Empathy is the cornerstone of trauma care and PTSD treatment. It's crucial in understanding the faces of trauma clients and in treating their clients, and their experiences. The ability to identify and respond to emotional distress (Shama & others, 1999) is vital in the treatment of PTSD. In this book, we will refer to such reactions as trauma victim reactions. The term "trauma victim" refers to the individual who has experienced a traumatic event, and "PTSD" refers to the psychological condition that can result from the experience of trauma.

Some research suggests that the ability to empathize is fundamental to the treatment of PTSD. For example, in a study by Wilson & others (2006), trauma-related symptoms were significantly reduced in individuals who were able to empathize with their therapists. This highlights the importance of empathy in the treatment of PTSD.

Empathy is not just about sharing emotions, but also about understanding the perspective of the other person. It involves being able to put oneself in the shoes of the other person and see the world from their point of view. This ability is crucial in trauma care, as it allows the therapist to better understand the client's experience and respond appropriately.

However, it's important to note that empathy can be challenging to practice in trauma care. Clients often experience intense emotional distress, and it can be difficult for therapists to remain composed and empathetic. This is why it's important to receive appropriate training and support to practice empathy effectively.

In conclusion, empathy is a crucial component of trauma care and PTSD treatment. It allows therapists to better understand their clients' experiences and provide effective treatment. However, it's important to recognize the challenges of practicing empathy in trauma care and to receive appropriate training and support to do so.

To summarize, empathy is the cornerstone of trauma care and PTSD treatment. It's crucial in understanding the faces of trauma clients and in treating their clients, and their experiences. The ability to identify and respond to emotional distress is vital in the treatment of PTSD. In this book, we will refer to such reactions as trauma victim reactions. The term "trauma victim" refers to the individual who has experienced a traumatic event, and "PTSD" refers to the psychological condition that can result from the experience of trauma.

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must adjust himself to the point in the theatre where he is attending to the patient's condition.

When the patient is in the theatre, the surgeon's role is to be an observer and to provide support. This involves maintaining a calm and serene atmosphere, which allows the patient to focus on their breathing and other physiological responses. The surgeon should also be prepared to intervene if necessary, but only after consulting with the anaesthetist and other members of the surgical team.

The surgeon's role is also to provide reassurance to the patient, who may be experiencing anxiety or fear during the procedure. This can be achieved through the use of soothing words and gestures, as well as by providing clear and concise information about the procedure and expected outcomes. Additionally, the surgeon should be attentive to the patient's non-verbal communication, such as body language and facial expressions, and respond appropriately to any signs of distress.

Empathy is also important in the surgeon's role. It is the ability to understand and share the feelings of the patient, and to respond with kindness and compassion. This involves being able to listen actively and to be present in the moment, which allows the surgeon to connect with the patient on a deeper level. Empathy can help to alleviate anxiety and build trust, which are essential for a successful surgical outcome.

In conclusion, the surgeon's role is multifaceted and requires a combination of technical skill, observation, and empathy. By carefully considering these aspects, the surgeon can provide the best possible care for the patient and enhance their experience during the procedure.
SUCCESS DIMENSIONS IN POST-TRAUMATIC TREATMENTS

- Affective reactions (disregulated affective states, empathic strains, compassion fatigue, vicarious traumatization)
- Therapeutic alliance/maladaptive emotional, engagement, and empathic work
- Empathic process modalities of empathic attunement vs. empathic disavowal
- Determinations of treatment efficacies/Outcomes

Figure 3.1: Processes dimensions of post-traumatic therapies (PTTs). Copyright John P. Allen, 2020.
functions ... Morgan and LeDoux (1995) conclude that without orbital prefrontal feedback regarding the level of threat, the organism remains in an amygdala—driven defensive response state longer than necessary, that it humans, conditioned fear acquisition and extinction are associated with right hemispheres dominant amygdala function (Leifer et al., 1990) and that a defective inhibitory system operates in PTSD (Moyer et al., 1993). (p. 239, italics ours)

Moreover, as part of this complex neurological system governing adaptation to traumatic stressors, the dysregulation in the right hemisphere of the brain activates mechanisms that make pathological dissociative states an integral part of adaptive and protective organismic responses to trauma. Schore (2003a, 2003b) describes this process:

The neuroscience literature also indicates that dissociation is associated with a deficiency in the right brain. Consul and colleagues described a dissociation between the emotional evaluation of an event and the physiological reaction to that event, with the process being intact on right hemisphere functioning.... A failure of orienting function is seen in the hypostabilistic state of pathological dissociation, and this dysfunction would interfere with its normal role in processing, motivational information and maintaining the motivational control of goal-directed behavior, and therefore manifest as a deficit in organizing the expression of a regulated emotional response and an appropriate motivational state for a particular social environmental context. (p. 137, italics ours)

The PTSD patient presents in treatment with a pretest psychological disposition to manifest varying degrees of affect dysregulation as a kind of infrastructure to the full-blown cluster of PTSD symptoms which include changes in the self-structure and fluctuating ego-states (e.g., hypervigilance, rage, fear, helplessness, dissociation, hyperarousal, etc.). Since psychotherapy has a circumscribed therapeutic context, the patient's initial perceptions of the therapist's capacity to be genuinely empathic, understanding and capable of “holding” (i.e., sustained empathic empathy) are important, and will influence the pattern of trauma related transferences which, of course, will likewise “unfold” and change in their dynamics over time. Therefore, the combination of strong affect dysregulation, proneness to dissociation and testing the therapist's capacity to "receive" the trauma story always exists as treatment begins. As noted by many clinicians (Chu, 1999; Courtotis, 1999; Parson, 1988; Pearlman & Saakvitne, 1995), the creation of a safe therapeutic sanctuary is essential to facilitate the "flow" and disclosure of information on how the patient's sense of well-being was compromised by her or his trauma-tization. Further, with good initial empathic attunement, a critical therapeutic structure develops which will undergo transformations in the
The concept of secondary traumatic stress and vicarious traumatization has been validated through empirical research, and these effects can be compared to symptoms experienced by individuals who have been directly exposed to trauma. Secondary traumatic stress is a natural reaction to witnessing or hearing about traumatic events, and it can significantly impact the mental health of caregivers, therapists, and other professionals who work with trauma survivors. This process is similar to the psychological trauma experienced directly by the client, and it can lead to emotional exhaustion, burnout, and secondary traumatization in the professional. Addressing secondary traumatic stress is crucial for maintaining the well-being of professionals who work in the field of trauma therapy.
manifestations of fear and anxiety states associated with dysregulation in the limbic system and especially the amygdala.

The relevance of these findings to therapists working with trauma clients is the possibility that, through intense exposure to trauma clients' self-pathologies (i.e., borderline), the therapist themselves begin to experience mirrored stress responses.

The results of the CTRS provide evidence of the presence of dysregulated affect and somatic reactions in therapists. Among these affective 92.6% confirming these reactions to their work with trauma clients, clients' conditions (e.g., PTSD, dissociative disorders, etc.) would have little effect on their work. When analyzing these findings, they lead to important conclusions: therapists who report feeling of emotional and a sense of sadness (48.2%), associated with the awareness of a malevolent presence in perpetrators, stand out among the others.

It is possible to speculate that the dysregulated affects experienced by trauma therapists are related to somatic reactions. If persistent exposure to intense dysregulated affects (e.g., PTSD) leads to internalization in somatic ways. The results of the CTRS show that, on average, 51% of participants reported feeling of emotional and a sense of sadness (48.2%), associated with the awareness of a malevolent presence in perpetrators, stand out among the others.

Why headaches? Are headaches a form of "affect signal" to the therapist about the patient's internal working model? Are headaches a signal of muscle tension and loss of attunement, or the product of hypervigilance? Could headaches be a somatic form of defense against feeling overwhelmed? From outside (i.e., from the patient) to inside (to the therapist's inner-reached level of information in processing the client's inter- therapist self-reflection? How can we once again quote Allan N. Schore's book, "Psychotherapy and the Repair of the Self" (2003), in terms of principles of identification; these right brain defenses process the emotions into "blank states" charged with intense affects that can potentially traumatize therapists and organize the self-critical (p. 280, italics ours).

This quotation from Schore refers, of course, to the development of PTSD and dysregulated pathways associated with trauma. However, does it apply equally well to some trauma therapists? Do trauma-ized, in general, and post-traumatic therapists in particular, run the risk of experiencing distressing and over-whelming dysregulated affects (i.e., fear, vulnerability, uncertainty, sadness, grief) which lead them to use defenses as "non-conscious strategies" of emotional regulation to avoid, minimizing, or converging affects that are too difficult to tolerate? Are such defensive and adaptive tendencies part of the psychological domain and territory of vicarious traumatization?

TRAUMA THERAPIST AND TRAUMA CLIENTS: WHO CHOSES WHO?

In our sample of 354 respondents from the membership rosters of ISTSS and SSD, 58% reported a personal history of trauma, primarily childhood and adulthood abuse. As Figure 10.12 shows, those are also other professional, clinicians who were war veterans, battered spouses and survivors of medical trauma which is associated with direct of surgical procedures. The results of the survey reveal that 96.3% of the therapists, on average, were treating patients who had suffered the same types of abuse and trauma as the therapists had endured. The strength of this concordance of trauma history and background facts between therapists and client is interesting, and raises several questions pertaining to our further findings on vicarious traumatization affect dysregulation and PTSD-like symptoms reported by the participants.

First, do therapists consciously choose to work with patients whose history is similar to their own? If so, what effects do the therapists' background of trauma have on their therapeutic propensities during the course of psychotherapy? For example, do they have their own histories of abuse and trauma rekindled by exposure to their clients' trauma narratives? Are these phenomena I overidentification as a countertransference phenomenon? Are they "at risk" of professional role-boundary violations? Are they more secretive and nondisclosing of their stress-related reactions to patients, because of their own personal history of trauma and abuse?

Second, do therapists with a history of trauma possess more empathic capacity and resilience than therapists without a trauma history? Are "survivor" therapists analogous to members of alcoholics anonymous who share common problems in an arena of acceptance and commitment to recovery?