have significant clinical implications; therefore, the relational turn can change therapists’ positions and its practical manifestations significantly along with practical implementations in trauma treatment. Next, these theoretical concepts of relational theories will be reviewed deeply and divided into two main factors that can challenge relational trauma therapists.
**First Factor: The Use of the Self**

The paradigm shift in the relational approach shaped the therapist’s position and turned the use of the self of the therapist as the main therapeutic tool. This position includes deep affective and generous involvement and working in the here and now with the therapist’s own self as the central instrument (Barsness & Sorenson, 2017; Herman, 1992; Benjamin, 2018). Many characteristics of high empathy can be found in Barsness’s (2017) book, *Core Competencies of Relational Psychoanalysis*. One of the dominant competencies includes deep listening and affective attunement, described as when relational therapists pay deep attention to affective states, follow affects and recognize emotional rather intellectual, they recognize and stay with negative emotions, listen beyond words (Barsness, 2017).

Further, as part of the use of the self, relational therapists use self-disclosure. Self-disclosure in relational therapy usually refer to intentional self-disclosures (vs. nonintentional), a distinction is usually made between disclosures that relate to the therapist’s lived experience with his patient and revelations that relate to the analyst’s life outside the therapeutic context. This is a very controversial and discussed subject but mainly reflect the recognition of the therapist as a subject and the concept of mutual recognition (Hill & Knox, 2001).

The concept of *mutual recognition*, emphasized by Jessican Benjamin (2004; 2018) in her theory of intersubjectivity, means that each person in the relationships experiences the other as subject that can feel the other but at the same time to be separate. This requires high levels of relatedness and involvement, and therefore high empathy. However, relational therapy holds high levels of empathic response not only according to
a checklist of high and low empathy, or specific methods but mainly because of its theoretical approach overall as well as the spirit and values of the relational therapy (Harris, 2017; Benjamin, 2018).

**Therapeutic Relationship and Empathy.** Therapy in general and specifically trauma treatment requires empathy and building good therapeutic relationship. However, from a relational approach, the main instrument is our empathy; therefore, the main delivery of that person is the therapist (McWilliams, 2018). The therapist’s role, in the relational context, is more interactive and participative one which centers the relationship in the middle of the therapeutic action (Aron, 2006; Benjamin, 1988; 2018; Mitchell & Aron, 1999). As the therapist and patient engage, they change the field and directly affecting one another in an ongoing and ever-evolving process. Further, because relational therapists coparticipants, they observe how their own patterns interact with those of the patients (Itzkowitz, 2017).

The relational position emphasizes authenticity and use of the self, as opposed to neutrality, within the empathic position (Aron, 2006; Mitchell, 1993). What relational therapists mostly offer to their patients is a relationship with a real person who is present, alive and responding emotionally and intellectually, to work on the trauma. The use of the self, therefore, is the centrality of the relationship in the therapy (Shmukler, 2011). The relational turn, therefore, takes the empathic response and therapeutic relationship and puts them in the middle of the healing process.

Wilson and Thomas (2004) present modes of empathic attunement and empathic strain in trauma therapy. They refer to Kohut’s concepts of lower form and higher form of empathy and ask what defines higher empathy in therapy? Their general answer is that
higher levels of relatedness reflect high levels of empathy (Wilson & Thomas, 2004). In that sense and according to the relational theoretical approach, relational therapists may hold a high level of empathy because they engage with high levels of relatedness and are highly attuned to patients (Aron, 2006; Benjamin, 1988; 2018; Mitchell & Aron, 1999). The following section about intersubjectivity will also support the qualities of high empathy.

**Intersubjectivity and the ‘Third’**. The idea of intersubjectivity is that it inherently demonstrates the therapist’s use of the self in relational therapy. The theory behind intersubjectivity is the intersubjective system theory, developed by Stolorow and Atwood’s (1992), who discuss of what they term “the myth of the isolated mind” (p. 7). This suggests that a person has a personality structure that exists prior to his interaction with those around him. This theory argues that all parts of the psyche are created solely in the interpersonal context. Therefore, the analytical investigation that takes place during treatment should be focused, especially in the broad system created by the mutual interaction in the subjective world created between the therapist and the patient. Therefore, the psychoanalytic techniques in the relational turn, moved from a position of anonymity, neutrality and abstinence to position of self-expression, self-disclosure and spontaneous in therapy (Mitchell, 1995; Stolorow and Atwood, 1992; Stolorow, 2013; Stolorow et al., 1983).

The fuller concept of intersubjectivity also include the ‘third’ concept that has become popular and has been developed by theorists such as Thomas Ogden and Jessica Benjamin. According to Ogden (1994), a third “entity” is created in therapy, based on the unique interaction between the subjectivity of the therapist and that of the patient. Of
course, the third analytic term did not mean that subjectivity or a third actual and concrete entity was created: the third analytic term emphasizes the intensity of the effect of the interplay between the subjectivity of the therapist and that of the patient. In this unique interplay, Ogden (1994) emphasized how thoughts, ideas, emotions, and sensations are given a unique meaning that can be derived only from the specific context in which the unique encounter takes place between the subjectivity of the specific patient and the specific subjectivity of the particular therapist at a given moment.

Aron (2006) tried to clarify a variety of meanings of the third, especially within the framework of Benjamin’s (2004) intuitive theory. There are two types of the third, the first one is the “One in the third” - the harmonious element of oneness that is necessary for the experience of the third (also called the third rhythmic). It is easy to understand this third as a form of mutual accommodation. Benjamin (2004) described the third as two people who share a dance or rhythm with each other and compared the process to the creation of musical improvisation, in which both sides follow a pattern while at the same time creating and surrendering to it, creating a cocreated third. Benjamin (2004) conceptualizes the experience of oneness in a dyad, in which each member not only adapts to the other but also adapts to the rhythm that the couple has already created together. That is, it is not just about the ways in which two people influence each other, but also about the ways in which they are constantly affected by the patterns and rhythms they have created with each other (Aron, 2006; Benjamin, 2004).

The second type of the third, according to Aron (2006), is the “Third in the one” - this third creates a space of differentiation within oneness (also called the symbolic third or the “intentional third”). Benjamin (2004) used the term ‘marking’ to describe how,
similar to the relationship between a mother and a child—despite the mother’s attempt to adjust to the child and respond emotionally to emotional responses—they never match perfectly. The mother exaggerates some aspects of her reaction to distinguish her from her “real” reactions, thereby “marking” her reflection on the child, or showing him, this is her version of his reaction. The child, in turn, uses the quality marked to distinguish between the expressed emotion and the parent, and to feel ownership of the stimulus that triggered the parent’s response, expressing his own state of mind (Aron, 2006; Benjamin, 2004).

Aron (2006) suggested the two types of ‘the third’ of Benjamin are connected to each other—the rhythms and marking come together. The first type emphasizes the connection and the other emphasizes separateness, but both are necessary for each other. The clinical implications of the thirds are demonstrated in reflectivity and symbolism. The attempt to produce a third sometimes passes through certain types of self-disclosure of the therapist. The intention is to expose aspects of internal processes, especially conflicts and internal disorganization. Practitioners actually create a dialogue with themselves in the presence of patients, thus presenting a third element to the dyad and creating a mental space for reflective awareness and mentalization (Aron, 2006).

The intersubjectivity and the third exemplify the relational dynamic and the shift of relational theory in the attention to the ‘here and now’. The relational dynamic when working in ‘here and now’ can offer an insight about the ‘there and then,’ but it is also an opportunity for a new relational experience (Harris, 2017; Herman, 1992). The therapist engages with the patient in a direct relationship while holding the position that change
will come from working through co-created and co-constructed relationships in the therapeutic dyad (Barsness, 2017).

In addition to the use of the self-factor, the second factor that can challenge relational trauma is the trauma treatment dynamics.

**Second Factor: Trauma Treatment Dynamics in Relational Therapy**

The relational turn in psychanalysis has influenced understating and treating trauma (Boulanger, 2007; Gartner, 2017; Harris, 2018). Relational psychoanalytic theory emphasizes dialectical construction and multiple meanings and viewing trauma as an event but also as an experience that is influenced by previous experiences (Boulanger, 2007). According to Herman (1992) trauma inherently disempower and disconnect people from others. Therefore, recovery from trauma need to include empowerment and building connections with others, only within relationships. Meaning, recovery from traumas in general and specifically interpersonal traumas, should happen in a relational therapeutic space. This is the key point of relational therapy and trauma.

The main dynamic concepts in treating trauma refer to transference and countertransference (Dalenberg, 2004; Stern, 2004) and dissociation and self-states (Davis & Frawley, 1994; Howell & Itzkowitz, 2016). Those concepts are dominant in the theoretical and practical levels and essential to understanding what is going on in relational trauma treatment.

**Relational Transference–Countertransference.** Classical psychoanalysis views transference and countertransference as not happen in “real” relationship and that countertransference is residual unanalyzed aspects of the therapists’ past and can interfere with the patient transference and harm the therapy. However, relational approach,
specifically the intersubjective theory, redefined it and see all interactions in therapy as transference and countertransference. The countertransference is an intersubjective experience and helps to understand deeper the patient’s internal and interpersonal world (Barsness & Strawn, 2017).

Gartner (2017) claimed in the classical sense, countertransference is a neurotic reaction of therapists to trauma but in a more contemporary relational sense, this is a feeling emerging from a two-person system, co-constructed process together in the therapeutic relationships. Therefore, in the treatment of trauma and from a relational point of view, he suggests a new term: countertrauma as the dynamic between patient and therapist (Gartner, 2017).

In fact, Gartner’s interpersonal-relational perspective suggests a new understanding about the experiences of relational therapists treating trauma (Gartner, 2017). Relational therapists will experience their work according to the theory that in their mind and therefore will be affected differently. Meaning, therapists embrace a relational approach that emphasizes expressions of transference and countertransference and relatedness. This work allows accounting for emotions that emerge during trauma therapy and therefore includes overwhelming feelings that can impact relational therapists intensively (Itzkowitz, 2017).

**Dissociation and Self-States.** Freud, together with Pierre Janet introduced the dissociation model as a psychological defense mechanism of split and separation and as an adaptive response that appears in traumatic experiences in which the trauma victim is unable to fight or flight and integrate the traumatic experience and therefore uses detachment to protect himself (Freud, 1894). Freud didn’t use the term dissociation but
rather the splitting of consciousness and the term dissociation was not part of the psychoanalytic discourse for many years (Bloom, 2013; Freud, 1894).

The Diagnostic and Statistical Manual (DSM) defines dissociation as “a disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” (APA, 2013, p. 291). Trauma has long been accepted as one of the major causes of dissociation. In fact, dissociation enables a critical escape from emotional and physical distress connected to a traumatic event. However, the phenomenon of dissociation lies on a spectrum between normal and pathological reactions such as multiple self-states and dissociative identity disorder (DID) (APA, 2013; Brown, 2006; Howell & Itzkowitz, 2016).

Today, dissociation is in the center of the trauma discourse which emerged in psychoanalysis after the horrors of World War II and the Holocaust and child abuse damages (Bloom, 2013). The psychiatrist Ferenczi had an important role in studying dissociation and trauma. Ferenczi’s (1949) paper, “The Confusion of Tongues Between Adults and the Child” emphasized the controversy between him and Freud and the theoretical view of dissociation as fantasy versus trauma. Ferenczi’s view was that trauma has a critical role in pathological dissociation and this critical insight implied that dissociation played a much grander role in the analytic transference-countertransference. (Bloom, 2013; Ferenczi, 1949).

Dissociation has a major role in relational trauma therapy. Dissociation may occur to protect the mind and prevent the integration of the traumatic experience (or certain aspects of it). Unlike repression, which is an active process when the ego achieves control
over conflictual material, dissociation is a desperate attempt of an overwhelmed ego to maintain a mental function (Davis & Frawely, 1994). From a relational point of view, dissociation will always be on the interpersonal relationships level and will appear within a specific transference-countertransference dynamic. It does not mean that the connection with a certain therapist creates the dissociation, but rather allows it (Bromberg, 2006; 2011; Davis & Frawely, 1994; Howell & Itzkowitz, 2016; Itzkowitz, 2017).

Many survivors of sexual abuse trauma adopt a dissociative self-state that enables them to function on a daily basis and at the same time protect the child self that is still thriving for recognition and validation. The price is a split and dissociation of personality (Davis & Frawley, 1994). The traumatized child who lacks the recognition of his caregiver experiences a state of self which is unsolved. Because contradicts feelings and emotions cannot be experienced in a system of one-self, the child dissociates the self who is hurt. Therefore, dissociation can be viewed as a condition of flight without a flight when the traumatic experience left dissociated and therefore unprocessed and raw (Bromberg, 1998; 2006).

From a relational point of view, complex trauma causes to the destruction of agency since it robs victims of their sense of agency. Individuals who have been sexually abused by a closed family member are going through the denial of their mind because the trauma injures the capacity to differentiate between thoughts, feelings, desires, and a sense of the person own agency (Slavin & Pollock, 1997). The dissociated, unprocessed traumatic experience and the effects and emotions behind them, can be manifested in the therapeutic relationship between therapists and patient, in a dissociative process called *enactment* (Bromberg, 2006; 2011). The dissociate self-states can emerge during a
therapy, part of them are the terrified abused child, reliving the sexual abuse trauma or any other trauma in the inter-personal space that become flooded with extreme emotions of anxiety, horror and anger (Bromberg, 2006; 2011; Howell & Itzkowitz, 2016; Itzkowitz, 2017). In that sense, trauma therapy includes working with dissociation and self-states that occurs during the enactment process which can be intense and overwhelming for relational therapists.

After reviewing the two main factors in the relational practice treating trauma and how they challenge relational therapists, below both sections of the transmission of trauma and relational therapy are integrated. It is described how secondary trauma occurs in relational therapy and processes of compassion fatigue, resilience, and compassion satisfaction.

**Compassion Fatigue Resilience in Relational Therapy**

The relational approach while treating trauma puts the therapist in a vulnerable position (Saakvitne, 2017). Working from a relational position means bearing witness to trauma from a relational position. Ullman (2006) argued witnessing should be defined from a relational, two-person psychology perspective, like social-moral witnessing. The therapist should recognize the external realities of evil and suffering the evil and cruel reality, while treating trauma victims. This perspective views witnessing as a distinct function of the therapist as curative element in the psychoanalytic intersubjective process that invites the therapist to recognize the ‘otherness’ (Poland, 2000; Ulman, 2006). Further, Ullman (2006) claims witnessing inherently involves a state of crisis, when assumptions and categories of the existing world start to crack and when therapists’ identities are threatened because of encountering the otherness of patients.
In addition to witnessing, the high levels of empathic response in the relational position include the use of the self, intersubjectivity and high relatedness as well as working with countertransference and dissociation in this relational space. High levels of empathic response may lead to STS or CF over time (Figley, 1995; Figley & Figley, 2017), or from a relational point of view to countertrauma (Gartner, 2017). Countertrauma is more fluid, intersubjective, two-person system, whereas vicarious trauma implies a one-person model, with trauma residing first in the patient and then in the therapists (Gartner, 2017).

Thus, the relational therapeutic position of intersubjectivity and use of the self, essentially effects relational therapists (Gartner, 2017; Saakvitne, 2017;). The ideas of intersubjectivity and the third (Benjamin, 2004; Mitchelle, 1995;2000; Ogden, 1994) reflect the deep involvement and engagement of relational therapists in the trauma treatment. It is probably not possible to stay in this intensity of engagement and be emotionally protected at the same time (Harris, 2018). Therefore, it is argued that relational therapists are in high risk to develop CF.

Moreover, the relational paradigm refers to dissociation and enactment as a result of a real external traumatic event, violence and abuse, as opposed to the early drive theory in psychoanalysis, which privileges fantasy and wishes. The relational position validates the patient’s narrative by understating and working with dissociation, enactment and self-sates (Itzkowitz, 2017; Harris, 2018). Meaning, relational therapists acknowledge the truth of traumatic reality and fragility of life, which can promote CF (Itzkowitz, 2017; Pearlman & Sakkvitne, 1995). Further, working with enactment and self-states can be very intense and terrifying (Itzkowitz, 2017).
In CFRM, empathic response leads to STS; however, compassion and satisfaction may increase resilience (Figley & Figley, 2017). In the relational context, positive outcomes are influenced from the therapist’s position and use of self. When the therapist engages and participates, they can also experience personal growth from the mutuality and intersubjectivity space in the therapeutic relationship (Gartner, 2017). Gartner (2017) suggested, for many therapists, countertrauma is inevitable, including those who treat complex trauma over time but also for those who bear witness to other types of violence, terror, and traumas. For many therapists, however, countertrauma is accompanied by counterresilience (Gartner, 2017). These complex experiences will be addressed in the next section.

**Resilience and Compassion Satisfaction in Relational Therapy**

At the same time, high levels of empathic response can enhance positive outcomes and not just negative outcomes (Bartoskova, 2015). From a relational point of view, the positive outcomes are usually demonstrated in the patient and therapist experiences of meaningful therapeutic process that reflect resilience and can lead to compassion satisfaction (Stamm, 2002) or vicarious posttraumatic growth (Arnold et al., 2005). Meaning empathy can be a positive factor for relational therapists, by promoting resilience and growth (Gartner, 2017; Gold, 2017).

Therapists with high ability to empathize have more flexible schemas and therefore are more prone to be assimilated by the traumatic experience. However, flexible schemas enable also to develop a deep process of meaning making. Therefore, empathy it’s also a protector factor in term of meaning making in such way that empathic therapists can find a sense of meaning in their work helping others (Park et al., 2017)
From a relational point of view, Gartner (2017) suggested also the term counter-resilience and Gold (2017) expanded and suggested the term countergrowth; both terms assume a two-person psychology model that reflects give and take in the therapeutic dyad (Gartner, 2017; Gold, 2017).

Dialectical Approach

Boulanger (2007) claims that while treating trauma from a relational therapeutic position, vicarious trauma is inevitable but also that working with vicarious trauma is a necessary therapeutic tool. Vicarious trauma can be a form of unwelcome psychic contagion; however, only when the therapist acknowledges vicarious trauma they can work through their patient’s traumatic experiences. Meaning, therapists need to work through their own experiences of their patients’ experiences. Vicarious trauma, therefore, must become a dynamic, intersubjective process (Boulanger, 2007; 2016).

Another perspective is that this is a mutual process of love and healing. The relational therapeutic position of deep listening and affective attunement is a generous involvement, as simply being human and the person we are, when we engage with patients. From a relational perspective, it is a mutual affective involvement; it is a healing relationship of patient and therapist. According to Pizer (2017), generous involvement is not only an empathic witnessing and “being with,” it entails “going forth” from the therapist toward the patient’s need. Further, empathy in the relational context can be seen as love. Similar to Kohut, who considered empathy as the main therapeutic tool, by identifying ways of love between parent and a child (Show, 2017).

To expand the perception about empathic response, vulnerability needs to be discussed. Therapists are vulnerable persons who usually have an innate sense of
another’s pain, due to a receptivity to their own vulnerabilities and woundedness (Barsness & Sorenson, 2017). The idea of the wounded therapist is that the therapist’s vulnerability makes him a good therapist. This vulnerability is actually a gift, but it is also the place that arouses the therapist wounds. Still, vulnerability is not the opposite of resilience. It is important to put the light on the resilience of therapists, when one of the gifts of relational therapists that meet their patients in an intersubjective space, face to face as two persons, is the transformation (Barsness & Sorenson, 2017).

In that sense, relational therapists must open themselves to the possibility to be impacted by treating trauma, but the negative influence is also a sign that they are engaged in a process by helping traumatized individuals finding meaning in the traumatic experience, however painful that meaning may be (Boulanger, 2018). Therefore, when the therapists engage and participate, they can also experience personal growth from the mutuality and intersubjectivity space in the therapeutic relationship (Gartner, 2017).

**Self-Care in Relational Therapy**

The complex needs of relational therapists, the dialectical approach and intense empathic response need to be discussed and studied by therapists during their training process, on staff meetings and supervisions. Supervision and training in relational therapy is an important factor for the therapy success but also for the well-being of relational therapists. Use of supervision was conceptualized by Aron (2006) as the “third” for the therapeutic dyad. Through the training, a new potential space is created for multiple positions. Supervision gives a push to the therapist’s “relational compass,” enabling movement toward a variety of different identifications and attitudes. Within the
complexity of the therapeutic relationship, this position of the therapist, in turn, encourages the patient to examine and adopt new roles (Aron, 2006).

**Purpose of the Study**

In light of this study, with the help of supervision and training, trauma therapists need to familiar with the costs of their intensive work and to be attuned to their vulnerability. However, they also need to be familiar with the gift of this vulnerability, their resilience and to the opportunity to grow and make meaning. The goal of this research is to learn the in-depth mechanism of empathic response by investigating relational trauma therapists, to expand on ways therapists can apply better self-care for themselves, for better training, and for increased education on trauma therapy.

Therefore, this study aims to ask:

1. How relational therapists experience working with patients which have gone through a psychological trauma?

2. What is the connection between empathic response and compassion fatigue?

3. What is the relationship between empathic response and resilience?

4. What is the relationship between empathic response and compassion satisfaction?

5. What are the risk and protective factors of compassion fatigue among relational therapists?

6. How do they maintain their well-being while treating trauma?

The next chapter, Chapter 3, will present the methodology of the study. It will note the details in studying relational therapists and their experiences. We will return to these important questions.
CHAPTER 3: METHODOLOGY

The purpose of this study is to explore the experiences of relational therapists and how they manage the effects of treating trauma. The researcher believed that better understanding their experiences will help deeply explore the empathic response mechanism of service providers. This deep level of understanding will allow therapists, supervisors, and trainers to be familiar with the risk and protective factors in serving trauma survivors. This chapter describes the research methodology employed in this study. The qualitative phenomenological method and specifically Interpretative Phenomenological Analysis (IPA) approach is the main method used in this study. This approach included conducting in-depth interviews and a follow-up survey as a member checking method to validate the results. The chapter also describes the research sample of 12 relational therapists, how the data were collected, what information was needed, and how the data from the interviews were analyzed. Finally, the chapter addresses issues of ethics, trustworthiness, and limitations of the study.

Qualitative Research Design

As noted earlier, this research is a qualitative inquiry. Qualitative psychological research collects and analyzes non-numerical data through a psychological lens and is recommended for the assessments of psychotherapy (Hill et al, 2013). Here, the focus is on rich and deep descriptions about how people make sense of the world and experience their world and life events (Willig & Rogers, 2008). The goal of this research was to investigate empathic response by studying the experiences of relational therapists treating trauma, requiring a deep understanding of how those therapists make sense of their experiences.
Specifically, the initial goal was to study the risk and protective factors influencing how relational therapists detect and manage compassion fatigue and other indicators of resilience and compassion satisfaction. Therefore, a qualitative method enabled the investigator to focus on what can be learned from relational therapists and its applications to other therapists, their supervisors, and trainers. This type of investigation required an approach proven to be vital in capturing the lived experiences of the research participants (Willig & Rogers, 2008).

Qualitative research is rooted in the social constructivist philosophical approach, unlike positivist philosophical position, and therefore it is concerned with peoples’ subjective experiences and perspectives. Further, research that seeks to gain insight into peoples’ lived experiences usually utilizes a qualitative approach (Willig & Rogers, 2008). Typically, this includes the use of psychoanalytic approaches, a combination with social constructionism (Sullivan, 2010). The new psychoanalysis is interested in the dialogue of the self with the environment and intersubjectivity. This is the intersection of social constructivism and psychoanalysis (Sullivan, 2011). Moreover, part of the paradigm shift in the relational psychoanalytic approach includes the shift from a positivist position to a social constructivism position (Hoffman, 1991). In this sense, there is a match between the relational approach and qualitative research because both hold the same philosophical position. This position seeks to explore subjective experiences of therapists as well as the make meaning of their experiences.

**Interpretative Phenomenological Analysis (IPA)**

Within qualitative research methodology, the Interpretative Phenomenological Analysis (IPA) approach was selected for this study. The major theoretical foundation of
this method is phenomenology, a philosophical approach founded by Edmond Husserl. Rather than studying numbers emerging from research that represent reality, Husserl wanted to describe how the world is experienced through consciousness and intentionality, regardless of bias and preconceptions. In other words, phenomenology, according to Husserl, describes human existence. Later, phenomenology philosophy was also studied by Hidegger and Merleau-Ponty and moved from a descriptive to interpretative approach that emphasized meaning-making (Moustakas, 1994).

Beyond its original emergence, IPA has important implications for the social sciences. It seeks to understand anything that can be experienced through consciousness. This analysis enables to reach out whatever is "given"—it can be an object, a person, or a complex state—from the perspective of the conscious person experiencing it. The main important interest is the person's attitude to the phenomenon and not the phenomenon itself (Giorgi, 2009).

The aim of IPA is to explore in detail how participants are making sense of their personal and social world. The main goal of this method is to study the meanings of experiences and events of participants. Further, IPA aims to understand the meaning of experiences in the context of the concrete and meaningful world of humans (Smith & Eatough, 2007; Willig & Rogers, 2008). Therefore, the goal of this study is to learn the meaning of the experiences of relational therapists and the context of their experiences, to capture an in-depth picture of how they manage their well-being while treating trauma.

IPA emphasizes three main ideas: (a) being in the world, (b) hermeneutics, and (c) idiographic approach. Being in the world is a principle which, similar to the relational perspective, emphasizes relating to others and intersubjectivity. Intersubjectivity refers to
the shared experiences and relational nature of peoples’ engagement and relatedness to the world. Phenomenology and IPA believe in peoples’ relationships to the world, their interpretative position, as well as the meanings of their actions and experiences (Moustakas, 1994; Smith et al., 2009).

Another important factor in IPA is hermeneutics, the theory of interpretation. This approach explores how a phenomenon appears when the researcher is trying to make sense of its appearance. The hermeneutic circle is the dynamic relationship between the whole and the parts. Like the relational psychoanalysis approach, the hermeneutic circle describes the interpretation process, which is a dynamic, non-linear way of thinking (Smith et al., 2009).

The last factor is idiographic, which focuses on understating the perspective of particular people in a particular context. This has effect on sample size, which is usually small and purposive. Therefore, IPA does not seek to apply generalizations. Although idiographic seeks the particular and its meanings, the perspective on the experience is complex. On one hand it can be unique and specific, but on the other hand, it is a worldly and a relational phenomenon (Smith et al., 2009). The researcher’s challenge in this study is to capture the complexity of the experiences of relational therapists who are treating trauma and to explore the individual experience between the relationship and wider context.

**Research Sample**

The research questions inherently refer to and focus on a specific, knowledgeable therapist population. Therefore, the sampling of this study was purposive and a criterion based. Samples are selected purposively in qualitative research and specifically in an IPA
study because a purposive sample can offer insight into a particular experience (Smith et al., 2009). The inclusion criteria of this research were psychotherapists who: (1) Identify as relational therapists; (2) treat patients who have experienced a trauma; (3) have at least a master’s degree or higher; (4) have at least 5 years’ experience as relational therapists treating trauma; (5) are willing and able to participate in an online interview, and (6) speak fluent English or Hebrew. Therefore, this study’s sample included 12 relational therapists from different countries around the world. At the time of the study, all participants were treating patients who had traumatic experiences that they discussed in sessions. All participants spoke either fluent English or Hebrew. All participants had acquired at least a master’s degree and 5 years of experience (see Table 1).

**Sampling Procedure and Sample Size**

The sampling procedure included recruiting participants through the International Association of Relational Psychoanalysis and Psychotherapy (IARPP) by sending recruitment emails to the member list in English and Hebrew (see Appendix A). The sampling also included referral techniques and snowball sampling (Weiss, 1994).

Because the IPA is an idiographic method, there are implications for sample size. The number of participants might range from one to 30, with the norm being towards the lower end. Typically, IPA studies are conducted with a relatively small sample size. The logic behind this is that researchers will be able to conduct detailed, in-depth analysis for each case and avoid collecting too much data. Ultimately, there is no right answer about sample size, and it depends on the commitment to the case study and depth of analysis (Smith & Eatough, 2007; Smith et al., 2009; Willig & Rogers, 2008). The sample size of 12 relational therapists based on IPA suggestions as well as until the researcher reached
saturation. This sample size is within the common range of IPA studies that have been published, which is between one and 15 participants. Larger sample sizes are possible but less common in IPA (Pietkiewicz & Smith, 2014).

After recruitment emails were sent to the IARPP members list, eight relational therapists were recruited. Another four relational therapists were recruited through snowball sampling. The researcher followed the concept of saturation affecting sample size, which is an important guiding concept in qualitative research (Mason, 2010). Interviews were conducted until saturation was met, and no new information was gained from them. Saturation was reached by the completion of 12 interviews.

**Overview of Information Needed**

To answer the research questions and specifically to explore more about the risks and protective factors of relational therapists treating trauma, the study searched for extended information. The perceptual information needed for this study included learning the in-depth experiences of relational therapists treating trauma. The data needed were: (1) How do they identify trauma? (2) What is relational therapy, from the participants’ point of view? (3) What do they emphasize in relational therapy and in treating trauma? (4) How do relational therapists view empathy and empathic responses from a relational point of view? (5) What are the effects on practitioners from treating trauma, from a relational position (negative and positive aspects)? (6) What factors influence those effects and how do the relational therapists maintain their well-being (specific self-care methods)?

In addition, the contextual information included: (7) the place of work and type of therapeutic setting (private clinic or public service); (8) therapeutic experience and years
of practice; and (9) the type of population and types of traumas patients have experienced. The demographic information collected were age, gender, education, years of practice, ethnicity, religious affiliation, and personal background and circumstances.

**Research Design and Data Collection**

The use of multiple methods is critical in obtaining an in-depth understanding of the phenomenon under study; therefore, the strategy in this research will include two methods that will be conducted in two phases:

**Phase I: Interviews with Relational Therapists**

Semi-structured, in-depth interviews were conducted with 12 relational therapists and were the primary method for data collection in this research. Most IPA studies employ semi-structured interviews, which means developing a set of questions that are used to guide the interview (Smith & Eatough, 2007; Willig & Rogers, 2008). The interviews were guided by an interview questionnaire in English or Hebrew (see Appendix B) designed in advance to examine the experiences of the 12 participants, their thoughts, feelings, perceptions, and meaning making as relational therapists. The interview questionnaire aimed to elicit a more synchronic report, moving in a logical sequence from the beginning asking about general experience as a relational therapist treating trauma and later about the specific risks and protective factors while treating trauma and self-care methods (Weiss, 1994). Ten interviews were conducted in the English language, and two interviews were conducted in Hebrew. All interviews were audio-recorded, and 11 were video-recorded via Zoom. Each interview lasted between 60 and 90 minutes.

**Phase II: Online Survey for Member Checking**
An online survey designed by Qualtrics (see Appendix C) was sent to participants to gather their interpretations and feedback of results from the first phase of interviews. The method of returning the data to participants is known as member checking and is used to validate, verify, or assess the trustworthiness of qualitative results (Doyle, 2007). The goal was for participants to validate the main ideas generated from interviews. The survey asked participants to provide their feedback (thoughts, impressions, perceptions, etc.) about the themes generated from the interviews. All participants agreed to receive the survey via email; therefore, the survey was responded to them, and they gave feedback on each theme as a written open and descriptive answer.

**Human Subjects’ Protection**

An Institutional Review Board (IRB) application was submitted to the Tulane IRB and initial approval was received on November 15, 2019 (see Appendix D). An amendment was submitted later and was approved on January 30, 2020 (see Appendix E). The participants received a consent script to read before the interview (see Appendix F), which informed the participants before the interview about the study’s details and informed them that they can leave or stop the interview at any time, and they do not have to answer all questions. The risks that were possible in this research included distress, discomfort, or inconvenience while talking about the effects of treating trauma. However, there was no psychological risk, mainly since all participants were experienced trauma therapists aware of their mental health state, and the researcher is a therapist who could pay attention to distress. At the end of each interview, participants were asked about their mental state. All participants reported feeling good, and some of them reported feeling
better after processing these issues. Further, there was no risk of loss of privacy for the subjects because all data were stored securely per IRB regulations.

Data Analysis

The interviews were conducted through Zoom and were audio and video recorded. They were then transcribed using a transcribing computer application and the researcher, when the researcher listened to the audio recordings and tracked the transcriptions to fix mistakes and make sure the transcripts were accurate. Data analysis was done according to IPA while using the six steps presented by Smith et al. (2009):

Step 1: Initial and Rereading of the Transcript

The initial reading included listening to the audio recordings and reading the transcripts while mainly fixing mistakes in the transcripts and taking notes. This approach of listening to the audio while reading the transcript is important to ensure the participants are the focus of the analysis (Smith et al., 2009). The initial reading was rigorous and critical, while actively engaging with the data. Repeated reading allowed for deeper understating of the interviews and allowed the researcher to understand certain sections of the interviews while taking notes, as will be described in the following step. In fact, Steps 1 and 2 merged in practice.

Step 2: Initial Noting

This step included initial analysis of the data, which was the most detailed and time consuming, while writing initial themes in a systematic way. The researcher noted everything of interest in the transcripts on an exploratory level. The detailed noting allowed for a familiarity with the transcripts and for the researcher to start learning participant’s experiences. This analysis was phenomenological and descriptive but also
interpretative, and balanced the two aspects (Smith et al., 2009). Therefore, the initial noting included descriptive comments, staying close to participants’ explicit meaning. Alongside the noting, interpretive comments included linguistic meaning, context of the participants’ experiences, and abstract concepts. This step involves the investigator engaging in an interpretative relationship with the transcripts (Smith & Osborn, 2007). The initial notes and comments were written on hard copies of the printed transcripts, marking important quotes and sentences.

**Step 3: Developing Emergent Themes**

In this step, the main task was reducing the volume of details while maintaining complexity by analyzing the exploratory comments and turning them into emerging themes. The purpose of this step was to turn in the notes into themes to produce concise statements of what was important in the comments attached to each portion of transcript. Themes are usually expressed with phrases that refer to the psychological essence of the data, which can be grounded but also abstract (Smith et al., 2009). In practice, this step was merged with Step 4 when the development of emerging themes was done together with mapping and searching for connections across themes.

**Step 4: Searching for Connections Across Emergent Themes**

This step included charting the themes, re-organizing the order of themes, and deciding which themes to keep and which to discard. This search for connection was made by following several principles such as: abstraction to identify concepts; polarizations (e.g., risk vs. protective factors); contextualization (e.g., the narrative of relational therapists’ definitions of trauma); numeration; and the frequency of themes. Overall, organizing the themes involved breaking up the flow of the interview by re-
organizing the data (Smith et al., 2009). In this step, the investigator organized the themes in a table with categories and illustrated quotations for some of the themes. The order of themes was not necessarily chronological, but rather conveyed the essence of the analysis. The investigator created 12 files, a file for each interview, named “emerging themes.” The tables included two columns and few rows; in the right column there were the emerging themes, divided into intuitive categories in each row; in the left column there were quotes and page numbers for each quote.

**Step 5: Moving to the Next Case**

All the steps above were repeated for each interview transcripts. This process included bracketing the ideas emerging from the first interview while analyzing the second interview and in keeping with IPA’s idiographic commitment (Smith et al., 2009), meaning, the investigator was influenced by the findings from previous interviews while allowing new themes to emerge with every interview, until finishing 12 interviews.

**Step 6: Looking for Patterns across Cases**

This creative process included thinking about connections between themes, which themes to highlight, and which were most potent, which sometimes led to relabeling of themes. This step included presenting the results in a master table of themes (see Table 2) for the whole sample, showing how sub-themes were nested within themes and categories. Since the sample in this study was relatively high for IPA, the analysis of each case could not be detailed; therefore, the main analysis included a search for patterns and connections. Further, the analysis included measuring recurrence across cases, which is also included in the master table of themes (Smith et al., 2009). Finally, the findings, presented in Chapter 4, were written in a narrative, comprehensible, and systematic way.
The analysis in the results section report on the emerging themes will include illustrative quotes and will represent a dialogue between the participants and researcher by interweaving between analytic interpretations and direct quotes.

The second phase of data analysis included pulling the results from the Qualtrics survey and organizing them in a table. This analysis mainly included exploring how many participants agreed to each theme and if there were significant suggestions from the participants about the generated themes.

**Issues of Trustworthiness**

Qualitative researchers should assess the quality of the study. Therefore, the researcher should address issues of trustworthiness and biases during the processes of collecting and analyzing data. According to Guba and Lincoln (2008), the four criteria to evaluate the quality of a study and trustworthiness are: credibility and validity, transferability, dependability and reliability, and confirmability.

Trustworthiness of a study can be reached in different ways and depends on the paradigmatic position of the study. The methodological criteria for trustworthiness in constructionist and interpretivist paradigmatic positions include interpretive validity, which involves asking how valid the data analysis and interpretation of this analysis were. This includes embracing the authenticity, subjectivity, and reflexivity of the researcher, as well as understanding participants’ constructions of meaning, including context, culture, and rapport (Morrow, 2005).

Therefore, to enhance the validity of this study, the methodology required relatively prolonged engagement with participants during the in-depth interviews. Most of them lasted for around 90 minutes. Moreover, the interview questions were open-
ended and flexible, which allowed the researcher to gain trust with participants, allowing them to feel comfortable to disclose information, and letting the researcher learn about the context of their work and rise above preconceptions (Morrow, 2005). Developing a sensitivity to the context is an important criterion in IPA research. The researcher develops a sensitivity to context through close engagement with the unique personal experiences of participants. It also includes the interactional nature of connection during the interview, which requires interview skills and a high level of awareness of the interview process (Smith et al., 2009). The researcher was able to conduct engaged, in-depth interviews because the researcher is a skilled therapist herself. Her interviewing skills required a sense of responsibility, caution, and reflexivity, not confusion between being a therapist and a researcher (Morrow, 2005).

The researcher asked for feedback from participants about the interview process. Indeed, all the interviewees mentioned at the end of the interview that they felt engaged and comfortable, and some even said it was “a relational interview.” Another quality criterion in IPA studies demonstrating a sensitivity to the raw data and using a considerable number of quotes from the participants to support the argument. The use of authentic quotes gave greater voice to participants and allowed the reader to cross check the interpretations to the participants’ experiences (Smith et al., 2009). The findings in Chapter 4 included a fair number of direct quotes, which reflect the context and authentic voices of participants.

An important aspect of validity in this study was addressed in the member-checking method used in the second phase of the study. The member checking method was used to test the analytic categories and themes and interpretations and conclusions of
results with the participants (Doyle, 2007). This testing gave participants an opportunity to correct errors and challenge researcher interpretations or add additional information. Further, this helped assess adequacy of results as well as confirm specific ideas generated from the data. Another validity factor is the sample of participants, which included relational therapists from all around the world, reflecting a triangulation of sources, which enabled comparison between people with different viewpoints and cultures (Guba & Lincoln, 2008).

The criterion of dependability and reliability refers to the idea that the results of the study are consistent and can be repeated. The ability to replicate results in qualitative research and specifically in an IPA study, which holds an interpretative perspective, is limited. The interpretative perspective sees the co-construction of reality when there is no fixed truth of reality; therefore, two people can interpret reality differently (Guba & Lincoln, 2008). In this study, the researcher applied inter-rater reliability for the interview coding, questionnaire, and quotes, for checking the reliability of translation from English to Hebrew and vice versa. Additionally, the researcher conducted a rigorous process of analysis and documented all processes and stages of coding and data analysis.

The criterion of confirmability refers to the neutrality of the researcher, how the results are impacted by the participants or by the researcher biases, or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Guba & Lincoln, 2008). Because the position of the researcher in the IPA method inherently includes subjectivity, the appropriate technique to maintain confirmability in this study is through reflexivity. To greater enhance transparency, the process of reflexivity (i.e., an awareness of past experiences of the researcher that
influences data interpretations) and the use of a detailed writing of preconceptions, methodological rationale, and theoretical interpretation of the data was documented in the study notes. Any contradictions in the data were presented, where applicable, to present an unbiased and valid exploration of the lived experience of relational therapists treating trauma and the sense of their experiences (Smith et al., 2009).

This chapter presented the methods that were applied to investigate relational therapists and the rationale for choosing these methods. In addition, it presented the research procedure, the sample and sampling process, and the process of analyzing the data. Next, Chapter 4 will focus on the outcomes after analyzing the data and will report the findings, including describing and explaining the master table of themes. It will detail the data generated from the interviews and survey along with direct and relevant quotes from different participants.
CHAPTER 4: RESULTS

This chapter reviews findings discovered from both the interviews and surveys. The interview findings emerged from a rigorous analysis which revealed six main categories, which are mapped and elaborated on the Master Table of Themes (see Table 2). The categories include: 1. Working with trauma; 2. Relational therapy; 3. Empathy; 4. Trauma treatment effects; 5. Risk and protective factors; 6. Self-care. Each category in the table contains themes, with each theme including subthemes. One category included three subcategories. The results below are presented in a descriptive, informative approach, and include raw quotes from participants’ interview transcriptions. The quotes were chosen according to their relevance, description of the theme or subtheme, as well due to the powerful and strong impact on the researcher. The survey results are presented in a Table (see Table 3) and include the themes and how many participants agreed, partially agreed, or disagreed with each theme presented to them and any significant suggestions that emerged from their feedback.

Category 1: Working with Trauma

This category focuses on the professional perceptions of relational therapists of trauma treatment. This includes how they define psychological traumas, the types of trauma their patients have experienced, the reactions to trauma they have seen, and the needs of their trauma survivor patients.

Theme 1: The Broad Definition of Trauma

More than half of the participants indicated in one way or another their broad definition of trauma. Many of them referred to the diagnosis of PTSD, complex trauma, or CPTSD; some also specifically referred to dissociative disorders. Participants also
mentioned the wider cycle of trauma, such as family trauma, collective trauma, the transmission of trauma, secondary trauma, and witnessing trauma. Some of them also mentioned that trauma can be continuous or cumulative. Two participants mentioned that all patients and therapists have experienced trauma, some more significant some less.

Participant #6 said:

Every one of us, me included, has traumatized zones area of the mind . . . officially complex trauma clients these areas are more evident . . . I detect some kind of neglect, emotional neglect, in almost every kind of client, yes, complex trauma client, the neglect is huge.

Participant #8 said:

I think the issue of trauma is huge . . . I feel like we are all traumatized in some ways at different levels. Some psychic, some is somatic, some cognitive. So, there are a lot of levels of trauma, a lot of types of traumas.

One participant also referred to the context of trauma and to the historical and sociological background of trauma. The participant explained about the development of trauma definitions and trauma studies over the years; the denial of trauma in the past and the acknowledgment of trauma during the years. These contexts include The Civil Rights Movement, Women’s Rights Movements, as well as feminist movements and protests against the Vietnam war. These movements helped to acknowledge traumas and supported the relational turn in trauma treatment. Participant #2 described:

If it hadn't been for Civil Rights revolution, I think, you know, this was the foundation, yes, historical, sociological foundation because once was the beginning of a change in law and, and practice with regard to black people with
regards to African Americans, then this gave legitimacy to women's movement. But you can imagine how terrible it was . . . Yes. It was unbelievable. Anyway, it's in that context that abuse, the reality of sexual abuse was being reported more and more. I don't think it was reported more in therapy because it's always been the same . . . It's that slowly therapists starting to take their patients seriously. And believe them instead of trying to interpret in this crazy, you know, psychoanalytic way.

Theme 2: Types of Trauma

Here, the participants discuss types of traumas their patients have experienced, which reflect the broad definition of trauma, as well. Almost all participants – eleven in total – spoke about sexual trauma in different words (e.g., sexual abuse; rape; group rape; childhood sexual abuse; trafficking; incest). Ten participants indicated treating early childhood trauma (e.g., child neglect; child abuse; emotional and physical abuse, attachment issues). Six participants mentioned violence, such as physical assault or domestic violence. Four mentioned other types of trauma: war terror trauma; health trauma; poverty; drug and alcohol use; addiction; politically motivated trauma or torture; loss and death; victims of crime; immigration trauma; bushfires, etc.

Theme 3: Psychological Reactions to Trauma

During the interviews, participants talked about the reactions to trauma among their patients. Five participants mentioned different symptoms from PTSD clusters: intrusive, avoidance or arousal, feelings of horror, fear, anxiety, shock, and helplessness. Four participants mentioned the spectrum of dissociation, from normal to pathological dissociation and multiple self-sates. Three participants specified body symptoms such as
somatic symptoms, self-harm, and suicidal ideation. Three participants referred to the idea that trauma causes the destruction of agency, denial of mind, and breaks the senses of humans. Participant #2 described it in his words:

The real trouble of trauma is the destruction of agency. It's not just some terrible event that happened to you. It's the destruction of the mind. . . especially in sexual abuse where you have the denial of reality. It's a denial of the mind. And it's a destruction of agency because you don't know who did what, you don't know who wanted what you're lost in your mind.

Other participants mentioned different reactions, such as split and fragmentation, shame and guilt, the development of triggers, distortion of relationships, and sense of betrayal.

**Theme 4: Trauma Survivors’ Needs**

Five participants emphasized that traumatized patients, especially those who suffer from complex trauma and have been traumatized in the context of relationships, are looking for real and authentic relationships in therapy. Further, they explained that those patients are more vulnerable and develop high sensitivity in relationships, and therefore detect falseness and dishonesty very quickly. Participant #4 said: “They [trauma survivors] want you to be someone that can trust, a real person who actually walks the walk, doesn't just talk the talk.” Participant #7 added that these patients also need high devotion from their therapist. Three participants mentioned that it is important to work with traumatized patients on their hidden parts and aggression to teach them how they impact others. This protects them from being unaware of the damage they cause in their outside relationships. Two participants emphasized is the importance of letting traumatized patients process the trauma, but doing it sensitively and softly by giving them
freedom to talk about the trauma at their own pace. Others also mentioned the importance of working with the body and keeping clear boundaries.

**Category 2: Relational Therapy**

This category focuses on how participants perceived relational therapy as relational therapists. Participants referred to the relational turn in psychoanalysis and to the development and background of relational therapy. Thus, this category mainly includes their perceptions about the therapeutic position of relational therapists, the dynamics and frameworks of relational therapy, and also why they choose to work with this approach.

**Theme 1: The Relational Turn**

Nine participants indicated in one way or another the relational turn in psychoanalysis when discussing their therapeutic approach and becoming a relational therapist. Six referred to the comparison between classical psychoanalysis and relational psychoanalysis. They described classic psychoanalysis as passive, hard to engage, acting safe, strict, structured, rigid, resistant, and very cerebral as opposed to relational psychoanalysis, which they described as flexible and powerful. They added that the use of the self is engaging and porous and it works with the body as well. Participant #9, who was trained in classic psychoanalysis and now is more relational, described: “When I was young and started to study, trained as a psychoanalytic psychotherapist . . . And, you know, this structure, the strictness, the rigidity, around place the frame.” Further, the classic ideas of frame and setting are strict, as participant #9 continued: “I still think the frame is important, but I'm much more flexible now.”
Three participants focused on the relational turn as mainly turning the focus of therapy from drives to relationships. Four participants referred to the turn from one-person psychology to two-persons psychology, meaning the therapist is not in a neutral position anymore, and both the patient and therapist are subjects. Participant #1 explained:

I think the relational theories in this perspective is more focused in their relationship in the story, in the relational world, I mean, the relationships more than drives . . . So the therapist began to have a very important role, and not just a mirror . . . the neutrality of the therapist, changed a little bit in this approach, because you know, that you're, you're going to be involved.

Participant #8 said: “They understood that it's more than one in the room okay. It's a psychology of two people.”

Five participants referred to the relational turn and the trauma turn as related. Participant #2 described: “There's a very close relationship between what you're calling the relational turn and the recognition of trauma and the reality of trauma. The two are together.” Participant #10 added, “Actually, I credit the relational school with bringing together the best of the trauma world and the best of the analytic world.”

These parallel turns specifically refer to the change in perspective about psychological symptoms and distress as happening because of traumatic event, such as sexual abuse, versus drives or oedipal wishes. Participant #2 described:

There was not this understanding that there is today about sexual abuse. There was an old traditional psychoanalytic understanding you know, maybe there was abuse but the real problem was oedipal longings and oedipal wishes . . . slowly,
therapists starting started to take their patients seriously, and believe them instead of trying to interpret in this crazy, you know, psychoanalytic way . . . Something happened in the reality that changed the mind, and not the mind changed reality Therefore, according to participants, because trauma happens in relationships, the healing is in relationships as well.

**Theme 2: The Relational Therapist’s Position**

All participants, as relational therapists, discussed the centrality of therapeutic relationships. Nine participants specified it literally when asked about the relational approach and talked about the treatment focus in the relationship, meaning they work both *in* and *with* the relationships. Further, the relationships should be accessible and secure, and the witnessing of trauma happens in the relationships. Participant #12 described the working in relationship as:

being two people in the room and using our relationship and what happens between us as a way of understanding how they operate in their world. How the patient operates, what functions how they communicate and, in their relationships, and, you know, building a strong bond together. So that there, there is a level of safety at being able to go places that they wouldn't be able to go to if they didn't feel secure in in the relationship between us.

Participant #9 described her view:

I used to think that psychoanalysis was to be all and end all it was the best thing in the world. And now I don't think psychoanalysis I think, I think relationships matter, relationships, and it's about the availability of one person for another.
That's what seems to me to be critical. And I don't think the theoretical persuasion matters. I think the people matter.

The majority of participants described the main characteristic of the therapist’s position in the relational approach as focused on the use of the self and subjectivity. Participants used different concepts and terms that overlapped. Each term described the in-depth idea of the use of the self. The majority of participants described the therapist position as being open, authentic, transparent, spontaneous, honest, using self-disclosure, and maintaining equal relationships. Participant #4 explained:

Is the idea of being an authentic person, as a therapist, not just being kind of a blank face kind of therapist but being authentic, being yourself being open; being spontaneous. And also sometimes doing self-disclosure when it’s appropriate. The therapist is a real person and interacting with a client, not so much in a hierarchy, but in a more egalitarian way.

Further, many participants also described the relational therapist’s position including involvement, active participation, and sense of partnerships in therapy. Participant #1 said: “You're going to be involved, your feelings are going to be there, your story is going to be there, your training is going to be there.”

They also described that the therapist should allow themself to be human and can be touched, moved, cry, feel feelings and sensations that arise, and is present in the here and now in therapy. Participant #8 described:

I am letting my feelings be present and allowing them and not being ashamed or afraid. Yeah or something like this it usually works. That’s why I love relational
psychoanalysis and psychotherapy because yes, it allows you to feel free to feel with them, okay.

Three other participants emphasized that the use of the self position included when the therapist borrows their psychological internal parts and works with their own traumatized parts as a way to understanding the pain of others through their own pain. Participant #6 described it as: “To build bridges from our trauma zones, to our clients trauma zones. So without a clear awareness of our trauma zones, we are not able to help our so-called traumatized clients.”

Four participants described the relational therapist holding a somatic approach, by viewing the physical body as a tool because trauma happens also to the body. They described the therapeutic work also as “two bodies psychotherapy.” Participant #10 explained:

I’m trying to have their body and their mind speak together, and not just for my relationship with the mind. So maybe that’s another distinction. I think of relational work, because we're not emphasizing the realm of fantasy. . . . It's not just a construction of the unconscious in the mind, you know? Yeah. So I'll ask about the body I'll notice the body.

Two participants mentioned the importance of being a reflexive therapist, being aware of power dynamics, using self-disclosure with responsibility, and acknowledging gender and other differences. The same two participants emphasized the importance of the perception that the knowledge resides in the patient and therapists should emphasize the capacity of patients to heal themselves. One participant also emphasized the importance of doing an ongoing therapeutic contract in the therapeutic process.
Theme 3: Relational Dynamics and Frameworks

Participants referred to certain dynamics and frameworks while working relationally. Half of the participants emphasized the dynamic of transference-countertransference, dissociation, and self-states. Four participants mentioned focusing on enactment and reciprocal mutuality. Two participants mentioned the co-construction and the idea of agency, and one mentioned attachment. Participant #2 described these dynamics as happening in the deep process: “but in the process is something deeply emotional goes on. Yeah, we call that transfer. Some countertransference. Yes, or we call that projective identification, or we call that reciprocal mutual influence.” Participant #9 mentioned: “I still work very much in the relationship with transference and countertransference, but I think I approach it differently.”

Participants referred to working with dissociation, enactment, and self-states specifically regarding trauma work. Participant #4 described enactment, dissociation, and self-states:

The concept of enactment, especially in trauma . . . So you’re just kind of looking at the enactment and has it presents some issues both on the service side and on the patient side. Since we talk about working on trauma, dissociation is a big deal. And . . . self-states, that the self is not a cohesive, that different, different parts, different self-states, and it's fluid and it's changing, and it's not something that solid.

Theme 4: Choosing to Work Relationally

Participants were asked how they became interested in the relational approach. Four participants referred to working relationally intuitively and only after discovering it
in theory, meaning they were practicing this approach prior to learning about the theory. As participant #2 described: “Some of the classical institutes in the U.S., people will say to us, you know, I've been practicing this way all along, but I didn't have a theory for it.” Five participants referred to the relational approach as convincing, effective, contemporary, and relevant for all types of relationships. It is also useful for CPTSD patients, dissociation, and overall a strong and powerful therapy, especially compared to other methods (e.g., CBT, classic theory, etc.). Participant #5 explained why it was not enough working with the regular psychodynamic approach:

> When I started to work more dynamically, to tell the trauma story and work on split, work on memory, but still patients had symptoms . . . I felt I was fooling myself that I’m a trauma therapist because I felt nothing is penetrating the patient . . . not changing the internal structures . . . there is no sense of healing.

Three participants explained that the relational approach suits their personality, like participant #11, who said: “I don't know fully if I really consciously chose that approach. I think it fits. It fits with, with me much, much better than other methods.”

Four participants indicated that they chose working with this approach for personal reason; two of them indicated that practicing is a therapy for them and the motivation to be relational therapist was their own trauma and personal background.

Two other participants indicated that they became interested in this approach as patients and grew from it, or they were drawn to it from having relational supervisors. Participant #6 talked about curiosity as a factor for choosing this approach, and participant #10 chose this approach because it is not a symptom-focused approach.

**Category 3: Empathy**
This category includes the perceptions and experiences of relational therapists regarding empathy and the empathic response in the relational approach. The main theme includes the empathy and the use of the self. The other two themes include specifically the perception of the participants about the role of feelings and the role of the mind in the relational empathic response.

**Theme 1: Empathy and Use of The Self**

This theme has many subthemes that overlap with the previous subtheme, Use of The Self and Intersubjectivity. However, it is important to present this here to show that when participants were being asked about empathy in the relational approach, they specifically indicated the use of the self as inherently part of the empathic response of relational therapists.

Six participants talked about empathy as involvement and connectedness. Participant #6 described the meaning of empathy and:

I think that empathy in relational terms . . . So it's more like if a client is stroppy if a client is angry with me, my empathy is not that I am able to feel the anger in the client, my empathy is that I experienced the blow of her anger. And so I have a very strong perception just because she's angry with me. So I feel her anger in a more direct way. And not just because I'm a subject who is able to understand, but because *I am involved in her anger* [emphasis added].

Participation is a similar concept. Five participants used the concept of empathy to actively participate with the emotional and physical experiences of patients. Participant #5 described her experience: “This is where you succeed to feel what happens inside the patient, within me, this is even stronger feeling from the word empathy, it is a
participation in the deepest physical and emotional experience.” However, Participant #2 indicated that empathy in the relational aspect is not necessarily participation:

I think it's a mistake to relate relational with being, you know, being participatory, which is a matter of style. It's because everybody has to listen. And I think if you're a classical you also are, you know, being pulled in. And, and you are, you know, your mind is being constructed by the patient, whether you acknowledge it or not.

Similarly, four participants defined empathy as intense relationships, interactions, and mutuality.

Five participants referred to authenticity as an important part of empathy. As in the previous category, authenticity includes being a real person, being honest and transparent, developing trust, and being free to express yourself, as opposed to being in a classical interpretive position. Participant #7 explained: “When the therapist’s reaction is authentic it gets relevant emotion and real emotion, and that’s empathy.” Participant #4 even explained that sometimes being empathic is being authentic in moments when you feel negative feelings:

There's more freedom for the therapist to experience and even express his states of mind. And sometimes I can be angry and sometimes I can be frustrated. And sometimes there are limits to my empathy. So empathy is part of being a therapist, but you don't have this pressure to always be empathic and only be empathic. You can be a real person.
Five participants indicated that an essential part of being empathic is engaging in the patient’s deepest painful places, including dissociation, which necessarily causes pain and has a deep impact on the therapist. Participant #6 described the process:

My clients taught me a lot about becoming more empathetic year after year. I had to enlarge and also break my heart, thanks to them. It's like giving birth to a baby; a huge pain, which year after year has made my heart a little bit more open. And only in this way I felt I was becoming empathic.

Four participants viewed empathy as containment, or the ability to absorb and be a vessel or container. Participant #8 described: “[Empathy] is me having the capacity to perceive, understand, to get to receive, to hold to contain. So, all these all these things that being able to go there with them, being able to understand what they feel.” Four participants referred to empathy as self-disclosure and the active use of the self and being open. Participant #7 shared her experience from supervision:

Many times, when you think about relational therapists, people say ‘self-disclosure.’ But I have learned something very meaningful from my supervisor that I need to understand: we are always in a position of self-disclosure when we are being ourselves.

One participant described empathy as the verb of witnessing:

Like empathy is the verb of for witnessing. Right? That’s what I mean. Okay? There might be pointed moments where you actually say something like, wow, that happened to you. And then it's like a verbal recognition of witnessing, but like this, the empathy needed exists in the verbal space, it can be an unconscious,
like just making yourself available to feel and participate and partake in the environment the patient creates, is itself a kind of witnessing.

This participant expands the empathy concept by viewing it as witnessing and recognition, consciously and unconsciously.

**Theme 2: The Role of Feelings and Emotions in Empathy**

One of the dominant issues of empathy in relational therapy was the role of feelings and emotions. Participants indicated that empathy is feeling and experiencing the patients’ feelings as well as holding and registering feelings. Participate #6 described empathy in relational terms: “So I think that in relational terms, empathy is a more engaged notion. Yes. It's not just oh, I can understand you, I can feel you. Yeah. It's more painful.” Participant #12 simply stated: “Empathy is just feeling for another person. Putting yourself in their shoes.”

Participant #1 indicated that empathy also includes emotional moments, which can be a combination of feelings, negative and positive, verbal and not verbal. Participant #1 said:

Also, other feelings, right? It's not necessary. I mean other moments and they're not quite empathic, I would say I mean, you can feel rejection for example, you can feel there, you know, strong feelings also. Um, but yes, I will say that yeah, that's those emotional connections I will definitely understand that as empathic to.

Two participants emphasized that empathy is about feelings and less cognitions or intellectual consideration. They believed that empathy is rather a more basic instinctual or emotional response versus a Logical or interpretive response. Participant #6 described his empathic response: “My response is more and first, a basic animal emotional
response.” Another two participants explained that empathy happens when patients feel free and safe to talk when the therapist lets them be themselves and helps them reduce shame.

**Theme 3: The Role of the Mind in Empathy**

Not many participants referred to the role of the mind in empathy. Two participants indicated the process of two minds in therapy of co-constructions and shared thinking. Two participants described empathy as understanding the trauma, analyzing the trauma, how unbelievable the trauma is, and where traumatized patients are coming from. Two participants talked about curiosity and desire to know as empathy. Participant #9 said: “Curiosity is another word that I attach to empathy. I think being curious about another person is fundamental to empathy.” One participant talked about steady dialogue as empathy.

**Category 4: Trauma Treatment Effects**

This category focuses on the experiences of relational therapists treating trauma with a relational approach. The first subcategory includes the negative effects participants experienced and presents the wide range of negative reactions that are under the compassion fatigue theme. The other three themes include the negative effects specifically on feelings, the body, and the mind. The second subcategory includes the positive effects participants experienced, including the experiences of compassion, satisfaction, and personal growth. The third subcategory includes the mechanism of compassion fatigue, the different ways participants described their dialectical experiences, and the mechanism of resilience despite its negative effects.

**Subcategory: Negative Effects**
**Theme 1: Compassion Fatigue Reactions**

Participants mentioned different symptoms that reflect compassion fatigue. More than half reported they feel exhaustion, tiredness, energy loss, drained, bored, or sleepy. These terms reflect the fatigue of relational therapists while treating trauma emotionally and physically. Participant #6 shared: “And I don't have these energies, so it's a very specific sense of, if I can do that I need a kind of amount of energies, but I cannot find those energies anymore within me.” Six participants also described a kind of heaviness and burden, using the words like “weighed down,” “awful,” and “seriousness.”

Participant #5 described how she became a less ‘light’ person:

> I have become a less light person, I always need to monitor myself, my honesty, when I’m not precise all the time. . . . Part of the idea of being in close relationships is that it is ok not to be in control all the time in, not being empathic, not feel like listening.

Half of the participants indicated that the relational therapist position of bearing witness, which emphasizes the use of self, is hard and painful, and sometimes the therapist needs a witness. Participant #9 said: “Because I think from a relational perspective, position, we are in a position of bearing witness. And that's also for you – it's intense.” Five participants reported they feel estranged and distanced from people or not present in social situations. Some even said they feel loneliness because they feel they are speaking a different language than others. Participant #4 shared her experience with her husband:

> A lot of times I felt that it was kind of an estrangement from my husband, let's say because it wasn't something he could relate to. So, I felt like he couldn't
understand me. It really kind of distance us from each other. That was something that I was involved in and thinking about all the time.

Five participants talked about the difficulty of listening; that they reached a capacity of hearing about trauma and listening to people all day. Participant #4 shared: “I have experienced from time to time that I don't want to hear about trauma anymore. I don't want to know about child sexual abuse or any abuse; I've had enough.” Three participants also added that during “compassion fatigue times,” they even considered stopping practicing. When self-resources started to deplete, they had no desire to go to work or hoped patients would not arrive. Participant #6 shared: “But I cannot find those energies anymore within me. I was hoping that people will not call me. People drop.”

Five participants described the need to recover, relax, disconnect, take a shower and release the energy, escape, to be alone. Participant #10 described:

I'm not so great at realizing when I need to take a vacation. So sometimes, if I haven't had a vacation in a while or time off, I'll feel that in the work, and I'll feel it when I come home. Like if someone contacts me about scheduling or something. I'll be late. I'll feel like please, I like my sacred space.

Three participants mentioned the cumulative factor of feeling burned-out when the work is emotionally taxing. Two participants said compassion fatigue is part of the work, while one participant said they feel inherently vulnerable and another mentioned the need to drink glass of wine every night.

**Theme 2: Effects on Feelings and Emotions**

Almost all participants indicated at least one negative effect on their emotions or feelings. Participants described negative feelings and emotions; six of them described
sadness when hearing about trauma, for example, Participant #2 said: “it's also very sad to hear the terrible things that happened in the world, is very sad”. Participant #5 described anxiety, fear, and stress. Participant #9 described health anxiety: “My patient who got the diagnosis of ovarian cancer, I start imagining I'm going to get cancer . . . like anxiety that it will happen to you. Yeah, it's like it's contagious.” Two participants, parents of young children, also talked about being more anxious and protective of their children and having higher awareness of child abuse. Participant #11 shared:

I guess maybe I have become a little bit more anxious or protective of our children when they go and be with a neighbor. I wouldn't let them walk the dogs, cannot be with strangers, and being really aware of who are the adults around.

Four participants feelings of anger, frustration, and arousal. Participant #10 shared that it happens especially with suicidal patients: “With the suicidal patients, your mind is going, you know, it's, it's worrying. . . . And it shows up as like a shorter fuse at home, more agitated or irritable. I have trouble just relaxing into playing on the floor.” Four participants mentioned feeling self-aggravation, guilt and worry that patients will drop when they become angry, especially CPTSD, suicidal, or self-abuse patients. Participant #9 described: “I mean, the word that came into my head was I often feel guilty like I haven't done enough.”

Four people indicated feelings of helplessness, especially regarding treating trauma, like Participant #4 described: “Sometimes I feel lost. I feel like I don't know what to say or what to do, like helplessness . . . but it's like not knowing how to respond to some something somebody tells me.” Three participants described they feel emotional pain, agony or hurt. Participant #6 said: “I lost many, many night's sleep because of the
pain of the anxiety and of the anguish of my clients.” Another three participants said they felt depression or despondent. Participant #6 described the price: “So the price that I paid was not sleeping, being enraged, being afraid, being sad, being despondent.”

Two described feeling traumatized and another two described less emotional availability and tolerance for family members. Like participant #11 shared:

It has an impact around emotional availability for my family. So when I'm very stressed and two small children, small children that got my attention is sometimes difficult. Yes, I'd sometimes have a disagreement with my wife as well.

**Theme 3: Effects on the Body**

More than half of the participants reported negative effects on the body. The majority of nine participants referred to being exhausted, tired, drained, or sleepy; similar to the previous theme about emotional effects, but here it is affecting the physical body. Participant #12 said: “I think I'm tired. I think I'm you know, I get tired often, I'm, like emotional tiredness or physical.” Four participants reported experiencing body pain and body fatigue. Participant #6 said: “My body told me ‘Stop it, you cannot do that anymore.’” Three reported on psychosomatic reactions; Participant #8 described her stomach problems: “My stomach would not metabolize anything. Okay, it was because it was my body was telling me that I cannot metabolize that much information.” Two participants reported developing illness, such as cancer. Others reported heavy breathing, chest contractions, sleeping problems, tension in the body, and dizziness.

**Theme 4: Effects on the Mind**

More than half of the participants also reported some effects on the mind. Six participants reported being overwhelmed, speechless, could not believe what they were
hearing, as well as difficult to grasp the content and realizing the cruelty of people. Participant #2 talked about the unimaginable aspect of trauma: "Crazy people out there, some of them have to be people's parents or relatives or who knows what, and it's terrible what happens people sometimes there are real monsters and, and it's hard to imagine how." Other participants indicated different effects such as concern about patient’s life and their experiences, being bothered when patients don’t return, thinking a lot about the session (reflection), worrying, thinking or dreaming about patients (especially when patients die), and even having flashbacks or unwanted memories.

**Subcategory: Positive Effects**

**Theme 5: Compassion Satisfaction**

Most participants indicated in one way or another about compassion satisfaction experiences. Ten participants referred to the terms: satisfaction, fulfilling and rewarding regarding treating trauma and relational therapy. Participant #4 referred to relational therapy as even more fulfilling:

You can be a therapist in different kinds of methods and to see the change that the person do and that can be fulfilling. But when you're in the relational position, you're part of this so you're not just using your theory or your technique. Yes, you're not outside of it. You're in it.

Seven participants talk about the satisfaction specifically from helping to make the change and see the change in patients’ lives. Participant #2 shared:

It's a wonderful experience to be able to give a safe place for people to be able to talk about things that happened to them in their lives and in their minds. And to make it something that they can and put words to and feel some agency in their
minds . . . she (the patient) can see what happened to her and how it affected her.

It's, it's a gift.

Half of the participants indicated that as relational therapists, the relationships with patients is nurturing. They feel real connection, they are being authentic, engaging, feel love, involvement, and devotion. Participant #6 described:

It's a really nurturing situation. I mean, I have relationships with my clients, so they give me a lot. It's not like a blank screen. I take a lot of energies, emotional energies from them, even if it's hard. The whole balance. I feel it's healthy to me.

Mm hmm. Because I also I feel I have their affection their love.

Seven participants talked about how remarkable is to see patient’s resilience despite trauma, as having a sense of awe and honor to patients as well as it is inspiring to witness patients’ courage, taking risk and willing to share/trust and the marvel human spirit. Participant #3 explained:

I think that keeps me going to is that when I see that, despite all the brutality some of these people have experienced, that they can still be that resilient is remarkable, right? That they can You know, even I mean, and most of the people even the most damaged. . . . Like you can see them like their beauty and they still have moments of like joy and resiliency and courage.

Another two participants indicated that the mutual growth and mutual recognition from the relational perspective, is very satisfied and even participant #10 said that compassion satisfaction affirms the relational approach:

It feels like it affirms the relational approach. Because when you have that compassion satisfaction, like what we're really saying is like the subjectivity of a
human being who cares and is trying to make meaning with you can change a life or can change lives. Yes that So, in a way it affirms that relational approach, like you know, what I mean, like a compassion satisfaction, a part of it really is like, this is healing or this is mutative if you know what because then it also affirms yourself, right, like your subjectivity has something to, to offer others. And so that comes with satisfaction.

**Theme 6: Personal Growth**

All participants in one way or another expressed the experience of personal growth. More than half talked about transformation as result of being therapists and especially when working relationally. Participant #8 feels she is building a new self of her: “In this process of me becoming a therapist, I felt that because of trauma and relationality I was reborn. . . . Like me being becoming something I'm in the process of becoming the building a new me.” Similar to transformation, four participants indicated the experience of growing as persons and becoming better persons. Participant #4:

I think in some ways also changed me as a person that I became maybe more comfortable with being who I am with being with being myself. So even when I teach students, I think I'm probably more myself than a lot of other professionals.

Four participants talked about getting this work as an opportunity or a gift. Participant #3 said:

I feel very privileged to do this, I feel very, I can close the door and people tell you these things that they haven't told other people or, you know, and you're given an opportunity to really share their experience with them.
Three participants said this work expanded their ability to contain and being more tolerant, Participant #7 explained: “. . . very satisfied parts; opportunity to seriously expand the container to deal with difficult life stories that arouse strong feelings, it is a strong experience to learn you succeeded to contain these difficult moments.”

Four participants talked about a strong personal experience of self-acquaintance and getting to know themselves, especially when working relationally. Participant #5 said:

It allows me every time to discover more and more parts in me through patients, it allows self-acquaintance, so it is deepen my reflexive abilities in myself, which allows me to see things that I couldn’t have seen if I wasn’t a relational therapist.

Another four participants talked about getting meaning and spiritual meaning. Others described how this work nurtured them and rejuvenates, they feel truly energized and very enlivening. Some described becoming more confident, capable and look at problems in proportions. One participant even shared she became more feminist and more progressive in her worldviews and also mentioned it turned her to be a better writer and a better reader.

Subcategory: Compassion Fatigue Mechanism

Theme 7: The Double-Edged Sword of Empathy and Dialectical Experience

Five participants indicated in one way or another about the idea of the double sword and dialectical experience of compassion fatigue and compassion satisfaction in the context of treating trauma with relational approach. Participant #6 explained the double sword from the empathy, use of the self and intersubjectivity aspects. He
explained that this relational empathy opens and enlarges his heart but at the same time breaks his heart, this empathy opens the heart by going through pain. His words:

   My clients taught me a lot about becoming more empathetic year of the years, I had to enlarge and break my heart, thanks to them. It's like giving birth to a baby a huge pain, which year after year has made my heart a little bit more open. And only in this way I felt I was becoming empathic.

   He also referring to this dialectical experience by explaining that he is ‘taking’ compassion fatigue by intersubjectivity but without being traumatized because he is setting ‘intersubjective boundaries’. In his words:

   I see that this is a very healthy way taking vicarious traumatization without becoming traumatized myself . . . these boundaries are intersubjective boundaries and in these places where relational theory helps me. I'm not putting some ethical boundary, I'm not saying to them- you cannot do that or this is not allowed in treatment. Okay, I never use the counter boundary. I use our real boundaries say “I'm pissed off with you. Yes . . . I'm stuck with you. You cannot do that with me. And you cannot do that with your sister with your daughter the same.” So you transferred in this very concrete way. And then I use this is more of an emotional boundary. I have to have my feelings.

   Participant #10 talked about sense of liveliness when working with intersubjectivity even if it is hard. The cost of subjectivity gives life but facing pain at the same time. She described in her words:

   But for me the worst and unbearable feeling is to be dead or feel dead. You know, emotionally and so for me, even though it could be hard, because they're intense
feelings to witness when something is coming through that means there's a self now that's there that can bear it. Yeah. Even if it's hard.

Participant #4 talked about freedom, when the subjectivity and authenticity in relational therapy give freedom to therapist but at the same time to be the therapist is exposed and can be more vulnerable. She described her dialectical experience:

On one hand, it gives you more freedom. On the other hand, it's more difficult for me because I have to be transparent. And I have to show myself and to be out a lot more, I can't hide behind my empathy, or I can't hide behind the blank face. . . . So it's it's both. It's both freeing and difficult . . . you have to expose yourself. . . . That's why it makes me vulnerable.

Similarly, participants #7 and #8 talked about the use of the self as hard position that can burnout but at the same time it is meaningful and also heals the therapist.

**Theme 8: Compassion Fatigue Resilience**

Half of the participants indicated in their own words the resilience within the compassion fatigue experience. Participant #2 said that tears and sadness different from compassion fatigue and that he can feel the assault, but the assault does not stay. Participant #3 said she aces for patients, but this don’t hurt her. Participant #6 described that he never felt devastated or ‘zero bottom’. Participant #10 said that she does not have a lot of burnout because the payoff outweighs the costs. Participant #11 said that despite the difficulties he did not think about stop practicing, however, he wants to work differently (private practice instead public service). Finally, participant# 9 said she gets a lot more from therapy, far from then compassion fatigue.

**Category 5: Risk and Protective factors**
This category is divided to two subcategories: risk and protective factors. The risk factors presented here are related mainly to setting and work environment but also factor that related to therapist and the dynamics in therapy. The protective factors presented here are also mainly related to the therapy setting but also related to the therapist’s position and to the issue of boundaries.

**Subcategory: Risk Factors**

**Theme 1: Setting**

Most risk factors indicated by participants were related to the work setting and work environment. Participants referred to the type of patients. Four participants indicated that high number of patients is a risk factor. In addition, four participants also indicated that type of patients such as: high number of sexual abuse and complex trauma cases is a risk factor and explained that sexual abuse in childhood stays longer in the mind. Another four participants also mentioned that many death cases are very difficult, such as when working with HIV patients and health facilities, as well as to lose patients and even when patients leave. Three participants said that self-harm and suicidal patients are also very hard and can be a risk factor.

Another factor that was mentioned only by three participants but was very significant for them was the factor of type of service. These participants said that higher compassion fatigue is due to working in community service or public clinic vs. working in private clinic. The explanations they provided were: Must treat everybody; high volume places; high demands; the system doesn’t support structurally; less professional freedom; power and control dynamics and other stuff members that are not compassionate, etc.
Three participants said that having no boundaries and no structure, can be a risk factor for compassion fatigue. Boundaries referred to boundaries regarding money, communication but also emotional and therapeutic boundaries. Participant #12 said:

One of the main things that I think is so important for therapists to know is to be able to know their limits and to be very clear on their boundaries, therapists boundaries. . . . I feel like it's really important for me to share in you know, in your study, that a lot of people I see for an out as I supervise a number of analytic candidates, and I do see people burning out because they give way more than they really can, and then just don't want to do anything more.

**Theme 2: Therapist**

Seven participants agreed that being a young therapist with less professional experience is a risk factor. Some emphasized the young age but most of them referred to the lack of experience, like participant #4 described:

I feel like at this point in my life, I'm actually probably, maybe I've learned how to compartmentalize and not to, to, you know, after they finished a session and I reflect on it and think about it for myself and take notes, but I don't feel like I usually take it out on other people or into my other life. I'm able to kind of put it aside. I think it's the beginning of my career. It was very different story and it was very hard to for me to separate my focus life and my other life, but after all this year, it's much, it's much easier to do that.

Thus, one participant also mentioned that the training time in young age is a lot of burden as well.
Five participants referred to the therapist personal background as a risk factor, it can be the therapist’ personality or personal background of trauma or other similar issue- ‘the wounded therapist’, which can put the therapist in a be vulnerable position or have personal triggers. Participant #3 said she is aware to that vulnerability: “but I know that that I'm more vulnerable to, you know, just so, you know, my personal history.” Two other participants mentioned that high levels of responsibility and protection especially with patients with high levels of self-abuse. Meaning being in a position of savor fantasy or with a sense of omni-potency can be risky for therapist. Participant #5 explained that: “when the levels of internal responsibility over the patient are very high and there is no ability to do the separation between me and the patient, so I think the possibility to get secondary traumatization is higher.”

**Theme 3: Therapeutic Contents/Dynamics**

Three participants said that a risk factor is the traumatic content in therapy. Hard traumatic contents include things that the therapist never heard before, stories patients tell out of nowhere or surprising or extreme situations. One participant also mentioned that graphic pictures or descriptions are very difficult as well.

Only two participants said that working with enactment and dissociation can be a risk factor. Participant #12 said:

When I'm working with someone who dissociates I'm helping them stay with their feelings rather than go away from their feeling, So I have to be very connected to my own feelings about what's happening, to be able to help . . . that's exhausted. That's hard. That's intense, it's very intense.

**Subcategory: Protective Factors**
Theme 1: Setting

As opposed to the risk factors category, one participant here indicated that working in public service can be rewarding. Four participants referred specifically to working in a good team with respect, positive communication as well as having professional network and sharing with colleagues, which create a sense of belonging can be protective factors. Similar to the risk factor category participants indicated that longer experience, when building up the therapeutic muscles and getting more education, are protective factors as well as wide professional network/sharing with colleagues. One participant mentioned that having patients with very hard stories that are very “far” from you, can be easier to disconnect and therefore is a protective factor.

Theme 2: Therapist Position

More than half of participants indicated that subjectivity and use of the self is a protective factor, some referred to involvement as an advantage and resilience and some referred to authenticity as protecting them. Participant #1 talked about involvement:

I feel a little bit everything that you mentioned, you know, like it's a it's a mixture, I could say, but um, I think, you know, I don't think it's negative for the, I think it helps with a secondary trauma . . . you're going to be very involved and you're going to be traumatized but at the same time, you're going to have the possibility to reflect on that and do something with that.

Participant #4 explained why being authentic protects her:

I do feel compassion fatigue and secondary trauma and all of those feelings once in a while, but I think the fact that I have permission to be a real person and that not always to be compassionate and not always to be empathic, I think really can
protect . . . I don't feel compassion and I accepted that there are limits on my ability to be with patients sometimes and I can’t be everything somebody might want, and just accepting that and realizing that that's, that's okay. That's being a human being. I think I think that's, you know, probably is a protection from compassion, fatigue . . . Yeah, and it's not about saving the patient. It's about engaging in this mutual process, which includes your being a human being with limitations, and sometimes not knowing what to do something. I'm not saying the right thing so. I think that's That that is really a relief. And I think it does help with this compassion fatigue issue.

Three participants indicated that holding a humanistic approach to both: the patient and therapist, protects the therapist. This approach allows the therapist to accept that humans are making mistakes and therefore it takes out a lot of the pressure from the therapist. I addition this approach allows the therapist to see in patients the person behind the trauma, as well as see the resilience and have hope and faith in human strengths. Participant #2 explained that despite the trauma people are resilience and that helpful for the therapist as well:

In the meantime, there's a person in front of you who's going to have a life and is coming alive. And I do not just see that (the trauma) I see a whole process that this person got themselves into therapy . . . people can do amazing things in their life . . .

Two participants indicate that working dynamically in an approach that encourages movement can be a protective factor. Two participants indicated that being in contact with your body, be mindful for the moment and being presence in the mind and in
the body, can be a protective factor. Another two participants said that the more depth in therapy along with more awareness, the there is more change and satisfaction.

**Theme 3: Boundaries**

Seven participants pointed out that boundaries in general are an important protective factor. Specifically, four participants mentioned that setting clear boundaries in the therapeutic setting such as: availability, cancellation, communication, and money is protective. Three participants suggested boundaries in the emotional/therapeutic level as protective factor. They suggested that therapists should compartmentalize, separate and not identify with everything as well as not giving more than they really can. Participant #12 described that to set external boundaries helps her with the internal boundaries, because the psychological boundaries are hard to determine.

(researcher): where do you see when therapists are crossing the boundaries in terms of emotional investment? (participant#12): I think that's it’s so individual. I'm so difficult to determine. which is why I use outside structures to help me.

Two participants suggested setting boundaries in terms of separating work and personal life and taking time for self-care/vacation. Three participants talked about boundaries in terms of balance of doing other things except therapy, such as teaching or doing research.

**Category 6: Self-Care**

This category presents the self-care methods suggested by relational therapists. The first theme suggests how to approach and understand self-care, the second theme focuses on specific self-care methods participants have been doing and the third focuses specifically on boundaries and self-care.
**Theme 1: Understanding Self-Care**

Only two participants referred to the idea of self-care in general and not just referring to specific methods. Both participants indicated that it is important to remember self-care is not a list or prescription and it is unique for every therapist. Participant #10 answered to the question, "How do you maintain your well-being?"

I just want to say that it’s not a prescription for anyone because a relational approach means subjectivity is going to point towards certain things that may or may not work for other people.” Participant #1 also referred to the importance of agencies’ awareness to self-care, the importance to pay attention to early signs when therapists need self-care and that self-care should be an active action that evolves during time.

**Theme 2: Self-Care Methods**

Nine participants suggested that supervision is an essential method for self-care. Participant #2 explains that it is important and essential to think together about cases “I do supervision and I; you know . . . , first of all, it's another mind when it's a supervision there's two minds. So, to have somebody else's mind, good idea.” Part of the participants referred to individual supervision, but some referred to group supervision. Further, they indicated that the purpose of supervision it is not only thinking together about cases but also talking about their personal experiences in the therapeutic relationships. Participant #9 described:

My supervision group is part of my self-care. It’s a very good group. And it’s very relational and we don’t just talk about the people we work with. We talk about ourselves in relation to people we work with and it’s very, very supportive.
Most participants emphasized that supervision is helpful because it enables processing their experiences as trauma treatment, as participant #1 indicated: “As a therapist, we need to process that to, you know, outside the session/ Yes. Because so it's important . . . having supervision.” The need to process was also mentioned not just regarding supervision. Six participants mentioned that sharing/talking/processing with colleagues’ therapists formally and informally by keeping in touch with colleagues, participate in peer groups or join professional associations is an essential self-care method. Participant #4 describe that processing with colleagues helps in critical times “if I run into a situation where I feel stuck, I do process with other colleagues.” Participant #1 even mentioned that sharing with colleagues have a therapeutic role:

We share what we do. Okay. You know, that's, that's, that is nice to hear colleagues talking about what do you do. Yeah . . . Because you you're going to find different, you know, different things. Yes. And, and I think that the fact that you are sharing that is also therapeutic.

Eight participants referred to writing as central and important self-care method. Some referred to more personal writing like personal writing such as notes or diary and some referred to more public writing such as academic writing or writing a blog. Participants described why writing is an effective self-care method for them. Participants #9 described: “my writing it’s, it’s my great escape. . . . I will write the two or three hours and that really helps me if I do that/ I feel good.” Participant #5 also said it helped her to create a sense of separateness after sessions:

I have a notebook since I started to work relationally and working with the body that I can remember who I am, my thoughts, my feelings and even a face my
patient did and I feel I did the same face. I write it down in order to create separateness.

Similarly, participant #10 also described the in-depth impact of writing as a way to ‘leave’ the trauma on the paper without continue carry it after the session and also helpful in stuck moments in therapy:

Writing is huge and important . . . writing helps me, maybe store some of the experience or store some of the trauma in a way that it’s there but I don’t have to carry it in my body in the same way or, you know it’s also helps me to keep the record of sometimes of what’s happened so that when I am in a stuck moment I have something to review and remind myself where we were or whatever . . . , I find writing to be a huge part of my self-care.

Three other participants said that reading is also their self-care method. Four participants said that engaging with family, friends and intimate relationships is very helpful for them. As participant #1 said: “The connection with my family really helps me. . . . Engaging with people that you like you feel good is really important.” Thus, three other participants said that it depends on the situation, sometimes their self-care is to be alone and sometimes is to engage with people, depends on the context.

Seven participants indicated that doing a diversity of things and additional activities to treating trauma such as research, teaching, workshops, leisure time activities, etc, is important for self-care. Five participants indicated that walking help them clear the head, as it could be a regular walk around the house, walk with the dogs or also walk to work. Different five participants indicated that physical activity such as sport, gym or swim are essential and very important to their self-care. Additional methods which are
similar but different from regular physical activities are the Yoga/Meditation/Relaxation methods which mentioned by four participants. These methods are embodied but at the same time include mindfulness and even more spiritual tuning. Participant #4 explained about these practices:

I think all those practices yoga and meditation and walking in nature is all about connecting with your body. And when I sit with a patient, I tried to be very aware of my breathing and my body and what I am as a healer now, I try to be connected to that. Definitely.

Five participants reported that being in nature, such as in the woods or beach, is very calming and helpful. Participant #4 even pointed out on a specific method name Forest bathing. Participant #5 explained what being in the nature provides: “I go out to the nature to the woods or beach to get proportions on life that there are good things and that I can be engaged to something that is bigger than me and to be nurtured.”

Other methods that were mentioned were: rituals between sessions; take many showers; sleeping/snoozing/napping; taking massages and personal care; going to therapy; buying gits for oneself; take the weekends or vacations to recover.

Theme 3: Boundaries

Seven participants emphasized in one way or another that boundaries are an important part of self-care. Boundaries should be in the practical level meaning, by setting clear boundaries around money and communication after sessions as well as separating home and work spheres. In addition, boundaries should also be at the psychological level when putting the previous session behind and moving to the next
session or separating home and work not just physically or doing a retreat. Participant #5 said why it is important for her to set boundaries:

Very clear boundaries between me and patients very very clear, because the relationships are so confusing I set the boundaries in a very strong way around money and around communication and around sessions . . . it is like contradicts the intensities of the relationship but theses boundaries are my self-care for myself and also for them.

Participant #12 also explained: “You know you love these people, but you also have to love yourself, take good care of your yourself. . . . And they need to trust that you're taking care of yourself that they don't have to take care of you” And she added: “So sometimes I think therapists fall into a trap of enjoying being taken care of by their patients and rather than keeping that boundary there.”

**Survey Results**

**Theme 1: Relational Therapy and Empathy**

The relational therapist position inherently includes the use of the self, intersubjectivity, and authenticity. This position was also described as the empathic response of relational therapist which was adopted by relational therapists because trauma survivors’ patients, especially complex trauma patients, need authenticity and honest relationships. This empathic response of relational therapists can include combination of feelings, positive and negative (so called not only “empathic” reactions) as part of being authentic and transparent in the therapy.

An analysis of the participants’ feedbacks shows that 9 out of 12 participants agreed with the theme, some only wrote they agree and some added details and mostly
agreed about the importance of authenticity in the treatment of trauma, for example: “Yes, I agree with the statement. The fact that the therapist will experience that combination of feelings it also implies a constant self-evaluation in our response. The idea would be to be aware the most we can of what's going on in therapist and client relationship.” Three participants did not understand fully the theme and added clarifications and/or their own perspective, such as: “I’m not sure I understand the “negative” I agree the reactions are multiple and complex, but I don’t understand the “negative” aspect mentioned.” One participant partially agreed.

**Theme 2: Double-Edged Sword of Empathy—A Dialectical Experience**

The empathic response of relational therapists can be a risk and protective factor at the same time. Intersubjectivity and the use of the self can be hard, painful, intense and make therapist more vulnerable and exposed but at the same time it protects them while being authentic, transparent, involved, and free to express themselves. The authenticity of therapists serves as an emotional boundary when the therapist can express his own subjectivity and that protects himself.

Seven participants agreed with the theme, while four were partially agreed and did not understand the way the theme phrased and mainly the authenticity as a ‘boundary’, for example: “I’m not clear what this means- the authenticity of therapist serves as an emotional boundary” How does the authenticity of the therapist protect the therapist?” and also other participant: “I am not sure I understand this finding the way it's phrased. I don't think of authenticity as a boundary. . . . It's a context—a context that's open enough to handle all sorts of 'incoming' affective/sensorial data.” One participant
described her own perspective/reaction to the theme but without implying agree or disagree.

**Theme 3: Relational Therapy, Empathy, and Resilience**

The use of the self, intersubjectivity and authenticity gives freedom, liveliness, real connection, sense of satisfaction and growth. The empathic response in the relational position is rewarding and fulfilling, despite the cost of caring.

Ten participants agreed with the theme such as: “I agree with the statement, Boundaries are so important”. One participant was not sure about the theme: “Not sure I agree, it is a general statement on therapy”, and one participant disagreed.

**Theme 4: Boundaries as a Protective Factor and Self-Care Method**

Boundaries at the setting level such as around money, communication and meetings are important because the relationships are so intense. The external structure helps with the internal boundaries because the internal boundaries are more challenging in relational therapy. Further, the use of the self and intersubjectivity can assist with setting emotional boundaries because the therapist can be himself and can express his emotional boundaries authentically. Ten participants agreed on the theme and supported the importance of boundaries and self-care. Two participants were not sure about the statement and one disagreed.

The next, chapter 5 will synthesize the results presented above while suggesting ways to interpreted them and practical implications. This final chapter will include a deep discussion about the results summarized in this chapter. Moreover, the final chapter will discuss the meaning of these results to the therapeutic field. As with most, this final chapter will note the limitations of this study and address this directly. Also, the chapter
will include suggestions for future research focusing on secondary trauma and suggest some of the more important implications of the study regarding both the improvement of practitioners practice with clients and with the self of the practitioner.
CHAPTER 5: DISCUSSION AND IMPLICATIONS

This chapter provides a discussion and in-depth reflection on the results presented in the previous chapter. The purpose of this chapter is to provide interpretive insights into the findings from the previous chapter. In Chapter 4, the results chapter, I separated the pieces of data, reported the results, and provided the narrative of results, this chapter is providing a more holistic view on the study. This discussion is based on my analytic perspective on the findings and includes interpretations and relevant literature. The chapter addresses the implications for theory and strategies of therapy practice. The implications are offered to all therapists and service providers who treat trauma survivors across different contexts. The limitations of the study are suggested and discussed, as are the recommendations for future research and the conclusions.

Discussion

The results of this study revealed new findings regarding the experiences of relational therapists treating trauma and at the same time, the findings suggest new characteristics about the mechanism of compassion fatigue, resilience, and compassion satisfaction. The main findings refer mainly to the research questions. Specifically, the findings indicate relational therapists are treating patients who have experienced a wide range of traumas and traumatized clients. In most cases the therapists are treating patients who experienced sexual abuse or childhood traumas. The participants acknowledged the concept of complex trauma and the needs of their patients with complex trauma-going through a relational trauma, and the need to heal in relationships because they were traumatized in the context of relationships.
The study suggests that relational therapists put the therapeutic relationship in the center of their work and emphasize intersubjectivity, use of the self, and authenticity. These therapeutic positions were seen by the therapists as part of their empathic response. Relational therapists experience compassion fatigue symptoms and retain this empathic response position when treating traumatized clients. The symptoms relational therapists noted include: (a) exhaustion of the mind and body, (b) sense of burden, (c) sense of being estranged from people, and (d) need to recover. Relational therapists also report on negative feelings such as sadness, anxiety, anger, and negative effects on the body and the mind. These negative effects were reported in addition to the positive effects of both compassion satisfaction, and personal growth. The compassion satisfaction was mainly reflected in the therapists’ sense of fulfillment, rewarding work to see the change in patients’ lives, and personal growth. Further, despite the compassion fatigue experiences, most participants reported compassion satisfaction is stronger than compassion fatigue and they expressed their resiliency despite the difficulties of treating trauma.

The empathic response of relational therapists, which includes intense use of the self, intersubjectivity, openness, and authenticity is a double-edged sword. The experience of being an open and an authentic therapist is a dialectical experience, on the one hand, the use of the self, leave therapists vulnerable and exposed but on the other hand it gives them freedom to be themselves and express their subjectivity. Therefore, authenticity is a protective factor. Finally, participants report on the importance of self-care and boundaries. Self-care includes different methods of relaxation and personal treatment, according to each therapist’ preferences and boundaries refer to boundaries in the setting such as around money and communication, but also emotional boundaries in
the close and intimate relationships with patients. The next section will elaborate and interpret these main results and will discuss them with the literature.

**The Experiences of Relational Therapists Treating Relational Trauma**

Many participants refer to relational trauma as the center of their work, according to the results in category 1 and the relational therapeutic framework as the main framework, according to the findings in category 2. These perceptions of relational therapists about the focus of their work inherently influence their experiences. As reflected in the findings from category 1, their work focuses on relational trauma and consequently influences their perception about the needs of their patients (Theme #4). The focus on relational trauma and the needs of survivors of relational trauma influence their perception how they should work as therapists and their therapeutic position (Category 2, theme #2). These perceptions are fundamental to answer the first research question about the experiences of relational therapists. The experiences of relational therapists are impacted by their awareness to the uniqueness and the challenging aspect of complex trauma, which was clear from many participants who see the broad definition of trauma (Category 1, theme #1) when referring to complex trauma. This awareness of participants to complex trauma aligns with Herman’s (1992) perspective on the development of trauma studies in the last 3 decades, suggested here as “the trauma turn”.

**Acknowledging Complex Trauma**

Herman (1992) was the first to suggest the new diagnose of “complex post-traumatic stress disorder” as a syndrome that follows a prolonged, repeated trauma. This is based on the perspective that it is important to understand trauma on the spectrum of conditions rather than a single disorder by suggesting this diagnose (Herman, 1992). In
fact, on 2021, the *International Classification of Diseases 11th edition* includes Complex Post Traumatic Stress Disorder (CPTSD) (Felding et al., 2021) and gives it a formal recognition.

According to the results in category 1, themes #1 and #2, many participants treat patients who have had sexual abuse/complex trauma. One participant indicated how the rates of sexual abuse patients in her clinic have increased over the years. This probably happens because the awareness to sexual trauma has increased, and therapists ask more about sexual trauma. The awareness to sexual abuse versus denial reflects the “trauma turn” and the “relational turn” (Harris, 2018; Malone, 2018). Therefore, these relational therapists reflect the new psychoanalysis generation.

Sandor Ferenczi put the foundations for the relational understanding suggesting that multiplicity of self and dissociation are connected to actual trauma and not fantasies (Malone, 2018). Later, Davies and Frawley (1994) were one of the first scholars to criticize classic psychoanalysis that underestimate the impact of sexual trauma by stressing that intrapsychic conflict associated with incestuous fantasies is the decisive factor in determining pathogenesis. This criticism suggests such an approach damage the patient’s reality-testing functions and retraumatizes the patient. Davies and Frawley (1994) also offered a new relational model for treatment of adult survivors of childhood sexual abuse. The new relational approach toward trauma treatment and the ‘relational turn’ were acknowledged by participants (category 2, theme #1), led them to choose to work relationally (category 2, theme #4) and design their therapeutic position (category 2, theme #2) by exposing, acknowledging, and validating the trauma within the therapeutic relationships.
The theories relational therapists use directly affect their practice, their therapeutic position, and the way they listen and understand the narrative of their patients. Therapists who hold a theory that understands childhood memories by drives and fantasies, will skew the interpersonal field and will lead therapists to interpreted symptoms instead of focusing on the patients’ lived experiences. And the opposite-therapists who understand that victims who have had complex traumas, will work relationally to help them heal from the traumas (Itzkowitz, 2017).

This new psychoanalysis, the trauma-turn and the relational-turn perspectives, is important because trauma therapy occurs in a social and a political context that influences therapists. The relational therapists embrace the new and the progressive approach to trauma, sexual abuse, and complex trauma, which is important, given social movements and political awareness to traumas in the present and in the future. Relational ideas and practices were influenced by global social movements for civil rights, against the war in Vietnam, and for women’s rights. According to Robb (2006), “the personal is political and the political is psychological, in their (trauma survivors) work and in their (trauma survivors) lives” (p. xv). Therefore, therapeutic ideas should continue and be influenced by social movements such as #MeToo and #BlackLivesMatter because they can encourage more trauma survivors to acknowledge their traumas and ask for therapy.

The Relational Position

Relational therapists adopted the new psychoanalysis and tuned their position (category 2, theme #2) to trauma survivors’ needs. The needs of complex trauma patients were detected by participants in this study (category 1, theme #4). Participants stressed the importance of putting the relationships in the center of therapy. But beyond this
relational position, they emphasized the position of the use of self and intersubjective (category 2, theme #2) with complex trauma survivors. The interpersonal approach suggests trauma occurs in an interpersonal context; therefore, abused survivors bring the core of internalized experiences and expectations to relationships, especially therapeutic relationships (Herman, 1992; Stolorow & Atwood, 1992).

This relational position is a challenge for trauma therapists and for the trauma victims. Boulanger (2007) claims that the core of relational therapy is intersubjectivity; however, this is difficult because trauma uproots the self-experience of trauma survivors and leaves them with questions about their own self as subject and doubting intersubjectivity. This challenges trauma victims in relational therapy that need to be reconnected to their self and subjectivity and challenges therapists because it requires high levels of empathy from them.

These perceptions of relational therapists design their experiences regarding trauma treatment and next it will be detailed about their empathic response and the challenges they experience with regard to trauma treatment.

Empathy, Intersubjectivity, and Use of the Self in Relational Therapy

Participants described their empathy in many ways (category 3). This reflects the literature about empathy as a concept relevant to all different therapeutic methods and relationships. Indeed, empathy is a wide overarching concept and can be expressed cognitively, emotionally, somatically, etc. (Kaluzeviciute, 2020). Although participants described their empathic response in many ways, the main descriptions in the results indicate the foundations of the relational approach of intersubjectivity and use of the self as the empathic position of relational therapists (category 3, theme #1). Further,
participants emphasized the importance of being open, transparent, and using self-disclosure and authenticity in the use of the self and intersubjective position.

Philosophically, empathy and intersubjectivity are connected concepts because they connect us mentally and psychologically to each other (May, 2017).

**Authenticity**

Some participants indicated the importance of authenticity (category 3, theme #1) and explained that trauma survivors’ especially complex trauma patients’ need for authenticity and honest relationships because of their high sensitivity to dishonesty (category 1, theme #3). The participants explained (category 3) the empathic response can include a combination of feelings, positive and negative feelings as part of being authentic, honesty, and transparency in therapy (Herman, 1992; Pearlman & Courtois, 2005).

The starting point of relational therapy is that trauma damages the ability to enter trustful relationships, especially among complex trauma patients. At the core of complex trauma is fundamental attachment disruptions (Herman, 1992; Pearlman & Courtois, 2005). Complex trauma patients have high abilities to read others’ emotional and cognitive states, like they do with their predators. Complex trauma patients bring these abilities to therapy. Thus, complex trauma survivors have high sensitivity and excellent attunement to the therapists’ reactions, conscious, unconscious, and nonverbal communication (Herman, 1992). This sensitivity of complex trauma patients requires therapists to use a certain approach and treatment to match the needs of complex trauma patients (Herman, 1992; Pearlman & Courtois, 2005).
Clinicians are encouraged to retain their honesty and authenticity in the therapeutic relationship and to emphasize the rule of truth telling and disclosure when treating complex trauma. Aron (1996) suggested therapists’ authenticity can enhance more meaningful communication between the patients and the therapists resulting in the more latent content of clients’ inner structure to emerge in therapy to allow more growth. By creating authentic engagement through the therapeutic process, the therapists and the patients engage in the intersubjective process that is important to the success of relational therapy (Aron, 1996).

There is a wide and deep dialogue in relational psychoanalysis literature about empathy and authenticity, while arguing that sometimes empathic response can be inauthentic (Stern, 2009). However, according to the participants in this study and from a dialectical point of view, authenticity is part of empathy. Further, empathic responses can become more powerful because the patient experiences the therapist as a real person who is responding to him or her in a unique, personal, authentic way (Stern, 2009; Orange, 2002).

Moreover, Orange (2002) asked about the compatibility of empathy and authenticity in relational psychoanalysis and argued that empathy and authenticity are more than compatible but also necessary for each other and explained authentic participation is an intersubjective process. According to Orange (2002), this is a mutual recognition process and being faithful to one’s sense of the system. Like Benjamin (2018) who discuss mutual recognition in the intersubjective therapeutic relationships. These theoretical suggestions around empathy in relational therapy reflect the participants sense
of intersubjectivity, use of the self and authenticity. Next, the experiences and challenges of relational therapists working in this empathic position, will be discussed.

**Empathy as a Double-Edged Sword**

The core results of this study reveal the experiences of relational therapists as a double-edged sword (category 4). The next section will address the research questions about the connection between the empathic response of relational therapists to CF, resilience and CS, and about the risk and protective factors treating trauma relationally. The empathic response of relational therapists can be a risk and a protective factor at the same time (category 5). Intersubjectivity and the use of the self can be hard, painful, intense, and make therapists more vulnerable and exposed (category 5, risk factors, theme#3). But at the same time, it protects them as they are authentic, transparent, involved, and free to express themselves (category 5, protective factors, theme#2).

All participants reported of having different types of symptoms of compassion fatigue because of treating trauma (category 4, subcategory: negative). This aligns with the literature about compassion fatigue and trauma treatment which suggest therapists and service providers who treat trauma survivors can have a wide range of symptoms on the psychological, emotional, cognitive and body levels (Figley, 1995; Mathieu, 2012; Cohen & Collens, 2013). At the same time, participants reported about meaningful experiences of compassion satisfaction and personal growth (category 4, subcategory: positive). This also align with the literature about compassion satisfaction and vicarious growth (Arnold, et al., 2005; Cohen & Collens, 2013; Linley et al., 2005; Stamm, 2002) and specifically from a relational perspective (Gartner, 2017; Gold, 2017).
The negative and positive experiences at the same time among therapists who treat trauma was found in previous studies. In a qualitative metanalysis of 20 studies, Cohen & Collens, (2013) found that therapists who work with traumatized patients experience vicarious trauma and vicarious post traumatic growth at the same time. The empathy as double-edged sword was even found in a recent study during COVID-19 pandemic (Lai et al., 2021). This study found that hotline counsels during COVID-19 shows negative and positive outcomes and supporting the dialectical experiences of trauma workers (Lai et al., 2021).

The interesting part in this study is that relational therapists reported the pain and compassion fatigue are inevitable, but this is also part of their process of compassion satisfaction (category 4). When therapists allow themselves to feel, be open, be invested in the relationship and use their subjectivity they can also experience satisfaction and personal growth in addition to the pain. According to participants, the compassion satisfaction is due to the meaningful change and healing process their patients went through and they were part of it and the personal growth is also because of the hard but rewarding work (category 4, themes #5 and #6).

Therefore, the findings reflect the concepts of counter-resilience and counter-growth suggested by Gartner (2017) and Gold (2017) which view the process of healing from trauma as a relational-interpersonal process that promotes resiliency and personal growth in both members of the therapeutic dyad (Gartner, 2017; Gold, 2017). Furthermore, participants indicated (category 4, theme #8) eventually the payoff outweighs the costs, which confirm the resilience factor suggested in the Compassion Fatigue Resilience Model and emphasizes the resilience as a major factor as well; and
compassion satisfaction contribute to the resilience of therapists and service providers (Figley & Figley, 2017).

The Dialectical Experience

Participants indicated specifically the experience of treating trauma in a relational approach as a dialectical experience (category 4, theme #7). They mainly referred to their therapeutic position and empathic response which include the use of the self and intersubjectivity as part of the mechanism of the double-edged sword. They explained to a certain point, compassion fatigue is inevitable and the pain from being in such an open position is part of the therapy. This is like Boulenger’s (2018) argument that only when therapists acknowledge the compassion fatigue they can begin to work through their patients’ traumatic experiences. In other words, compassion fatigue of relational therapists who work in countertransference and intersubjective areas, is inevitable.

Further, when engaging in a long-term dynamic treatment, when there is an emphasize on the relationships compassion fatigue becomes an important tool in the treatment itself (Boulanger, 2018).

The position of the intersubjectivity (Mitchell, 2000) and the idea of the third (Benjamin, 2004; Ogden, 2004), reflect connectedness and separateness at the same time. Emotional attunement and empathy in the relational perspective is dialectally contain elements of authenticity and do not wipe the therapist’ self, it is neither a sadistic destruction of the other nor masochistic betrayal of the self. Further, the idea of the third in the relational approach, is the differentiation within the very connectedness (Aron, 2006; Benjamin, 2004). Perhaps this dialectical approach is what enables relational therapists to experience resilience and growth because they can experience high levels of empathy,
meaningful and effective therapy but at the same time, they keep their own subjectivity and separateness.

**Intersubjectivity and Authenticity as Protective Factors**

The focus in this study is empathy, the use of the self and authenticity of therapist. The use of the self and authenticity were found to be protective factors because they enable therapists to set emotional boundaries (category 5, protective factors, theme #2). Further, this authentic position enhances real, deep, and meaningful connection that promotes the success of the therapy, which increase sense of satisfaction and growth.

When the therapists can express their own subjectivity in a genuine way that allows them to say their thoughts and express their feelings, it gives them freedom to use their own subjectivity. This authentic position serves as a boundary which help therapists to express their subjectivity in a way e patients can engage and protects the therapists from compassion fatigue. However, according to the survey results, some participants found it hard to understand the theme of authenticity as a boundary—likely because it is confusing which type of boundary the theme referring to. It is important to clarify that boundary here is the idea of separateness. As much as it is important be connected, it is important to be separate. Like the relationships between a mother and a child.

In early psychoanalysis the mother appears only as an object that satisfies the needs of the infant and not as a person with independent existence. This approach was a one-person psychology approach. However, the new psychoanalysis emphasizes the two persons psychology, following Winnicott (1956) who suggested the ‘good enough mother’ concept and the subjectivity of the mother and why it is important to both the child and the mother. According to him, the good enough mother is not just an object for
the fulfillment of the child’s claims and needs. In fact, she is another subject, whose independent center must be outside the child if she wants to give him the recognition he seeks (Winnicott, 1956). This theory was one of the foundations of Benjemin’s mutual recognition theory (Benjamin, 1988, 2018). The mother should not only reflect what the child expresses, she should be another independent who responds in her own different way. Thus, as the child gradually establishes his or her center of independent existence, her recognition of it will be significant only if it reflects its subjectivity, which is no less separate (Benjamin, 1988).

The mutual recognition theory focusses on the reciprocal recognition to each other’s minds and the awareness of the other as subject rather than object also in therapy. Benjamin (2018) did not except the split between empathy to suffering, from the opportunity to be recognized. Thus, the reciprocal interactions create a shared third that transform both the therapist and the patient. This space of the “thirdness” is to surrender and simply being, but it is different from submission and the ideal of “pure empathy,” which is more “oneness.” Oneness, unlike thirdness, is a denial of the self and inauthentic “leading ultimately to the complementary alternative of ‘eat or be eaten’” (p. 37). Benjamin argues against the opposition of empathy and authenticity which splits oneness and thirdness, identification and differentiation that turns the therapeutic dyad to a complementary space in which there is room only for one object. Submission to the ideal of being an all-giving, all-understating, pure empathic attunement can shift to being depleted and losing empathy (Benjamin, 2018). Therefore, being an authentic as part of being empathic can protect the therapist and enhance mutual recognition and transformation.
Furthermore, Stern (2009) discussed the dialectic of empathy and freedom and suggest that analytic empathy is an equally important core value to analytic freedom, and as existing in constant dialectical tension with analytic freedom. Stern (2009) argued that this is a necessary paradox. Yes, therapists aim to ultimately be empathic and understand their patients and patients want to be understood. However, this cannot be forced, and therapists need to feel free to experience their subjective experiences and use them for the benefit of the therapy. This dialectical approach can protect therapists as they feel subjects and free persona. The intersubjectivity and authenticity as protective factors are part of a whole system of methods and position that can protect therapists. Next, self-care and boundaries will be addressed and the research question about how relational therapists maintain their well-being will be addressed.

**Self-Care and Boundaries**

The results show (category 6, theme #3) that boundaries in the setting level, such as around money, communication, and meetings as well the boundaries within the therapeutic relationships are very important because the relationships are so intense and might be confusing. Further, according to the participants the external structure helps with the internal boundaries because sometimes the internal boundaries are difficult to determine and are more challenging in relational therapy. The importance of boundaries in the therapeutic settings and relationships aligns with the literature (Kinsler et al., 2009). The results of this study, therefore, suggest to keep the authenticity as an emotional boundary in a way that it is reminds that the therapist is a subject as well. This freedom to express themselves gives relational therapists a tool to be empathic but be separate subject at the same time.
The importance of boundaries in the setting such as around communication, money, appointments are relevant for all therapeutic approaches and trauma treatments. Thus, relational therapy requires a special attention to boundaries because of the needs of complex trauma patients and the focus on intersubjectivity and use of the self. Authenticity, emotional availability, and self-disclosure are not to be confused with over-disclosure of personal information or engagement in dual roles with the client such as confusing about the patient being a friend, romantic or sexual partner, or business partner. The violation of boundaries and role reversals are against professional ethical standards and can cause harm to patients by retraumatize via reenactment (Pearlman & Courtois, 2005).

Self-care in general was found (category 6, theme#1) to be an important factor for relational therapists treating trauma. This aligns with the literature about the importance of self-care to preventing compassion fatigue and burnout (Figley, 2002; Stamm, 1995). Also, according to this study, there is no doubt that self-care is crucial for trauma therapists for safety and efficacy. Specifically, supervision or consultation is an essential component of trauma therapy where therapist can recognize their emotional, physiological, and spiritual response and their vulnerability to exhaustion (Saakvitne, 2018).

Participants explained self-care is not a prescription or a fixed “to do” list and every therapist should search and find his own self-care. However, it was interesting to find common self-care methods they mentioned (category 6, theme #2) which include writing, sharing with colleagues, supervision, and physical activity/mindful activity. The most meaningful conclusion of this study regarding self-care is the in-session methods
This in-session self-care method learned here is the empathic response and use of the self. Therapists should be mindful to their empathic response and use of the self in a way that promote the effectiveness of the treatment and protect them at the same time. Therapists should remember to see the separateness within the connection and not to be trapped by empathy. The awareness to the relational intersubjective dynamics as well as the trauma treatment dynamics are key factors in the self-care for relational therapists treating trauma (Glennon et al., 2019).

**Implications for Practice**

The main implication for practice includes the understanding the mechanism of compassion fatigue and empathic response. Studying the empathic response from relational therapists’ point of view, sheds light on the way practitioners and service providers can hold their therapeutic position. Although not all practitioners and service providers hold the same therapeutic approach as relational therapists and each method for treating trauma has its own theoretical approach, a lesson can be learned from relational therapists.

First, therapists who treat trauma victims should be aware to their empathic response and how it affects them and bring this to their attention, and to their supervisors and educators’ attention. In general, practitioners should consider the risk and protective factor suggested in the CFRM to evaluate their compassion fatigue resilience model. In addition, and according to this study, practitioners should consider that the empathic response presented in this model can be a risk and protective factor at the same time. The empathic response has two pathways to increase and to decrease resilience. Therefore,
they should emphasize the pathway to increase resilience and grow and try as much to decrease that decrease resilience.

Moreover, according to the results, participants also described empathy on the emotional and mind levels (category 3, theme #2 and #3) these descriptions can apply to different types of trauma practitioners. Trauma practitioners can adopt the idea that empathy and the use of the self can be a risk and a protective factor. Therefore, therapists should develop awareness to this double-edged sword perhaps adopting dialectical thinking while reflecting on the therapeutic work. The dialectical thinking enables to hold both sides and contain mixed feelings and states of mind. This can help balance the cost of caring and the gift of vicarious resilience and growth and even grow together with our patients (Gold, 2017; Stern, 2009).

Second, the awareness should be about the negative and positive of the empathic response but mainly remembering that the internal boundaries in the therapeutic session refer to separateness but not to disconnection or detachment. The therapist and the patient are always connected but sometimes they are separate within the connection. This will allow the effectiveness of the therapy, by establishing healing relationship, protecting the therapist and even grow and blossom (Gold, 2017). Meaning, therapists should remember the use of the self does not mean “pure” empathy with no boundaries. Therefore, they should set firm but not rigid boundaries in the therapeutic relationships (Pearlman & Courtois, 2005).

Third, according to this study, practitioners should feel the freedom of being authentic in their empathic position, this can allow them being human and express their empathy in a genuine way. The authenticity is empathic response, and it allows for
freedom while being empathic (Stern, 2009). The meaning of this is that authenticity enables being empathic with less vulnerability to develop compassion fatigue but rather being more resilience. This can be learned as a protective factor and part as the compassion fatigue resilience. This freedom enables movement, according to Stern (2009). The movement can be in and out intersubjective spaces; in and out from transference and counter-transference enactments and in and out dissociation spaces (Stern, 2009). This freedom and movement in therapy is in fact an in-session self-care method (Glennon et al., 2019).

Fourth, because the compassion fatigue resilience mechanism also includes the compassion satisfaction, therapists should enhance resilience and growth. From a relational perspective, Gold (2017) formulated a new approach for treating trauma that also helps to promote resiliency and growth. The contextual model for treating trauma recognizes the capacity for human resilience in the face of adversity when one of the first rules is the difficulties of trauma survivors had reflected what they have gone through but not a reflection on them. This model does not focus on the disorder but rather on human development and on interpersonal relationships. The idea of seeing the patient as a whole person and not just from the trauma lens founded in the therapist position under category five and sub-category as protective factor. This approach was found as a factor and mentioned by participants in this study and therapists should adopt for practice. Focusing on the person and not on the trauma, focusing on human resilience and the meaningful relationships can enhance mutual growth and satisfaction.

Fifth, organizations, educators and supervisors should screen their workers, evaluate their resilience and risk and protective factors, and take responsibility for the
well-being of practitioners. The risk and protective factors mentioned by participants (category 5) were also part of the bigger picture. First, they mentioned few factors that depend on organizations such as caseload and settings factors. Second, they also talked about support, education and supervision, which depend on educators and supervisors.

Sixth, according to the results regarding the self-care (category 6), participants indicated the self-care method it is not a list or prescription. Therefore, trainers and educators should encourage therapists to develop awareness and senses to their needs and unique self-care methods (Newell & Nelson-Gardell, 2014; Sansbury et al., 2015). Thus, according to the results (category 6, theme #2) some methods can be recommended due to the agreement across participants. These methods are out of the session self-care methods and are recommended and including: writing, supervision, consulting, sharing with colleagues and doing sport or other mindful activity such as yoga. These findings align with the literature about recommended self-care methods (Glennon et al., 2019). Further, clinicians who treat trauma should get trauma-informed training and especially therapists who work with survivors of complex trauma (Kumar et al., 2019).

**Limitations**

This study has few limitations on the following sections: The sample and sample size; the qualitative method; concepts and practical implications.

**Sample and Sample Size**

The main limitation of this research refers to the ability to generalize the findings to relational therapists and trauma practitioners. The sample size of 12, a snowball sampling (non-random sample) and most of them recruited from the same organization which can be limited as dependent on social networks and less representative (Sullivan,
2010). However, an interpretative phenomenological analysis study, as qualitative research, has no attempt to generalize further, no two therapists work in the same way and no two patients of the same therapist will be treated in the same manner. Therefore, the research will produce rich data about the experiences of therapists in practice and to provide findings that can represent only relational therapist treating trauma.

The participants in this study were relational therapists from all around the world. However, qualitative research does not have a figurative or symbolic system that exceeds culture. The in-depth analysis derived from another person’s perspective that requires the researcher’s deliberate engagement of the participants and detailed readings of the participants’ story is limited. Although the sample included participants from different cultures, the study does not account for culture. However, this, as it turned out, was rather a minor limitation. I discovered participants were sharing the same professional culture of being relational therapists in terms of language used, therapeutic approach, and overall experiences as therapists.

**Method**

As a qualitative framework, interpretative phenomenological analysis has strengths and limitations. The approach is attractive due to its applicability, accessibility, and especially flexibility. The flexibility used responsibly can be positive, but when the flexibility of the framework is not balanced, the interpretive analysis can appear to lack reliability (Larkin et al., 2006). Therefore, as was explained above, to enhance the reliability, I was committed to a strong research design, rigorous data collection, member checking, detailed analysis, and attention to the quality of the process, including reflexivity embodies credibility and trustworthiness.
**Conceptual Limitation**

This study included many concepts from two different areas: trauma studies and relational psychoanalytic studies and the overlap between them. These areas contain many theoretical concepts and terms, some of them are broad and opens a whole new area of discussion and some are complicated and hard to describe in words or in a concrete way. Specifically, the concept of empathy, which is a central concept in this study, is a blur and has many definitions. The literature suggests different interpretations to the idea empathy (Kaluzeviciute, 2020; May, 2017). This can influence way this study addressed empathy and interpreted the study results.

**Future Research**

Based on the study findings, future research should examine in depth the risk and protective factors suggested in this study. For example, many participants suggested working in public service vs. private clinic is a risk factor. As such, future research can investigate this specific factor to consult for trauma institutes and public services to learn how to provide the best work environment for therapists and help them manage compassion fatigue and increase resilience.

Other future research can examine the research findings among other populations of therapists and other service providers treating trauma. This study examined the empathic response of relational therapists, but it would be interesting how does the use of the self and authenticity position can influence other therapists and service providers. In general, more research is needed to learn more about how to facilitate growth among therapists (Bybee, 2018) and service providers. More research is needed to learn about the implications of vicarious resilience and compassion satisfaction and what
interventions can be done to encourage growth among different service providers who work with trauma.

Further, future studies should discuss the implications of empathic response and compassion fatigue resilience considering the different types of traumas such as collective trauma and how does it can influence therapists and their empathic response. New research should learn how different types of trauma influence therapists and other service providers. This will allow to study the empathic response mechanism for each type of trauma and enhance the understating about secondary trauma.

Moreover, more research need to be conducted for developing interventions and methods specifically to address compassion fatigue and well-being among trauma helpers (Hill et al., 2016). Further, future research should focus on in-session self-care methods as well as research aim to test the effectiveness of existing models (Glennon et al., 2019). In general, we need to develop new models and techniques to help practitioners to manage their empathic response on their daily practice treating trauma.

**Conclusions**

Investigating relational therapists treating trauma revealed the power of relationships and intersubjectivity as inherent in their empathic response. Although it can be risky and increase vulnerability for therapists to be open and involved in the therapeutic relationships, but empathy that include authenticity can protect therapists. The empathic response is major factor in producing compassion fatigue, but it is also can produce compassion satisfaction and enhance resilience. I hope this study will inform therapists, supervisors, educators, and many other service providers who treat trauma victims. The main takeout of this study suggest observing the therapeutic dynamics in-
session and be aware to the empathic response in live during the therapeutic session. The main two suggestions refer to: 1. Practitioners should consider the risk and protective factor suggested in the CFRM and consider that the empathic response presented in this model can be a risk and protective factor at the same time. Therapists should perceive the empathic response as emotional connection and separateness at the same time and adopt a dialectical thinking while treating trauma, this flexible thinking can increase resilience and growth and prevent secondary trauma. The CFRM should adopt the separateness word, as different from detachment. Being separate is different from detachment because you can still be in touch, in relation and empathic, while being an authentic, separate person. While being empathic, practitioners and service providers can be connected but distinct in times because they are different subjects. This will not hurt the empathy but rather protect both- the patient and therapist. 2. Authenticity can be viewed as protective factor. Practitioners should feel the freedom of being authentic in their empathic position, this can allow them being human and express their empathy in a genuine way. The authenticity allows for freedom while being empathic with less vulnerability to develop compassion fatigue but rather being more resilience.

I would like to end with a song shared by one participant when she explained what empathy for her is:

Oh, the comfort, the inexpressible comfort of feeling safe with a person; having neither to weigh thoughts nor measure words, but to pour them all out, just as they are, chaff and grain together, knowing that a faithful hand will take and sift them, keep what is worth keeping, and then, with a breath of kindness, blow the rest away. *Dinah Maria Mulock Craik, A Life for A Life*
Empathy is the engine that runs and guides therapy, which leads to healing and hope for the trauma survivors. However, I hope relational therapists and all trauma therapists who do this meaningful and hard work learn how to sift what is not worth keeping and hold onto their sense of satisfaction and growth. Hopefully this study will be meaningful for them. It certainly was for me.
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Appendix A: Recruitment Emails in English and Hebrew

Email number 1:

Dear _____,

My name is Michal Toporek and I am a PhD candidate in Tulane University’s Social Work (City, Culture, and Community) Program. My research goal is to study the experiences of relational therapists treating trauma to learn about the challenges in their work in order to improve training, education and supervision and make their voice heard.

I write you to ask if you would please participate in a video interview as part of my dissertation research. Like you, I practiced trauma therapy with strong inclination to relational therapy and became interested in the secondary stress, if any, experienced by relational therapists. I aim to understand how relational therapists experience their work treating traumatized clients/patients. I estimate that the interview would last between 60-90 minutes and scheduled at your convenience.

The Institutional Review Board at Tulane University has approved this study (study number: 2019-1355) your participation in this study is completely voluntary. Once you agree to participate, you will be provided with a full description of the research purpose, personnel, procedures, risks, benefits, and a reiteration that your participation is completely voluntary. By expressing interest in participating in the study, you will be read a consent script before the interview starts that describes more information of the study and allows you to provide consent. The risk in this study is minimal and can include mainly inconvenient or stress while answering about the experiences treating trauma. The benefit will be mainly the produce of knowledge for relational and trauma therapists. You will also be allowed to withdraw participation from the study at any point.

Should you be interested in participating in this interview, please respond to this email. You can also contact Dr. Charles Figley as he serves as my faculty advisor for the study. He can be reached at figley@tulane.edu or (504) 862-3473.

Best,

Michal

Michal Toporek, MSW
Doctoral Candidate
Social Work (City, Culture, and Community)
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
(504) 605-8884
Follow up email, Email number 2:

Dear _____,

Thank you for your response and interest to participate in this study.

Please answer briefly to the following questions:

1. Do you treat patients who have had traumas?
2. Do you identify yourself as a relational therapist?
3. How long have you been practicing therapy?
4. What is your education degree?
5. Are you able and willing to participate in an online video interview?
6. Do you speak fluent English or Hebrew?

We will inform you soon if you participate in this study.

Thank you again for your response,

Best,

Michal

Michal Toporek, MSW
Doctoral Candidate
Social Work (City, Culture, and Community)
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
(504) 605-8884

If the person meets the inclusion criteria the following email will be send:

Follow up email, Email number 3:

Dear _____,

Thank you for your response, we are happy to inform you that you can participate in this study.

Please send optional dates and times to the online interview, please pay attention the interview will last between 60-90 min.

Attached is an informed consent script to read before the interview.

The interview will be conducted through Zoom application, it is a straight forward process:
1. Open this link to Zoom website  https://zoom.us/join
2. Add the meeting ID number ________
3. Make sure you have a camera and speaker open

See you online!

Best,

Michal

Michal Toporek, MSW
Doctoral Candidate
Social Work (City, Culture, and Community)
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
(504) 605-8884

If the person won’t meet the inclusion criteria the following email will be send:

Follow up email, Email number 3:

Dear ____,

Thank you for your response, your information did not meet the inclusion criteria of our study.

We are deeply appreciating your willing to participate in this study. The final results of the study will be sent to you by email.

Best,

Michal

Michal Toporek, MSW
Doctoral Candidate
Social Work (City, Culture, and Community)
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
(504) 605-8884
Mail number 1:

To ______,

I am Michal Toporok and I am a Master of Social Work at Tulane University in the USA.

The purpose of my research is to study the experiences of trauma therapists who work with trauma, to learn about the challenges in their work, and especially for educational and training purposes. In order to hear from you.

I am sending you this email in order to check if you would like to participate in an interview on--line as part of my research.

As a clinical social worker, I have dealt with trauma, with a significant tendency to a humanistic approach. As a researcher, I am interested in secondary trauma and wish to understand how therapists in a humanistic approach work with people who have experienced trauma.

I expect the interview to continue for 60-90 minutes and will be arranged according to your convenience. The Tulane University Ethics Committee approved this research project (project number 2019-1355), and you must ensure that you know that your participation in this research is voluntary. Moreover, before agreeing to participate in the research, you will be provided with a detailed description of the research objectives, risks, benefits and reminder that your participation is entirely voluntary. You can stop participating in the research at any stage.

The research involves minimal risk and may include discomfort or stress during the interview of the effects of trauma treatment. The main benefit is the creation of practical knowledge for therapists.

If you wish to participate in this interview, please reply to this email.

If you have any questions, please contact me or create a connection with Dr. Charles Figley who is the study leader. In my email figley@tulane.edu or 504-862-3471. Thank you in advance and all the best,

Michal

Michal Toporok, MSW
Student of Social Work
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
+1 504-862-3471 or figley@tulane.edu

Mail number 2:

To ______,

Thank you very much for your response and interest in this research project!

MSW

PhD student in psychology

Tulane University
127 Elk Place
New Orleans, LA 70112-2627
+1 504-862-3471 or figley@tulane.edu

Mail number 3:

To ______,

We are looking for volunteers for this study. Please respond to the invitation.

MCES, Tulane University

PhD student in psychology

Tulane University
127 Elk Place
New Orleans, LA 70112-2627
+1 504-862-3471 or figley@tulane.edu
אנא עני בקצרה על שאלות אלו:

1. האם אתה מתפשלบางคน עם ניסיון נגרים וטרגמאות?
2. האם אתה מעוניין באעדים ממציאים ו矻יתות?
3. כל—who בא לך להשקףacie?
4. מה התכלית (לטאר אתך, שעון, וכו')?
5. האם אתה מתחלף ומעוניין להשתתף בריציון וידאמר מוקדש?
6. האם אתה מבין ומעוניין או אנגלית או ספרדית או אנגלית?

אני נעדיך אותך בקרוב אם תשתתף במחקר זה.

תודה מראש, כל טוב.

מיכל

מיכל טופורק, MSW

דוקטורטורל לצבאות פלסיילאיס

אוניברסיטת טולין

Tulane University

127 Elk Place

New Orleans, LA 70112-2627

1+5046058884

מייל מספר 3: אם האדם נמצא מתאים למחקר יישלח לו מייל זה

לזכות

תודה על המון והרצון שלך להשתתף במחקר זה.

אני שמחה להודיע כי נמצאת מתאימה למחקר זה. אנא שלחי תאריכים או שעות אופציונליות לראיון און ליין. שימי לב כי אורך הריאיון הוא בין 60-90 דקות.

מצורף תופס הסכמה לפני קריאה לפני ההאの一 והריאוןICAL מוט.

הריון ייקרא במבואות אפליקציה ומור, והיון מואר מחוז: https://zoom.us/join

1. פתרון القرآن וניונים לבריאר ומי

2. הנסכים את מוספר המגניב

3. וודא שיש מצלמה וرمز פלוגת

תודה בברכה ואני-לי!
כל טוב.
מיכל

MSW, מיכל טופורק
דוקטורנטית לענדה פוליטאלית
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
1+5046058884

אם האדם אינו נמצא מתאימה למתוך יישלח לו מייל הבא:
לכן.
שוב תודה על התשובה שלך למתוך בפקור, ז"ל. לפי המידה של השלחת אינך יוכל למשתתף בפקור. זהemin פאודאר את המחשים שלך למתוך ולקנייה שלך, התרחבות המתחק יישלח אליור במייל.

כל טוב,
מיכל

MSW, מיכל טופורק
דוקטורנטית לענדה פוליטאלית
Tulane University
127 Elk Place
New Orleans, LA 70112-2627
1+5046058884
Appendix B: Interview Questionnaires

Interview questionnaire in English:

1. **Demographic information**
   - 1.1. Age
   - 1.2. Gender
   - 1.3. Ethnicity/religion
   - 1.4. Education
   - 1.5. Years of practice
   - 1.6. Place of practice and patient’s population

2. **Experience as a Therapist**
   - 2.1. Tell me a little bit about your therapy experience. How long have you been treating trauma? What types of trauma?
   - 2.2. Tell me a little bit about your therapeutic approach. How did you become interested this approach?
   - 2.3. Can you describe the empathy role in your therapeutic approach? Can you describe your empathic responses during therapy? Can you give examples.

3. **Impact of your work on the therapist**
   - 3.1. Can you describe the effects of trauma treatment on you as a therapist? Negative and positive effects
   - 3.2. Can you describe how you first became aware of these effects? What effects you the most positively and negatively?
   - 3.3. Can you describe the main factors of those effects? And how these factors relate to your therapeutic approach?
3.4. Are you familiar with the concepts of compassion fatigue/secondary trauma and compassion satisfaction? What do you know about it?

4. **Self-care Practices**

1.1. How do you manage to your well-being during your work? Describe how you cope with any challenges that arise doing this kind of work?

1.2. How did you process your experiences in treating trauma? Did you talk about it with your friends/family/supervisors?

1.3. What coping strategies have you found that work for you?

1.4. Has there ever been a time when you thought about stopping practicing? Can you describe what was going through your mind then?

2. **General questions as a research participant**

2.1. Why did you decide to participate in this interview?

2.2. How did you feel during the interview? And how do you feel now?

2.3. Is there anything else that I haven’t ask that you would like to add or emphasize?

**Interview questionnaire in Hebrew:**

שאולות ריאיון בעברית:

1. נתונים דמוגרפיים

2. גיל

3. מגדר

4. מוצא/דת

5. השכלה
שבוע ניסיון מקצועית

6. מヶך עבורה והוגה אוכלוסייה עם פּילם

2. ניסיון טיפולי

1. ספר/י לי בקצרה על הניסיון הטיפולי שלך. במהלך כמה זמן את/ה מטפל/ת בטראומה? ובאילו סגנים טראומה?

2. ספר/י לי בקצרה על הihilation הטיפולי שלך. בכמה להותלת אנייזוג ניינון בינשם?

3. תאר/י לי את המpaque temasית בוגרש העיטוףית שלך. האם תוכל/לחר את התנובת האופטימית שלך

ב了一会儿 הטיפולי? התוכל/לחת אחדות

3. השפעות הטיפולי על המتناول

1. תאר/י ליokus השפעות הטיפולי כדי_story? كالשלמות שליליות והחיוביות?

2. מתי שמתי למפגשון להשלמות את? זכר? מה השפעות עליך היה רובה?

3. האם תוכל/לחר את הגרמנים העיטוריים של השפעות את? זכר ורגמים אליי/share פלטש של השיטות הטיפולי?

שכל?

4. האם את/ה מכיר/ת את השמות טראומה משנית ואיפוניה? מה את/ה יודע/ת על זה?

4. התמודדות עם ניסיון צידי


1. מודע ההלחת להשתתף בריאה? זה?

2.乒זר ההלחת בטראומה זכר את/ה מרגישה/כעת?

3. האם יש מушки שלוש אסאנה לגבלי ויחי להזין لهذه לשלים אם לודגית?
Appendix C: Online Survey in English and Hebrew

Phase two: Online follow-up survey

Dear participant,

Thank you for being interviewed for this study. Your perspectives led to the data I will share with you here: Important themes that emerged from the interviews.

Now I seek your help in the second phase of the study. From offering ideas in the interview, now I need you to help me get it right; Therefore, you will be asked to write your feedback regarding the themes generated from the interviews. The goal of this follow-up survey is to confirm with the participants the data analysis results and get their impressions. This phase seeks to learn the in-depth accurate experiences of relational therapists by checking with the participants if the researcher collected and analyzed the data properly. I sincerely appreciate your participation and hope this study will give voice to relational therapists’ experiences treating traumatized patients.

This survey should take no more than 30 minutes. During this time, I will ask you to write your feedback about each theme. You are required to answer in your words do you agree or disagree with the generated themes and why. You can express your thoughts, perceptions, experiences and knowledge, etc. As with the interviews, this survey is completely confidential and anonymous. Feel free to skip any questions and, you can stop participating at any time. Attached is also the consent script from the first phase.

Thanks again for participating.

Now, please write your feedback (thoughts, impressions, perceptions, etc.) about the following themes generated from the interviews.
**Theme number 1:** Relational therapy and empathy- the relational therapist position inherently includes the use of the self, intersubjectivity and authenticity. This position was also described as the empathic response of relational therapist which adopted by relational therapists because trauma survivors patients, especially complex trauma patients need authenticity and honest relationships. This empathic response of relational therapists can include combination of feelings, positive and negative (so called not only ‘empathic’ reactions) as part of being authentic and transparent in the therapy.

**Feedback:** "I agree with this theme and the examples provided because I have seen it myself...." etc

**Theme number 2:** Double-edged sword of empathy and intersubjectivity/ a dialectical experience- the empathic response of relational therapists can be a risk and protective factor at the same time. Intersubjectivity and the use of the self can be hard, painful, intense and make therapist more vulnerable and exposed but at the same time it protects them while being authentic, transparent, involved and free to express themselves. The authenticity of therapist, serves as an emotional boundary when the therapist can express his own subjectivity and that protects himself.

**Feedback:**
Theme 3: Relational therapy, empathy and resilience - use of the self, intersubjectivity and authenticity gives freedom, liveliness, real connection, sense of satisfaction and growth. The empathic response in the relational position is rewarding and fulfilling, despite the cost of caring.

Feedback:_____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Theme 4: Boundaries as a protective factor and self-care method - boundaries in the setting level such as around money, communication and meetings are important because the relationships are so intense. The external structure helps with the internal boundaries because the internal boundaries are more challenging in relational therapy. Further, the use of the self and intersubjectivity can assist with setting emotional boundaries because the therapist can be himself and can express his emotional boundaries authentically.

Feedback:_____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Shib Shen shel haMeshir: Soker Meshubah Totan

Mshehatef yikra,

Tohod beera shehatavinei lo metoker, ze kowudat beemetsi soker sapikeh gomot veveza b'hamsher yeladim va yemeot

mecheriot shuvu bekehach gomot veveza. Kem, v'ashesam leklel ata ururak ve beshel hoshi shel metoker. Lezahor

shiyafet ve hara'ot uveha'shivot soker beshel harsa, beshel ze terakr lava aton batki'im. Le, beshel dh

etnakhevi lehit mashiv le hadomim shemopo beriauot.

Mesetoker meshuv zeh hi leazer umshehatefot ve ha'tazman gomot veveza lekibal at v'ishme. Shel zeh nu'd

lomalot ve ha'hore'ot ha'midkatot shel metropol ha'tishivot zeh di' v'deka gomot veveza b'mshehatefot yaam etaka

a'sapka v'ishit gomot veveza. Kay, v'merikha mo'ad ve lesheshafot omkoh shemtoker ze simi et kol' shi

metropol ha'tishivot metapolot be'taramahot.

Shofetoker meshuv zeh ha'yit lei nirt meshava. B'mahal 'tem, abokha memet kel'tav at meshuv soker et kol' ybeh

shehaleh bekelheh gomot, etnakhevi l'efr atm etom mes'ava ala mes'ama et'om mes'macha veu mes'ama meleha yemeot

omo'dul. Etom mo'makot leben at mokhimok, tiposok, yosikic, nide shervashok. Kem, etom, soker ze so'ad et anokim

lehalot. Teshub leziyn yi be'afshavot hal le hal shela sh'taretz ve'afseqet at etshafotet bal ket. Mazerik et to'se

tes'meca medat melshel ha'rasuon shel metoker.

Shofetoker meshuv bale shehafotetc.

Anay gbeha at meshuv soker (mishbat, resmim, tiposet ko) (le yemeot ha'midkatot shel mahriyan)

Tin'mec sefer 1: Tiposet ha'tishivot Amfitatik - Etom ha'metapel ha'tishivot kolote at etshofet be'emote, anovtr-

so'ibetikvez otzamaye. Etom ze v'ahorot ve gom Canyon Amfitatik shel metapel ha'tishivot she'amataz et di'metapel

ha'tishivot milam Zion, taramet, b'mitot taramet meribac, kokim la'os'atamit veureret it'isim ke neh. Zehub

amfitatik ze shel metapel ha'tishivot milam v'kolel sh'lever shel t'amot, bo'ibim ve'sh'elit (mah Sherket lekh teribot

'amfitatik) kelak matim la'os'atamit ve'kipol be'po'el.
משוב: (לודגא: "אני מסיכיה על הנושא זה ולהלכל הדגמהות ואינו קיים")

תימה מספר 3: חיבור בעברית בأخلاقית/סובייקטיבית / חוויה דיאלקטית - התנובה האפגנתית של
מתפללים התסמנויותי הולדה לזורם סיכום זורם למג בטרה חנתה. הנעדר האן-סובייקטיבית
והשימש בצלבתיו יולדה לזר ולשה, נבראון ויונסיביט הולדה של התיפול ל Ninja והשיק וחרק יד גם עם זאת
עמדה זו גם מוניה קויי שמתפרף אאותני, ש्, מוטורב והשף לבר את עצמו. היאנותנייה של התיפול יולדה
לשם כבול רעש כשלו התיפול יול באתי הוסיבית בול זה המג על
משוב: (לודגא: "אני מסיכיה על הנושא זה ולהלכל הדגמהות ואינו קיים")

תימה מספר 4: חיבור הנבולה גוגר למג ושתייה

לטיפולי עצמי

התוצאת מצחיה שבנול התפנית בכרם סיכון, תקשורות ופגישות הם בטבעה בשיטות
הטיפוליים משכילים מקוון של החיסים התסמנויות איון-סובייקטיבית. יד על כל המבנה החיסוני משני בנבולה הפנימיות
מכים שקטה להב אש הבוגר הפגנית והם מתנגרים יורד טיפולי החיסותי.
משוב: (לדוגמה: "אני מסכימה עם הנושא הזה ولתדונהות באיםモノים וו")

משוב: (לדוגמה: "אני מסכימה עם הנושא הזה ولתדונהות באיםモノים וו")

משוב: (לדוגמה: "אני מסכימה עם הנושא הזה ولתדונהות באיםモノים וו")
DATE: November 15, 2019

TO: Michal Toporek

FROM: Tulane University Social-Behavioral IRB

STUDY TITLE: Emphatic response and secondary trauma: The experiences of compassion fatigue, resilience and compassion satisfaction among relational therapists

REF #: 2019-1355
SUBMISSION TYPE: Initial Submission

ACTION: APPROVED

On November 15, 2019, the Tulane University Social-Behavioral IRB provided an expedited review and approval determination for the initial submission of this minimal risk study. The review was provided in accordance with the appropriate research regulations.

The following items were submitted as part of the submission:

- CITI_training_CERTIFICATE_toporek (Training Certificate)
- consent script (Consent Script)
- consent script in Hebrew (Consent Script)
- email_script (Other Recruitment Material)
- Follow-up survey (Questionnaires/Surveys)
- Follow-up survey_Hebrew (Questionnaires/Surveys)
- interview questionnaire (Questionnaires/Surveys)
- interview questionnaire- Hebrew (Questionnaires/Surveys)
- Letter of support from IARPP (Letter of Support)
- Letter of Translation (Certification of Translation)
- phone_call_script (Telephone Recruitment Script)
- PROTOCOL (Study Protocol)
- recruitment emails - Hebrew (Recruitment Letter)
This study is approved for the local enrollment of 30 subjects.

This study is granted approval on November 15, 2019. The Annual Progress Report will be due on November 14, 2020.

All research must be conducted in accordance with this approved submission.

Please submit any proposed changes to the research study, including enrollment of additional study participants, to the IRB for review and approval prior to implementation, unless a change is necessary to avoid immediate harm to subjects. If subject safety becomes an issue, please notify Tulane University Human Research Protection Office (HRPO) as soon as possible.

The informed consent process begins with a description of the study and assurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study with dialogue between the Investigator and research participant. Federal regulations require each participant to receive a copy of their signed consent form unless the IRB waives this requirement.

Please submit any unanticipated problems involving risk to subjects or others, deviations from the approved research, non-compliance, and complaints to the IRB in accordance with Tulane University Human Research Protection Program (HRPP) Standard Operating Procedures (SOPs). Please contact the HRPO via irbmain@tulane.edu or (504) 988-2665 if you have questions and/or concerns regarding reporting events. In addition, please also submit any reports generated by the DSMB or oversight committee to the IRB, if required.

Pursuant to Tulane University HRPP SOPs, a study progress report will be required annually.

If your study is supported in whole or in part by a federal grant, please note that Federal regulations prohibit the use of Federal funds for human subject research that is not conducted under current IRB approval. Loss of IRB approval for this study due to lapse, suspension or termination will be communicated by the Tulane IRB to Tulane’s Office of Grants and Contracts Accounting, which may result in an administrative hold being placed on the related grant(s). Therefore, to avoid an interruption in research activity, including use of coded, identifiable human data or biospecimens, and access to grant funds it is critical that IRB approval for the study be maintained.

Please notify the IRB within 30 days of completion of all study activities and data analysis by submitting a Study Closure Form.

The Principal Investigator is responsible for being familiar with and complying with Tulane University HRPP SOPs found at https://research.tulane.edu/hrpo. Please do not hesitate to contact our office with any questions or concerns.

Sincerely,

Tulane University Human Research Protection Office

Please note that the actual signature by the IRB Chair(s) is not required for this document to be effective. IRBManager generates this letter pursuant to the IRB Chair’s electronic signature and approval. This process is consistent with Federal Regulations and Tulane Standard Operating Policies with respect to the IRB and Human Research Protection Office, which consider electronically generated documents as official notices to sponsors and others of approval, disapproval or other IRB decisions. Please refer to Tulane's Electronic Signatures and Records Policy by visiting the HRPO website at https://research.tulane.edu/hrpo.
DATE: January 30, 2020
TO: Michal Toporek
FROM: Tulane University Social-Behavioral IRB
STUDY TITLE: Emphatic response and secondary trauma: The experiences of compassion fatigue, resilience and compassion satisfaction among relational therapists
REF #: 2019-1355
SUBMISSION TYPE: Amendments
ACTION: APPROVED

On January 27, 2020, the Tulane University Social-Behavioral IRB provided an expedited review and approval determination for this minimal risk amendment submission, in accordance with the appropriate research regulations.

The IRB approved the requested changes of updating the Protocol, Consent script and the recruitment emails.

The following items were submitted as part of the submission:

- consent script Hebrew_clean version (Consent Script)
- consent script Hebrew_tracked version (Consent Script)
- consent script_clean version (Consent Script)
- consent script_tracked version (Consent Script)
- Letter of translation (Certification of Translation)
- Point by point response (Point by Point Response)
- Protocol_clean version (Study Protocol)
- Protocol_tracked version (Study Protocol)
- Recruitment emails Hebrew_clean version (Recruitment Letter)
- Recruitment emails Hebrew_tracked version (Recruitment Letter)
- Recruitment emails_clean version (Recruitment Letter)
• Recruitment emails_tracked version (Recruitment Letter)

This study is approved for the enrollment of 30 subjects. The Investigator reports that 3 subjects have been enrolled to date. An Amendment must be submitted for review and approval before exceeding the total number of approved subjects.

The Annual Progress Report is due on November 14, 2020.

The most recent Tulane University IRB approved and stamped informed consent and/or assent form(s) must be used when enrolling subjects.

Research activity cannot commence if there are any pending approvals from any other institutions or research oversight committees including, but not limited to, the Tulane Institutional Biosafety Committee, Tulane Radiation Safety Committee, and any other committee approvals required by the University. The PI must provide the HRPO/IRB with a copy of all approval letters as received. Additionally, for sponsored research, the research cannot commence the PI provides an executed Sponsored Research Agreement.

Please do not hesitate to contact our office with any questions or concerns.

Sincerely,

Tulane University Human Research Protection Office

Please note that the actual signature by the IRB Chair(s) is not required for this document to be effective. IRBManager generates this letter pursuant to the IRB Chair's electronic signature and approval. This process is consistent with Federal Regulations and Tulane Standard Operating Policies with respect to the IRB and Human Research Protection Office, which consider electronically generated documents as official notices to sponsors and others of approval, disapproval or other IRB decisions. Please refer to Tulane's Electronic Signatures and Records Policy by visiting the HRPO website at https://research.tulane.edu/hrpo.
Appendix F: Consent Script in English

What is the research study and why is it being done?
You are invited to participate in a research study on the impact of trauma treatment on relational therapists. The questions will refer to the effects of trauma treatment, your thoughts, feelings and perceptions regarding the risk and protective factors in treating trauma. You are being asked to participate in this research study because you are an experienced relational trauma therapist that familiar with the experiences of relational therapists treating trauma. A total number of max 30 individuals will participate in the study, from different countries who speak fluent English or fluent Hebrew. The data of this study is for the purpose of the IP dissertation but will be used to other studies in the future with the same goal.

What will you do if you participate in the study?
You will be asked to answer questions during an interview of maximum an hour and a half. The interview will be online via Zoom Web Conference in a quiet and a private room, according to time availability of participants. The questions you will need to answer will be ready in advance but also questions the researcher will be deciding during the interview. With your permission, the interview will be video, and audio recorded. If you do not wish to be video or/and audio recorded, please indicate this to the researcher. After the interviews you will get an email asking to participate in an online survey using Qualtrics platform to get your feedback about the study results from the interviews, known as member checking method. The results presented in the survey will not include any identify information. You can take your time and answer the survey at your free time and the survey will be anonyms. Your participation will take approximately an hour to complete the survey.

What are the possible risks from being in the study?
The risks associated with this study are minimal risks, a possible inconvenience may be during the interview such as distress while talking about your experiences treating trauma. In any case of distress, you can share it with us, leave the interview and ask for help.

What are the possible benefits from being in the study?
The benefits which may reasonably be expected to result from this study are the knowledge gained from the study that may benefit society in general. Anticipated benefits might include a participant’s greater understanding of the risk and protective factors treating trauma. Additionally, knowledge gained from the study can be used by trauma practitioners as well as organizations and agencies treating trauma. We cannot and do not guarantee or promise that you will receive any benefits from this study. Your decision whether or not to participate in this study will not affect your employment.

If you take part in this study, how will we protect your privacy?
If you have read this form and have decided to participate in this project, please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. The alternative is not to participate. You have the right to refuse to answer particular questions. The results of this research study may be presented at scientific or professional meetings or published in scientific journals. Your individual privacy will be maintained in all published and written data resulting from the study.
The recordings will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your participation may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice or picture) will be used in presentations or in written products resulting from the study. Identifiers will be removed from identifiable private information and, after such removal; the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you.

**Will you be paid/receive credit to take part in the study?**

You will not be paid to be in this study.

**What if you have questions or concerns about the study?**

Take as much time as you like before you make a decision to participate in this study. If you have any questions or concerns about the study, whether before or after agreeing to participate, you can call the study Principal Investigator, **Michal Toporek, MSW at 504-605-8884** or **mtoporek@tulane.edu**. You can also call the Faculty Advisor **Dr. Charles Figley at 504-862-3473, Figley@Tulane.Edu** You can call about any matter having to do with the study, including complaints or questions about your rights as a study participant. If you want to speak with someone who is not directly involved in the study, you may call the Tulane University Human Research Protection Office at (504) 988-2665 or email **irbmain@tulane.edu**.

**Consent**

Please print a copy of this page for your records.

If you agree to participate in this research, please indicate this to the researcher before the interview. You will also get this script before the survey in the next phase.
שם המחקר: תגובת אמפתית וטראומה משנית: החוויות של עייפות חמל, חוסן וסיפוק

מהו המחקר ומדוע הוא נEEDED?

את/ה מוזמן/נת להשתתף במחקר בreligious ובו ת卅שפת נטיה בחינה על טיפולי החיסון. הטלושנים חוסנים וטראומה, המחוברים, החסינות והטיפוליים שלכם על גורמי סוכני וגרמיים אחרים. המחקר מתמקד בהרכב של המחקרים המחולקים לשתי חффית/מדפים הדומים לSetText_RELEASE/ RELEASE/TEXT-TEST/TEST

שאלה דוא"ל: האם תקבל תשלום כדי לקחת חלק במחקר?
לא.

מה ניתן לעשוי אם יש לך שאלות או חששות לגביש מה硼?
תוכל לקחת כמה זמן שתצטרך לפני שייך להשתתף במחקר. אם יש לך שאלות של חששות://מימדחי מתgetWindow או נמשכת לאחר מכן, תוכל להתקשר לחוקר הראשי של המחקר, מיכל טופורק, MSW טלפlığ' 504-605-8884 ניוסט. Figley@Tulane.Ed עזכיבים אוتطובב בטעמים כ_corrללי לפיה בר mostra. אתנהו. mtoporek@tulane.edu או 504-862-3473 1 לинтерес בחוקר, תמונה למבנה גישה יש לחיבור sondביח. Figley@Tulane.Edת תהליך שימור לתחביב🏻, אנל תוחזר על תחום,移送 לתחביב וא gameStateilia. irbmain@tulane.edu או 5049882665 evidיה לטפל עם על תחום זה, irbmain@tulane.edu או 5049882665 evidיה לטפל עם על תחום זה.

הסכמה מנדע
אנו hacen את העתק של דף זה עבוי הרישполнение שלקוח
אנו生产总/ה מסכים/مة להשתתף במחק hereby, לא鱿י zeigt בסכי הקחלה לחרוזי. תקביילג, גם
שאלה do הוראה והброוק בבלב הנה.
Appendix G: Glossary

Secondary traumatic stress (STS)- defined by Figley as "the natural consequent behavior and emotions resulting from knowing about traumatizing event experiencing by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1993b in: Figley, 1995, p. 7). STS, therefore, is when people are traumatized from experiencing indirectly traumatic event.

Compassion fatigue (CF) - Defined by Figley (2002), as “a more user-friendly term for secondary traumatic stress, which is nearly identical to PTSD, except it applies to those emotionally affected by the trauma of another (usually a client or family member) (Figley, 2002, p.3). Compassion fatigue considered as the cost of caring and refers to the physical and mental exhaustion that usually affect helpers and caregivers over time.

Resilience- Resilience in the trauma studies area, refers to the ability to maintain relatively stable, healthy levels of psychological and physical functioning after experiencing a traumatic event (Bonanno, 2004).

Compassion satisfaction (CS)- is a positive outcome from caring and it refers to the sense of fulfillment a therapist can feel from doing a job well and from helping others, particularly to those that are traumatized (Stamm, 2002).

Vicarious posttraumatic growth (VPTG) -is a process of growth following treating traumatized individuals and the benefits can include: improving relationship skills, observing and appreciating the resilience of the human spirit and the satisfaction from noticing a positive change in patient’s life (Arnold et al., 2005).
Empathy is the comprehension of another’s experience from that person’s perspective when the idea is to get a sense of how it feels to be in the other person’s shoes (Kohut, 1981). Overall, it is the ability to sense other people’s emotions, coupled with the ability to imagine what someone else might be thinking or feeling.

Intersubjectivity - Intersubjectivity generally means something that is shared between two subjective minds. Usually, it refers to the psychological relationship between people. In the contemporary relational psychoanalysis, it applies to the relationship between a therapist and a patient. The theory behind Intersubjectivity argues that all parts of the psyche are created solely in the interpersonal context (Stolorow et al., 1983; Stolorow and Atwood, 1992). The concept of the ‘third’, usually attached to the concept intersubjectivity in relational psychanalysis, and refers to the unique interaction between the subjectivity of the therapist and that of the patient and emphasizes the intensity of the effect of the interplay between the subjectivity of the therapist and that of the patient (Benjamin, 2004; 2018; Ogden, 1994).

Transference is an unconscious process of displacement of emotions to the therapist and countertransference is the opposite direction. The classical view has been understood by Freud as the way patients “transfer” feelings from important persons in their early lives, onto the therapist. Countertransference is simply the therapist’s response to a patient’s transference (Dalenberg, 2000).

Dissociation is a psychological defense mechanism of split and separation and a response that appears in traumatic experiences in which the trauma victim is unable to fight or flight and integrate the traumatic experience and therefore uses detachment to protect himself. The dissociation enables a critical escape from emotional and physical
distress connected to a traumatic event. However, the phenomenon of dissociation lies on a spectrum between normal and pathological reactions such as multiple self-states and dissociative identity disorder (DID) (APA, 2013; Howell & Itzkowitz, 2016).

*Enactment*- enactment is when the dissociated, unprocessed traumatic experiences and the and emotions behind them, can be manifested in the therapeutic relationship between therapists and patient. Enactment is a process of reliving the trauma in the inter-personal space (Bromberg, 2006; Howell & Itzkowitz, 2016).
<table>
<thead>
<tr>
<th>Partici</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity/Religion</th>
<th>Education</th>
<th>Practice</th>
<th>City/Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>piant</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>female</td>
<td>Latina</td>
<td>MA psychology; PhD clinical psychology</td>
<td>10 years</td>
<td>Nashville, US</td>
</tr>
<tr>
<td></td>
<td>77</td>
<td>male</td>
<td>American Jewish</td>
<td>PhD and Psychoanalytic Training</td>
<td>54 years</td>
<td>Nashville, US</td>
</tr>
<tr>
<td></td>
<td>62</td>
<td>female</td>
<td>Portuguese American</td>
<td>PhD, poetry and writing: MA psychology; MA clinical psychology</td>
<td>10 years</td>
<td>Pittsburgh, US</td>
</tr>
<tr>
<td></td>
<td>68</td>
<td>female</td>
<td>Jewish secular</td>
<td>MSW; Psychoanalytic training</td>
<td>30 years</td>
<td>Maryland, US</td>
</tr>
<tr>
<td></td>
<td>41</td>
<td>male</td>
<td>Jewish Yemen</td>
<td>BSW; MSW; FDP; Psychoanalytic training</td>
<td>15 years</td>
<td>Rosh Ha'ayin, Israel</td>
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<tr>
<td></td>
<td>44</td>
<td>female</td>
<td>Israeli Jewish</td>
<td>PhD Clinical Psychology; BA and MA Clinical Psychology</td>
<td>6.5 years</td>
<td>Tel Aviv, Israel</td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>male</td>
<td>English</td>
<td>PhD Philosophy: Clinical Psychology</td>
<td>12 years</td>
<td>France, Italy</td>
</tr>
<tr>
<td></td>
<td>86</td>
<td>female</td>
<td>Jewish secular</td>
<td>MSW; FDP; Psychoanalytic training</td>
<td>30 years</td>
<td>Rosh Ha'ayin, Israel</td>
</tr>
<tr>
<td></td>
<td>62</td>
<td>female</td>
<td>American</td>
<td>FDP; Poetry and writing: MA Psychology; MA Clinical Psychology</td>
<td>10 years</td>
<td>Philadelphia, US</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>female</td>
<td>American Jewish</td>
<td>FDP and Psychoanalytic Certificate</td>
<td>5.4 years</td>
<td>Boston, US</td>
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<tr>
<td></td>
<td>46</td>
<td>female</td>
<td>Latvian</td>
<td>MA Psychology; FDP Clinical Psychology</td>
<td>10 years</td>
<td>Riga, Latvia</td>
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<tr>
<td></td>
<td>44</td>
<td>male</td>
<td>Jewish</td>
<td>FDP; Psychoanalytic training</td>
<td>40 years</td>
<td>Haifa, Israel</td>
</tr>
</tbody>
</table>

Table 1: Demographic Characteristics of the Sample
### Table 2: Master Table of Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1: Working with trauma</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Theme 1: The broad definition of trauma</strong></td>
<td></td>
</tr>
<tr>
<td>Family trauma</td>
<td>P2; P2; P10</td>
</tr>
<tr>
<td>Transmission of trauma; Intergenerational trauma; Secondary trauma</td>
<td></td>
</tr>
<tr>
<td>PTSD, Complex trauma, CPTSD</td>
<td>P2; P3; P5; P6; P9</td>
</tr>
<tr>
<td>Continuous traumas</td>
<td>P5; P7</td>
</tr>
<tr>
<td>Cumulative trauma</td>
<td>P1; P5; P9</td>
</tr>
<tr>
<td>Collective trauma</td>
<td>P2</td>
</tr>
<tr>
<td>All patients and therapists have traumatized parts; All cases are</td>
<td>P6; P8</td>
</tr>
<tr>
<td>traumatic (Some significant some less)</td>
<td></td>
</tr>
<tr>
<td>Increase in trauma cases</td>
<td></td>
</tr>
<tr>
<td>Dissociative disorders – broad sense of- from ordinary dissociation</td>
<td>P9</td>
</tr>
<tr>
<td>to DID</td>
<td>P10</td>
</tr>
<tr>
<td>Historical background of trauma (The evolution of trauma studies, the</td>
<td>P2</td>
</tr>
<tr>
<td>recognition of trauma)</td>
<td></td>
</tr>
<tr>
<td><strong>Theme 2: Wide range of types of trauma</strong></td>
<td></td>
</tr>
<tr>
<td>Physical assault/violence; domestic violence</td>
<td>P1; P2; P3; P5; P7; P12</td>
</tr>
<tr>
<td>Sexual abuse; Rape; Group rape; Childhood sexual abuse;</td>
<td>P1; P2; P3; P4; P5; P7; P8; P9; P10; P11; P12</td>
</tr>
<tr>
<td>Prostitute Incest</td>
<td>P2; P5; P7</td>
</tr>
<tr>
<td>Early childhood trauma; Child neglect; Child abuse;</td>
<td>P1; P3; P4; P5; P6; P8; P9; P10; P11; P12</td>
</tr>
<tr>
<td>emotional/physical abuse Attachment issues</td>
<td>P2</td>
</tr>
<tr>
<td>War/Terror; Military trauma; Vietnam veterans</td>
<td>P3; P5; P8; P9</td>
</tr>
<tr>
<td>Holocaust survivors</td>
<td>P3; P4</td>
</tr>
<tr>
<td>Health trauma; Chronical illness; Terminal diseases; Neurodegenerative</td>
<td></td>
</tr>
<tr>
<td>diseases</td>
<td>HIV; HIV dimension</td>
</tr>
<tr>
<td>HIV; HIV dimension</td>
<td></td>
</tr>
<tr>
<td>Poverty and things around poverty; Homelessness</td>
<td>P3; P4</td>
</tr>
<tr>
<td>Drug and alcohol abuse; Addictions; by parents</td>
<td>P3; P5</td>
</tr>
<tr>
<td>Politically motivated trauma or torture; Political asylum</td>
<td>P3; P5; P8; P11</td>
</tr>
<tr>
<td>Loss; Death; Abortion; Witnessing death/violence</td>
<td>P3</td>
</tr>
<tr>
<td>Victims of crime acts, robbery, Kidnapping, Immigration trauma</td>
<td>P8; P9</td>
</tr>
<tr>
<td>Bushfires</td>
<td>P1</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>P1; P2; P7</td>
</tr>
<tr>
<td></td>
<td>P9</td>
</tr>
<tr>
<td></td>
<td>P11</td>
</tr>
</tbody>
</table>
### Theme 3: Psychological reactions to trauma

**PTSD** (Intrusive thoughts, Avoidance, Helplessness; Fear; Anxiety; Life threatens; Overwhelming; Difficult to register.

- Destruction of agency; denial of mind; Breaks the senses
- Dissociation; Dissociated traumatic parts Multiple self-states
- Body symptoms and sickness; Dissociation of the body; Self-harm; Suicidal
- Fragmentation; Split
- Shame and self-blame/guilt
- Triggers
- Distort relationship
- Sense of Betrayal

<table>
<thead>
<tr>
<th>P2; P3; P8; P9; P10</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2; P7; P12</td>
</tr>
<tr>
<td>P6; P8; P9; P10</td>
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<tr>
<td>P5; P7; P8</td>
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<tr>
<td>P8</td>
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<td>P9</td>
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<tr>
<td>P9</td>
</tr>
<tr>
<td>P12</td>
</tr>
<tr>
<td>P3</td>
</tr>
</tbody>
</table>

### Themes 4: Traumatized patient's needs

CPTSD patients need devotion of therapist
CPTSD looking for real/authentic relationships (very vulnerable therefore sense falseness and feelings easily)

- Working with the body expressions
- Processing the trauma but sensitively and softly;
- Giving freedom to talk about the trauma
- Need to talk about hidden parts, aggressiveness;
- Teach them how they impact others
- Traumatized need boundaries (because they tend to take care of parents/therapist)

<table>
<thead>
<tr>
<th>P7</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4; P5; P7; P8; P12</td>
</tr>
<tr>
<td>P8</td>
</tr>
<tr>
<td>P9</td>
</tr>
<tr>
<td>P12</td>
</tr>
<tr>
<td>P8; P11; P12</td>
</tr>
</tbody>
</table>

### Category 2: Relational therapy

#### Theme 1: The relational turn

Classic psychoanalysis vs. relational psychoanalysis: Passive vs. engage; strict vs. flexible; classic ideas of frame and setting; cerebral s. embodied; use of the self is porous vs. resistance

- Relationships vs. drives
- Neutrality changed; Two persons psychology

The trauma “turn” and the relational “turn”; Trauma happens in relations and healing also

- Traumatic event vs. drives/wishes; Sexual abuse vs. oedipal wishes

<table>
<thead>
<tr>
<th>P2; P8; P9; P10; P11</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1; P3; P9</td>
</tr>
<tr>
<td>P1; P8; P5; P7</td>
</tr>
<tr>
<td>P2; P3; P7; P8; P10</td>
</tr>
<tr>
<td>P2; P3</td>
</tr>
</tbody>
</table>

#### Theme 2: Therapists’ position

Treatment in relationship; Relationships is the focus; Work in the relationships, with the relationships accessible and secure relationship; Witnessing in the relationships.

| P2; P3; P4; P5; P8; P9; P10; P11; P12 |
Use of the self and subjectivity:

| Openness | P1; P3; P4; P6; P8; P9; P11 |
| Involvement; partnership | P1; P5; P9 |
| Allow (allow feelings; Allow openness, Intimacy) | P1; P2; P5; P8; P9; P11; P12 |
| Presence; Here and now | P1; P5; P8; P12 |
| Subjectivity of the therapist: intersubjectivity | P1; P4; P5; P6; P7; P8; P10 |
| Authenticity: Spontaneous; Transparent; Honesty; Freedom | P4; P5; P7; P8; P9; P11; P12 |
| Self-disclosure | P4; P5; P11 |
| Egalitarian: Eye level/Equal relationship | P2; P7; P8; P9; P11; P12 |
| Human; Touched; Alive; Moved; Tears/cry | P2; P3; P8; P9 |
| Feeling feelings and sensations that arises | P5; P7; P8; P12 |
| Participation: Process of two persons, Active | P5; P6; P12 |

The body is a tool/ two bodies psychotherapy; Working with the body and spirit, somatic approach
Requires reflexive observation, awareness of power dynamics, acknowledging gender differences Self-disclosure also requires responsibility
The knowledge resides in the patient; Emphasize the capacity to heal themselves
Ongoing therapeutic contract

| Theme 3: Relational dynamics and frameworks |
| Transference-counter transference | P2; P4; P7; P8; P9; P10 |
| Dissociation and Self-states | P4; P5; P8; P9; P10; P11 |
| Projective identification | P2; P8 |
| Reciprocal mutuality, Mutual recognition | P2; P4; P5; P7 |
| Construction, co-construction | P2; P8 |
| Enactment; Re-traumatization | P4; P7; P8; P11 |
| Attachment | P4 |
| Agency- the person is the center of himself | P2; P7 |

<p>| Theme 3: Choosing working relationally |
| Practice with theory or without, made sense, less a technician; Following intuition | P2; P3; P6; P10 |
| Convincing, effective and relevant for all kinds of therapy and types of relationships; Strong and powerful therapy; contemporary; Comparing to other methods (CBT/classic); Useful for dissociation; CPTSD | P1; P5; P6; P7; P10; P12 |
| Therapist’ personality | P7; P8; P11 |
| The wounded therapist; Therapy is a therapy for the therapist; The motivation to be therapist is your own trauma and personal background | P8; P6 |
| Became interested as a patient and grew form it; drawn to relational supervisors | P10; P12 |
| Curiosity | P6 |
| Not symptoms focused | P10 |</p>
<table>
<thead>
<tr>
<th>Category 3: Empathy in relational therapy</th>
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</thead>
<tbody>
<tr>
<td><strong>Themes 1: Empathy and use of the self</strong></td>
<td><strong>Themes 2: The role of feelings/emotions in empathy</strong></td>
</tr>
<tr>
<td>Involvement, Connectedness, Participation with emotional and physical experiences Not necessarily participation Authenticity: being real person/human; honesty/trust; Authenticity vs. classical interpretive, transparent, freedom Engaging in deepest painful places, include dissociation, involves pain, deep impact and identification Intense relationships, interactions, mutuality Active use of the self; Self – disclosure, openness Containment; absorb Being a vessel, container Empathy is the verb of witnessing; Witness not just for witnessing sake</td>
<td>Feeling the inside of patient; Experiencing the feelings of patient; Hold feelings; Register a feeling; Combination of feelings; emotional moments; Verbal and not verbal. Negative feelings can be empathic also Empathy is about feelings and less cognitions. Emotional vs. intellectual; basic animal emotional respond vs. logical/interpretive respond When patients feel free safe to talk; Let the other person be himself Reduce shame</td>
</tr>
<tr>
<td>P1; P5; P6; P8; P9; P12 P5; P6; P7; P8; P10 P2 P4; P5; P7; P9; P11</td>
<td>P5; P6; P7; P8; P10; P12 P1; P2; P3; P4 P6; P7 P9; P11</td>
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<thead>
<tr>
<th><strong>Theme 4: The role of mind in empathy</strong></th>
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<tbody>
<tr>
<td>Co-constructions; Share thinking; Two Minds Process /Process underneath Steady dialogue Understand the break of trauma/that trauma is unconceivable and where people are coming from Desire to know; curiosity</td>
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<tr>
<td>P2; P9</td>
<td>P2; P9</td>
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<tr>
<th>Category 4: Trauma treatment effects</th>
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</thead>
<tbody>
<tr>
<td><strong>Sub-category: Negative</strong></td>
<td><strong>Theme 1: Compassion Fatigue</strong></td>
</tr>
<tr>
<td>Exhausting; Tiredness; Loosing energies tired; drained; bored; sleepy; depleting Weighed down; Burden; Heaviness; Awful; seriousness Bearing Witness is painful; the therapist needs a witness to</td>
<td></td>
</tr>
<tr>
<td>P3; P4; P5; P6; P7; P8; P10; P11; P12 P3; P5; P6; P7; P10; P12 P3; P5; P6; P7; P9; P10</td>
<td></td>
</tr>
<tr>
<td>Theme 1: Effects on the body and mind</td>
<td>Theme 2: Effects on feelings/emotions</td>
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<td>-------------------------------------</td>
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<tr>
<td>Estranged and distance from people; Loneliness, talking different language; Not being presence Can’t hear about trauma; Reach capacity listening to people all day; Hard to listen During CF times: Had thoughts to stop being therapist when self-resources started to depleting; No desire to work Hoping patients will drop/not arrive Need to recover; to relax, to disconnect, to take a shower and release the energy; Escape, need to be alone; transitions require rituals Accumulative factor, Burnout; Emotional taxing, CF is part of work Drink wine every night Vulnerability</td>
<td>Sadness Pain, Agony, Hurt Anger; Frustration; Arousal; Shorter fuse at home; more agitated and irritable Traumatized Helplessness Depression; Despondent Anxiety; Terrified; Fear; Stress Self-aggravation/Guilt/worried doing damage/patients drop; raise competence issues (especially CPTSD or suicidal or self- abuse patients) Disconnections, Cut-off, dissociate More anxious and protective about children; higher awareness for child abuse Less emotional availability for family (small children); disagreement with spouse; less tolerance</td>
</tr>
<tr>
<td>P4; P5; P7; P11; P12 P3; P4; P5; P7; P12 P5; P6; P10</td>
<td>P1; P2; P3; P4; P6; P9 P1; P6; P10 P1; P7; P10; P11</td>
</tr>
</tbody>
</table>
Worry, In my mind a lot Often think/dream about patients, when patients die/suicide, think about it a lot ; Have flashes Unwanted memories

**Sub-category: Positive**

**Theme 5: Compassion satisfaction**

<table>
<thead>
<tr>
<th>Make a change/see the change</th>
<th>Satisfaction; Fulfilling; Rewarding</th>
<th>Nurturing real connection/being authentic, Engaging, Love, involvement, Devotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remarkable to see patient’s resilience despite Trauma; Sense of awe and honor, Hope and Faith in the human, Inspiring patients’ courage, taking risk and willing to share/trust; Marvel human spirit</td>
<td>Mutual growth/Mutual recognition</td>
<td>Compassion satisfaction affirms the relational approach</td>
</tr>
</tbody>
</table>

**Theme 6: Personal Growth**

<table>
<thead>
<tr>
<th>Transformation</th>
<th>Grow as a person, Better person</th>
<th>Gift; Opportunity</th>
<th>Expand the ability to contain, More tolerance; Compelling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong personal experience; Self-acquaintance</td>
<td>Spiritual meaning; meaningful</td>
<td>Better reader, better writer</td>
<td>Became feminist; Progressive views on gender fluidity</td>
</tr>
<tr>
<td>Feel more confident, able</td>
<td>Rejuvenates; Truly energized; Very enlivening</td>
<td>Look at problems in proportion</td>
<td></td>
</tr>
</tbody>
</table>

**Sub-Category: CF mechanism**

**Theme 7: The double sword and dialectical experience**

| Empathy opens and enlarge the heart but also breaks the heart, empathy open the heart by going through pain; Taking CF by intersubjectivity but without being traumatized – by setting intersubjective boundaries/emotional boundary | The cost of Subjectivity gives life but facing pain at the same time; Even when it is hard, it means that something happens, live | Relational therapy and subjectivity/authenticity give freedom but at the same time to be exposed/vulnerability | Use of the self is hard and can cause burnout but meaningful; Therapist heals with the patient, use of the self helps building yourself |

**Theme 8: Compassion fatigue Resilience**

| Tears and sadness different from compassion fatigue | Can feel the assault but the assault does not stay | |

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P1; P4; P5; P7; P8; P10; P11
P1; P2; P3; P4; P5; P6; P7; P8; P10; P11
P4; P6; P7; P8; P9; P11
P3; P4; P7; P8; P10; P11; P12
P5; P7; P10
P3; P4; P6; P8; P9; P10
P1; P2; P5; P8; P10
P2; P3; P6; P7
P3; P7; P9
P1; P5; P6; P8
P3; P5; P7; P10
P9
P9
P10; P12
P11
P6
P10
P4
P7; P8
P2
P2
P3
Aces for patients but not hurt me  
Never felt devastated or ‘zero bottom’  
Do not have a lot of burnout  
Payoff outweigh the costs  
Not wanting to stop practice but want to do it differently, work in different setting  
Get more from therapy, far more then compassion fatigue

<table>
<thead>
<tr>
<th>Category 5: Risk and Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors:</strong></td>
</tr>
<tr>
<td><strong>Theme 1: Setting</strong></td>
</tr>
<tr>
<td>Burnout/CF higher working in community service/ Public clinic: have to treat everybody; high volume places, high demands; the system don’t support structurally; less professional freedom; power and control dynamics; Other stuff that are not compassionate</td>
</tr>
<tr>
<td>High number of patients</td>
</tr>
<tr>
<td>Sexual abuse children cases, CPTSD</td>
</tr>
<tr>
<td>Most difficult – to lose patients and patients leave, Many death cases (AIDS)</td>
</tr>
<tr>
<td>No boundaries, No structure; no emotional boundaries</td>
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<tr>
<td>Suicidal/self- harm cases</td>
</tr>
<tr>
<td><strong>Theme 2: Therapist</strong></td>
</tr>
<tr>
<td>Beginning practice /less professional experience/Young age/ Training time a lot of burden</td>
</tr>
<tr>
<td>Personal background and history - vulnerability/Personal triggers/ therapist personality/ The wounded therapist</td>
</tr>
<tr>
<td>High levels of responsibility/devotion/protection especially with patients with high levels of self-abuse; Savor fantasy; omni-potency</td>
</tr>
<tr>
<td><strong>Theme 3: Therapeutic contents/dynamics</strong></td>
</tr>
<tr>
<td>Graphic pictures/descriptions Enactment, dissociation and use of the self----very exhausting and intense</td>
</tr>
<tr>
<td>Traumatic hard contents- things you never heard before; stories patients tell out of nowhere surprise/ extreme situations/Witnessing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors:</th>
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</thead>
<tbody>
<tr>
<td><strong>Theme 1: Setting and Experience</strong></td>
</tr>
<tr>
<td>Public service rewarding</td>
</tr>
<tr>
<td>Less patients</td>
</tr>
<tr>
<td>Not having all patients traumatized, Less complex patients</td>
</tr>
<tr>
<td>Private practice- don’t have to work with everybody; can refer patients who are stuck</td>
</tr>
</tbody>
</table>

P6  
P10  
P10  
P11  
P9  
P1; P3; P10; P11  
P3; P6; P8; P11  
P3; P6; P9; P10  
P3; P4; P8; P9  
P5; P10; P12  
P7; P10; P11  
P3; P4; P5; P6; P7; P8; P10  
P3; P5; P8; P9; P10  
P5; P6  
P1  
P5; P12  
P5; P9; P10  
P1; P3; P6  
P4; P7  
P10; P11  
P2; P7; P6 P10
| Good team-work - respect, communicate, sense of belonging; Wide professional network/sharing with colleagues | P7  
P2; P3; P4 |
| Very hard stories that are very “far” from you, easier to disconnect | P6 |
| More experience; Building up therapeutic muscles | |

**Theme 2: Therapist position**

| Subjectivity and use of self as protective factor; Authenticity Involvement as advantage /resilience | P1; P3; P4; P5; P6; P7; P8 |
| Dynamic work/ moving | P2; P10 |
| Holding humanistic approach to both the patient and therapist; human doing mistakes; see the person behind the trauma; See the resilience, Hope and faith | P2; P4; P7 |
| More depth/more awareness, more change and satisfaction | P5; P1 |
| Be in contact with your body/Mindful position/Being/allowing | P4; P6 |

**Theme 3: Boundaries**

| Success separate work and life, time for self-care/vacation | P2; P12 |
| Clear boundaries about availability/cancellation, communication/money | P3; P4; P7; P12 |
| Balance- doing other stuff (Research/teaching) | P3; P4; P6 |
| Compartmentalize/separate/Not identify with everything/not giving more than really can | P4; P6; P11 |

**Category 6: Self-Care**

| Theme 1: Understanding self-care | P1  
P1  
P1; P10  
P1 |
| Awareness; agency awareness | |
| Active self- care, evolves | |
| Unique self-care, not a prescription; not a list | |
| Signs; alone, overwhelmed | |

| Theme 2: Self-Care methods | P1; P3; P4; P5; P6; P8; P9; P10  
P3; P6; P8  
P1; P2; P4; P7; P8; P9; P10; P11: P12  
P1; P7; P8; P11 |
| Writing; take notes; Publish; Blog | |
| Reading | |
| Supervision | |
| Engaging with family and friends. Intimate relationships | |
| Take a walk and clear the head; Walk with the dogs; Walk to work | |
| Be alone vs. meet people | |
| Do other things: Research, teaching, workshops, leisure time | |
| Yoga/Meditation/Relaxation | |
| Sharing/Talking/ Processing with colleagues’ therapists; Join many association | |
| Being in nature/Forest bathing, Woods, beach | |

| | P3; P4; P9; P10; P11  
P3; P10; P12  
P2; P3; P4; P5; P7; P9; P12  
P3; P4; P8; P10  
P1; P4; P6; P8; P10; P12  
P4; P5; P8; P10; P11 |
| Rituals between sessions                          | P5                              |
| Take many showers                                | P5                              |
| Gym, sport, Swim                                 | P5; P6; P7; P8; P11; P12         |
| Sleeping snoozing napping                        | P6                              |
| Massages/Medical services/Personal care          | P8                              |
| Therapy                                          | P8; P12                         |
| Buy gifts for myself                             | P8                              |
| Need the weekends to recover/Vacations           | P9; P12                         |

**Theme 3: Boundaries**

<p>| Set clear boundaries around money and communication | P1; P5; P7; P8 |
| Moving to the next session                         | P3               |
| Separate home and work                             | P1               |
| Retreat                                           | P4               |
| Use outside structures to help setting internal boundaries | P12            |</p>
<table>
<thead>
<tr>
<th>Theme 1</th>
<th>Theme 2</th>
<th>Theme 3</th>
<th>Theme 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational therapy and empathy - the relational therapist position inherently includes the use of the self, intersubjectivity and authenticity. This position was also described as the empathic response of relational therapist which adopted by relational therapists because trauma survivors patients, especially complex trauma patients need authenticity and honest relationships. This empathic response of relational therapists can include combination of feelings, positive and negative (so called not only “empathic” reactions) as part of being authentic and transparent in the therapy.</td>
<td>Double-edged sword of empathy and intersubjectivity/a dialectical experience - the empathic response of relational therapists can be a risk and protective factor at the same time. Intersubjectivity and the use of the self can be hard, painful, intense and make therapist more vulnerable and exposed but at the same time it protects them while being authentic, transparent, involved and free to express themselves. The authenticity of therapist, serves as an emotional boundary when the therapist can express his own subjectivity and that protects himself.</td>
<td>Relational therapy, empathy and resilience - the use of the self, intersubjectivity and authenticity gives freedom, liveliness, real connection, sense of satisfaction and growth. The empathic response in the relational position is rewarding and fulfilling, despite the cost of caring.</td>
<td>Boundaries as a protective factor and self-care method - boundaries in the setting level such as around money, communication and meetings are important because the relationships are so intense. The external structure helps with the internal boundaries because the internal boundaries are more challenging in relational therapy. Further, the use of the self and intersubjectivity can assist with setting emotional boundaries because the therapist can be himself and can express his emotional boundaries authentically.</td>
</tr>
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<table>
<thead>
<tr>
<th>1</th>
<th>Very good</th>
<th>TRUE</th>
<th>Make sense</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>I somewhat agree with this but the way</td>
<td>I am not sure I understand this</td>
<td>You come to know yourself</td>
<td>Boundaries are important</td>
</tr>
</tbody>
</table>
it's phrased leaves out that receiving authenticity as a complex trauma survivor is not necessarily something one is conscious of needing and in fact, may cause real discomfort (whether initially or periodically). So the authenticity of the therapist is more of an internal awareness within the analyst that must be maintained, that may or may not be shared directly with the patient depending on the phase of the treatment and the patient's capacity to use the authenticity meaningfully.

finding the way it's phrased. I don't think of authenticity as a boundary. I think of it as the platform in which unprocessed and unformulated material is best met. But that's not a boundary per say. It's a context - a context that's open enough to handle all sorts of 'incoming' affective/sensorial data. In this way, it's double-edged because some of the content that comes through may be very painful. But even this implies that pain is only adversity and if we know anything as therapists, it's that the avoidance of pain causes more illnesses than facing it.

better and deepen your own subjectivity as you bear witness to others, so it is enriching.

because they re-establish safety for the patient and for the therapist. Trauma survivors do not typically have an experience of boundaries as caring and respecting their integrity, so the boundary communicates that right off the bat. Boundaries are not needed because the relationship is intense. But because the boundaries designate this relationship a therapeutic one - as opposed to a primarily personal one. The boundaries protect both parities in clarifying the implicit and explicit understanding of coming together in relationship for therapeutic purposes.

3

Not sure if I understand this but I would say that the use of the

I'm not clear what this means - the authenticity of therapist serves as

Agreed. But don't most forms of therapy use an

Yes - boundaries and self-care are
<table>
<thead>
<tr>
<th>RELATIONSHIP is even more important than the use of the self.</th>
<th>an emotional boundary” How does the authenticity of the therapist protect the therapist?</th>
<th>empathic stance? I don’t think its empathy that helps the trauma survivor in relational therapy- its the relationship.</th>
<th>critical in this work.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong></td>
<td>I wholeheartedly resonate with this!</td>
<td>Yes. Slochower (2017) about some risks, in my opinion she is too afraid of the risks.</td>
<td>Yes it is more rewarding than consuming.</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>As a relational psychotherapist, I use my body as if a musical instrument. I tune into the music in my head, whether it lulls me, whether It’s discordant. I am especially sensitive to a feeling of connection that comes to me in the form of feeling. Often it’s a sadness that can engulf me as if I’m feeling sadness for and with the person who is with me, or it can be anger, or sometimes</td>
<td>It's often tricky to figure out how much my response to a person is coming from me, my experience in the world more than theirs. I’m careful therefore not to spell out too loudly what goes on for me, but I try hard to look at the dynamic of what might be going on between us and suggest we try to have a look at that and see if</td>
<td>Gone are the days of the austerity model that said the therapist must keep all their desires at bay. Over time, the therapeutic emphasis has shifted slowly from the top-bottom model of the therapist as an expert making profound interpretations to the patient, the ignorant one</td>
</tr>
</tbody>
</table>
a sense of distance or boredom as if the person is not emotionally at home.

Likewise, there are times when my mind can become jumbled. This happens often with a woman with whom I work who has suffered multiple sexual abuses throughout her childhood including at the hands of her mother. This woman is acutely sensitive to what goes on in me and there are times when I can feel persecuted by this. Times when I feel no matter how hard I try I will still get it wrong. Times when I know that to express openly something of what I might experience of this confusion will be problematic as she will experience me as being just like her mother, always putting my feelings ahead of her. And yet my feelings in relation to this woman are essential in our work together as long as I travel slowly and do not expect too much of her.

It makes sense in terms of the person’s life experience. But given the inevitable nature of enactments, I try to listen hard to the person with whom I work for their response to my words, to hear as much as I can whether or not my words were helpful. To try to follow the links in the other’s thinking and how they link with my own, but it’s fragile and subject to human error. And also, to my mind, necessary. For me, to own my subjectivity and allow the person with whom I work to know about theirs.

In need of help, into a more mutual understanding. The co-creation of the therapy space with greater emphasis on enactments, where we begin to recognise more the value on the interplay between the therapist’s subjectivity and that of the person in therapy and how these two aspects co-create the therapeutic experience and add to or detract from its richness.

It is also important to recognise the value of therapy not only for the person in therapy but also for the therapist. This is akin to recognising that it’s not only mothers who feed their babies. Babies also feed their mothers, not

Winnicott’ wonderful quote comes to mind. It's a joy to be hidden, but disaster not to be found. (1965, p.186.) Much of the criticism directed at me when I first presented my work to an audience of mainly therapists for the level of my so-called self-disclosure, I had rubbed against the wounds of too much hiding. Of too much deprivation, that too many of us experience as therapists, the need for ourselves to be seen, to be heard and understood and not simply within the confines of our own personal therapeutic or analytic space where only one other can know. We want others to know us.

One of the joys
Authenticity and honesty are essential in this case as she can read me like a book. She knows when I become defensive and also when I intellectualise or lose touch with the little girl inside who is confused about the difference between love and hate. And also, I must bear her experience of me as a predator from time to time, which does not sit well with me given my best efforts to be anything but a predator. Given my own experience of being preyed upon as a child. But my experience is not hers.

milk, but something different, something to do with mutual recognition and shared caring which is why authenticity and honesty are fundamental.

of the supervisory group with whom I work, a small group of four whose travelled together for at least a decade, we are able to be open with one another about ourselves, our work, our relationships to one another. We talk about our secrets, and about our struggles both in the consulting room and outside in so far as it impacts on our work and our relationships. This is a fertile and nourishing space in which to grow as therapists as we do not judge and can deal with our subjectivity in powerful ways. Unlike my earlier experiences in training where the sense was, we must keep our mistakes and difficulties to ourselves for
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<tbody>
<tr>
<td></td>
<td>I agree, it would be a good idea to define empathy as going beyond compassion and being an attuned responsiveness the unique needs of each patients</td>
<td>this is unclear to me. How does it protect the therapist? and from what? it provides more freedom to the therapist, but not necessarily protection</td>
<td>Yes I agree, but not that it is different from the self psychological and relational perspective. Being empathic is not necessarily the same as being authentic, free and open</td>
</tr>
<tr>
<td>6</td>
<td></td>
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<td>while mostly true, note that due to COVID, the definition of the frame and boundaries has stretched to fit the context. Now therapists, including me, are more willing to engage in more flexible structure as long as the basic frame is protected</td>
</tr>
<tr>
<td>7</td>
<td>Yes, I agree with the statement. The fact that the therapist will experience that combination of feelings it also implies a constant self-evaluation in our response. The idea would be to be aware the most we can of what's going on in</td>
<td>I agree with the statement.</td>
<td>I agree with the statement. I agree with the statement. Boundaries are so important. Sometimes it can be necessary to find those boundaries in supervision. That check in with other professional is</td>
</tr>
</tbody>
</table>
therapist and client relationship.

necesssary specially when things are difficult or the therapist has the feeling of being overwhelmed.

empathy is crucial for psychotherapy and within the frame of a relational approach of course the therapist uses its own self to express, feel, understand and communicate with the patient. the response is not given by the empathy the therapist is feelings but by the approach he/she was trained to work. Trauma survivors are the most vulnerable category of patients so being too emphatic as a therapist might overload the therapeutic field, one has to be always cautious with that!

Yes in my opinion being authentic is the key that opens a lot of doors in therapy but as I say in my previous answer and as you point out it might be a "double-edged sword" if the trauma is too big or the therapist too opened.

no, the cost of caring is important, one has to have boundaries all the time and never forget thy dyad is in a therapeutic frame and they have to hang on for a long time and not "get lost" on the way. Lots of therapists suffer of burnout or they get sick so I would say the use of self has to be done in a certain way and with a clear purpose, one should always be careful with the use of self, resilience is build up on time but differs from one therapist to another, some make it some not! as the patients, so the therapists!

good, yes the point in my previous answers - boundaries - in therapy sometimes due to identifications or projective identifications or transference and counter transference boundaries tend to get lost or mixed up, parts of the patient are projected into the therapist and vice versa so the therapist has the responsibility to keep track of the dynamics and protect both himself and the patient, especially when a patient is very traumatized (see vulnerability). Responsibility comes with boundaries and bit by bit the therapist might
<table>
<thead>
<tr>
<th></th>
<th>I'm not exactly clear that I understand what this means. I don't know what an empathic response is as a technique. I don't know that you can consciously decide to be empathic. <strong>I do think that it's important that the patient's perceptions be responded to authentically.</strong></th>
<th>Here too I am puzzled. I don't know how to respond to this because it seems to presume that therapists have a choice of how to respond either empathically or not. Don't all therapists hope to be empathic? Are there some therapists who choose not to use themselves? Perhaps I'm not really understanding the framing of this.</th>
<th>Again I'm just not sure whether therapists choose to be empathic or not. We try to listen as closely as we can and we hope that our own treatments and supervisions have helped us see what we are responding to. But I don't know that that's unique to therapists who choose to call themselves relational.</th>
</tr>
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<tbody>
<tr>
<td>9</td>
<td>I'm not exactly clear that I understand what this means. I don't know what an empathic response is as a technique. I don't know that you can consciously decide to be empathic. <strong>I do think that it's important that the patient's perceptions be responded to authentically.</strong></td>
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<td>Again I'm just not sure whether therapists choose to be empathic or not. We try to listen as closely as we can and we hope that our own treatments and supervisions have helped us see what we are responding to. But I don't know that that's unique to therapists who choose to call themselves relational.</td>
</tr>
<tr>
<td>10</td>
<td>I’m not sure I understand the “negative” I agree the reactions are multiple and</td>
<td>I agree.</td>
<td>I agree completely. There is ‘an additional’ of something</td>
</tr>
</tbody>
</table>
complex, but I don’t understand the “negative” aspect mentioned.

have a h/o of trauma require support throughout their healing and clearly boundaries between self and other take place, but I’m not sure I would attribute that as a need to draw boundaries due to strong internal feelings.

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>Not sure I agree, it is a general statement on therapy</th>
</tr>
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<tbody>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

SUMMARY

9 out of 12 participants agreed with the theme. Three participants did not understand fully the theme and added clarifications and/or their own perspective. One participant partially agreed.

7 participants agreed with the theme, while 4 did not understand the way the theme phrased and mainly the authenticity as a ‘boundary’. One participant described her own perspective but without implying agree or disagree.

10 participants agreed with the theme, one participant is not sure about the theme, and one participant disagree.

9 participants agreed and 2 were not sure and 1 disagreed

Bold-Agree

Underline- Do not understand

Italic- Disagree
Figure 1: The Compassion Fatigue Resilience Model
Figure 2: Results Map

- Working with Trauma
- Risk and Protective Factors
- Empathy
- Relational Trauma Treatment
- Trauma treatment effects:
  - Negative effects
  - Positive Effects
- Compassion Fatigue Resilience Mechanism
- Self-Care
Biography:

Michal is graduating from the City Culture and Community PhD program at Tulane. Her dissertation investigates compassion fatigue resilience and growth among relational trauma therapists, and her dissertation chair is Prof. Charles Figley. Originally from Israel, Michal received her B.S.W and her M.S.W in Clinical Social Work from Tel Aviv University. Michal specialized in the treatment of stress and trauma and her thesis focused on secondary traumatization among wives of ex-prisoners of war and how it has affected their parenting; the revelations regarding the process and transmission of trauma were fascinating to her, providing greater insight into her work and substantial content for research.

Prior to coming to Tulane, Michal worked for nine years in mental health practice as part of Israel’s national health services, she worked as a Social Worker and Rehabilitation Coordinator for three years at two mental health rehabilitation organizations and also as a Manager of Sheltered Housing for Mental Health. Michal continued working as a Clinical Social Worker for six years, practicing Psychotherapy at Community Health Services, collaborating with physicians, nurses and health professionals.

Her research interests include Trauma; Secondary Trauma; Resilience and Growth; Family Relations and Trauma and Relational Therapy.