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Facing personal adversity while dealing with the pain of others: A hermeneutic literature review

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In April 2016, while I was in my third year of postgraduate psychotherapy training and only a few months into clinical work, my grandfather died. I journeyed through a hollow and non-linear grief experience while beginning to work with clients—many of whom were in great pain of their own—and began to notice that the experience of adversity among my peers while they, too, entered clinical work was seemingly ubiquitous. This indicated to me that most psychotherapists, while they work with their clients, are likely to experience some form of pain or suffering. The human scene is, after all, filled with surprising and disturbing events (Symington, 2016). As these embryonic observations were gestating in my mind, my wife's father was suddenly diagnosed with an aggressive and late-stage oesophageal cancer. This event excruciatingly reopened my slowly healing wound of grief. Then, in my last months of psychotherapy training, an even more chaotic and disorienting event occurred in my life. This would both shatter the delicately balanced equilibrium just restored and, ultimately, consolidate my desire to better understand the myriad issues that arise when the therapist's personal and professional lives touch (Morrison, 2013).

In what follows, which is extracted from my dissertation (Francis, 2018), the research for which I conducted under the supervision of Dr Kerry Thomas-Anttila, I first outline the methodology and methods of my research on therapist experiences of adversity. Following, I explore the impact of these experiences on the psychotherapist themselves. Here, I focus particularly on the therapist's internal experience when crisis presents outside of the therapy room. Next, I explore the multifarious impacts that such experiences can have on the therapeutic relationship; that is, the relationship between therapist and client. I conclude by exploring different ways of digesting experiences of adversity and directions for future research. In investigating this topic, my hope is that those who already think in terms of the influence of life events on the therapeutic relationship might find some resonance with what emerges. For others, I hope to offer a new way of conceptualising the inevitable intersection of the personal and the professional (Kuchuck, 2014). I also seek to draw attention to the fact that it is not just our histories that may influence our clinical work, but our current day-to-day lives as well (Adams, 2014).

This study was initially conducted in 2018 as part of a dissertation. Since then, the world has faced levels of adversity arguably not seen in decades: an ongoing and devastating pandemic, a worsening climate situation, a potential looming economic depression, other serious epidemics, and various crises of industry and relationship. Advances in technology continue to subsume our former analogue selves, and the impacts are only just being understood. Underscoring the urgent and disturbing conditions currently facing humanity is a new and frightening war that is being waged on Ukraine as I write these very words. In a

way, the very notion of therapist experiences of adversity has changed dramatically since I wrote my dissertation. Our experience as therapists aligns, perhaps, more closely with our clients than it ever has before. However, the focus of this paper remains the day-to-day moments of upheaval that most psychotherapists will experience to some extent in their working lives. By this, I mean events like sickness in the family, falling ill ourselves, purchasing a house, separation or divorce, losing money in an investment, facing difficult personal decisions, or encountering some other moment that challenges us in some way.

I do not intend to discuss historical trauma, a topic that has been well covered in literature on the popular concept of the "wounded healer" (Adams, 2014; Cvetovac & Adame, 2017; Farber, 2017). In addition, "therapist burnout" is a vaguely defined yet commonly discussed concept pertaining to exhaustion resulting from working in a helping profession (Emerson & Markos, 1996). As wounded healers and therapist burnout are well covered in the literature, I believe understanding the impact of current, day-to-day moments of crisis and adversity on the therapist and the therapeutic relationship is of great importance. We cannot circumvent global and personal catastrophe; we must find ways to continue to live and work through it.

Methodology and methods

I settled upon the methodology of hermeneutics, and employed the method of the hermeneutic literature review. I chose hermeneutics because of its strengths in uncovering and furthering understanding of human experience, and because it values subjectivity and seeks to bring the "shadowy and latent... into the clear light of day" (Crotty, 1998, p. 89; Laverty, 2003; Smythe, 2012). In conducting a hermeneutic study, I wondered whether the painfully uncertain shadows cast over my own small world may have some light shed upon them. Central to this methodology is the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010) which pertains to the researcher's non-linear immersion in the literature. While in the hermeneutic circle, the researcher reads and re-reads the literature while engaging with data, conversation, and writing; ultimately seeking to expand and develop their understanding of their research phenomenon (Boell & Cecez-Kecmanovic, 2014). The circular clarifying of different parts of the whole through interpretation and reinterpretation ultimately leads to a deeper understanding of the literature and thus of the research topic itself.

Given that the theoretical underpinnings of my training were substantially psychodynamic, this review primarily examines psychoanalytic/psychodynamic literature on the therapist's experience of adversity. However, I also include literature from psychology, counselling, medical, and more general scientific disciplines where it seemed particularly relevant. In keeping with the hermeneutic tradition, my approach to research was firmly grounded in interpretivism and was fundamentally "concerned with the life world or human experience as it is lived" (Laverty, 2003, p. 24). As such, each time I chose to engage with a piece of research, I entered a process of self-reflection. My experiences of and responses to the literature were considered, revisited, and considered again, and are interwoven throughout this study.

A vagueness comes over everything: The psychotherapist's experience of personal crisis

As I began to explore literature pertaining to the traumatic experiences of psychotherapists, I remembered an experience shared by a well-regarded instructor in my first year of postgraduate training. I recall him telling us of falling from a ladder during renovations to his home. What struck me about his story was that after the fall his immediate concern was not what might have happened to his body. Instead, he feared that his *mind* might have somehow been compromised. He was not concerned with spinal damage, paralysis, or some other enduring bodily injury. Instead, he was concerned about his brain and how damage to this precious organ might impact his ability to work as a psychotherapist. It occurred to me that as a therapist my brain and, by proxy, my mind and all of its power to connect me with another, is one of the most potent instruments in the orchestra of therapeutic engagement.

Mirroring the experience of my instructor, perhaps the most disconcerting element of my own encounters with adversity, both during clinical training and my more recent work as a psychotherapist, has been the subsequent worry that my mind might be somehow compromised by the experiences I am facing. I stumbled upon the poem *Fog* by Amy Clampitt (1997) within which I found an eerie resonance. Clampitt writes:

> A vagueness comes over everything,
> as though proving colour and contour alike dispensable:
> the lighthouse extinct,
> the islands' spruce-tips drunk up like milk in the universal emulsion; houses reverting into the lost and forgotten;
> granite subsumed,
> a rumour in a mumble of ocean... (p. 5)

For me, this poem evokes images and feelings reminiscent of my experiences of crisis—a fog rolling quickly in over my mind, the panic that sets in after the fading of clarity and, like granite subsumed by universal emulsion, the fear of becoming cut off, or torn away, from critical faculties that were once so easily accessible.

In moments of crisis I tend to liken my profession, which ultimately occupies a delicate position at the subjective crossroads of science and art, to more practical trades. I worry that if a carpenter could not work without a saw, a dentist without a drill, a pianist without keys, then surely a psychotherapist could not work without a fully intact mind. Perhaps there is a fear that a degree of cognitive collapse will tear at the very root of what it is to be a psychotherapist, given that, as a psychotherapist, I *am* the therapeutic instrument (Morrison, 2013).

Poets and scholars have long emphasised a personified "root" to the human psyche, recognising that this root can be damaged or split. In Plato's *The Symposium* (380-375BC/1989), he recorded that a central belief within Greek mythology was that humans

initially had four arms, four legs, and two faces. However, after becoming increasingly concerned about their power, Zeus split them in two, condemning them to live in a perpetual search of their other halves. This act served to split in two the very core—the root—of the human being. Moreover, in the late 18th century, Hebel wrote, "we are plants which—whether we like to admit it to ourselves or not—must with our roots rise out of the earth in order to bloom in the ether and to bear fruit" (as cited by Heidegger, 1966, p. 47). Additionally, in 1918, Hoyt wrote the poem *The Root*, essentially a lover's lament about a root becoming torn in one's heart after loss. The human experience of being torn at the root seems to have long been acknowledged, by poets and scholars alike.

Similar ideas can be seen among the earliest writings within the psychotherapeutic tradition. More than a century ago, Freud wrote of an internal "tearing" that can occur during times of loss (Clark, 1980). Reflecting on his father's death, Freud wrote, "I feel now as if I had been torn up by the roots" (as cited by Clark, 1980, p. 160). I was struck by this line as it so accurately captured my own experience of internal compromise. I wondered whether Freud, too, might have experienced a blunting of his perceptual tools at this time. Did he experience a fog settling over his previously clear mind? In his seminal *Mourning and Melancholia*, Freud (1917) observes a similar phenomenon, suggesting that "the ego debases itself and rages against itself" (p. 257) when the individual is in mourning.

More recent authors have discussed a similar phenomenon. This seemingly violent internal experience is also present in Stolorow's (2008) personal account of losing his wife. Stolorow writes "her death tore from me the illusion of our infinitude" (p. 41). Throughout his painful account, Stolorow refers to a subsequent collapse which precipitated major changes in the way he perceived the world.

Pines (2014) writes of her own encounter with mortality in terms of "tearing" after experiencing a stroke, expressing that her "life was torn asunder" (p. 224) after this traumatic event. What I noticed about her problematic and challenging journey back to health after her literal neurological tear was her discussion of shock. She describes this feeling as one of violence—recalling it was as though someone had broken into her house and beaten her. She had been in excellent health and could never have predicted this terrible event. Though I dare not compare my experience to a stroke, I was curious about her experience afterward. This idea that being robbed of something, being stripped bare to reveal one's total and complete vulnerability, could underpin a tear in some internal emotional fabric.

The idea of shock is also picked up by Hanscombe (2008), whose experience of ejection from psychoanalytic training offers another example of intrapsychic detachment. After Hanscombe's removal from training, which came without explanation, she notes that one of her primary responses was shock. Curiously, she writes that she had the sensation that her mind no longer belonged to her. For me, this spoke to another form of what Freud (1917) might refer to as "debasing", a tearing away at some kind of central part of the self. Hanscombe's experience of otherworldliness is echoed by Stolorow (2008), who refers to his own mourning leading him to feel that he was not of this world anymore.

A kind of intrapsychic detachment, then, seems to be a common thread running through therapists' experiences of personal trauma. In *Mourning and its Relation to Manic Depressive States*, Klein (1940) refers to "struggling against the chaos inside" (p. 144) while discussing her most likely fictitious patient, Mrs. A, who lost her son to a sudden medical event while he was at school. Attempting to re-establish social connections after this traumatic event, Mrs. A takes a walk down a familiar street only to find herself quickly overwhelmed by a sense of alienation in what should have been a familiar place. After retreating to a restaurant for relief, Mrs. A finds herself feeling "vague and blurred" and that the external world had become "artificial and unreal" (Klein, 1940, p. 144). Gradually, she manages to recover her sense of connectedness; but not until she has endured a period of detachment. Interestingly, according to Glover (2009), Mrs. A was a metaphor for Klein's own experience of grief. Tragically, Klein's son, Hans, had fallen from a precipice and died while out for a walk not long before she wrote this article. Thus, like Freud, Klein's account provides valuable insight into the potentially chaotic inner experience of a therapist undergoing personal trauma.

These feelings of alienation, otherworldliness, and detachment capture the essence of my experience of personal crisis. In their own way, each author has described an internal tearing which, in my opinion, often precludes difficulty thinking clearly. I do not believe these experiences exist in isolation, only occurring "out there" in the psychotherapist's personal life. On the contrary, I feel that they must impact clinical work in some way. As Stolorow (2008) suggests trauma can nullify all possibilities for being, reducing us to "skeletal consciousness" (p. 41). The pervasive and reductive impact of trauma leads me to wonder about what neurological mechanisms are at play in the brain when we experience the internal tearing of trauma. It seems to me that by first understanding this, we might gain a more comprehensive understanding of what happens in the therapeutic relationship during experiences of adversity in the therapist's life.

Trauma and thinking

Ringstrom's (2014) poetic and troubling lament "trauma, trauma everywhere and not a thought to think" (p. 147), captures the limited cognitive state—the "skeletal consciousness" that can be evoked by trauma. Ringstrom describes trauma as an assault which can incapacitate the mind and one that can "shatter heretofore illusions about reality" (p. 149). The human brain is "the master organ of stress and adaptation to stressors" (McEwen et al., 2016, p. 18). When confronted with psychological stress, two main mechanisms are activated to help restore neuropsychological equilibrium, known as homeostasis (Pabst et al., 2013). The first mechanism is faster-acting and involves the activation of the sympathetic nervous system, which is responsible for stimulation of the fight or flight response. By releasing catecholamines, such as dopamine and norepinephrine, the sympathetic nervous system readies the body for action. The second mechanism is slower and involves the hypothalamic–pituitary–adrenal axis, which releases the glucocorticoid cortisol from the adrenal cortex (Pabst et al., 2013).

The increased release of catecholamines and cortisol can lead to impairments in thinking and decision making as they affect the prefrontal cortex, where numerous glucocorticoid receptors—important moderators of stress—are located. Moreover, increased sympathetic nervous system activity has been linked to negative affect, which can impact neurological processing. Worry and other types of stress-related thinking have been shown to prolong this neurophysiological response, which can have neurological ramifications weeks and months later (Connor et al., 2013).

Van der Kolk (2000) discusses the "disintegration of experience" as one of the primary stress-related symptoms when facing trauma. For me, this concept jumped off the page as it seemed to be linguistically aligned with the concept of tearing. According to Van der Kolk, the neocortex, brainstem, and limbic system are those regions in the brain tasked with maintaining homeostasis and, put simply, overwhelming these areas results in difficulty thinking, in placing oneself in the world, and in finding words and language by which to describe one's experience. Although this allows the individual to maintain a certain emotional distance from the trauma, it inevitably reduces some areas of cognitive functioning.

Psychotherapeutic thinking

The correlation between trauma and cognitive impairment led me to consider what stress might do to psychotherapeutic thinking. The broad concept of psychotherapeutic thinking is frequently mentioned in the literature; yet, few authors offer a concise definition (Speeth, 1982). Fewer still discuss the concept in relation to therapist experiences of adversity. Speeth (1982) hypothesises that this is likely a consequence of psychotherapy being "an undefined technique applied to unspecified problems with unpredictable outcome" (p. 142).

Freud (1900) outlines the importance of the psychoanalyst's evenly hovering attention. To this end, Freud encouraged the analyst to become free from all preconceptions so as to appreciate everything the patient says equally. Speeth (1982) draws on Freud's early conceptualisation, developing a contemporary model of panoramic psychotherapeutic attention which emphasises that all therapists, regardless of orientation, are confronted with the same raw data—what they can see, hear, or sense as well as what they have going on inside them. Paying attention to this raw data is, for Speeth, the essence of psychotherapeutic thinking.

More recently, Mozdzierz et al. (2014) suggest that thinking like a therapist requires the ability to formulate cases, interpret the meaning behind certain behaviours, the need to understand the client's position, and to develop a plan that incorporates the unique set of social and emotional circumstances in which the client finds themselves. Mozdzierz et al. also emphasised the importance of "non-linear" thinking in psychoanalysis; a concept pertaining to seeing "beyond the facts to the patterns that emerge" and realising "that there may be more to a situation than is presented on the surface" (p. 2). Mozdzierz et al. assert that the benefit of therapeutic thinking is that it "maximises therapist flexibility in dealing with the infinite variety that clients and their circumstances bring to the treatment setting" (p. 2). Moreover, the authors contend that therapeutic thinking can transcend the

constraints of preconceptions and worldview. This is an important factor when attempting to attune empathically to a client.

Heidegger (1966) differentiates between calculative and meditative thinking. The latter of these, to my mind, bears strong similarities to psychotherapeutic thinking. According to Heidegger, calculative thinking is always happening as we consciously and unconsciously make plans and process increasingly "economical possibilities" (p. 46). Conversely, meditative thinking floats "unaware above reality" (Heidegger, 1966, p. 46). This form of thinking exists outside normal understanding, requires practice and patience, and must be carefully crafted. It is not dissimilar to the type of thinking one must do when sitting with clients—a form of *reverie* which involves "our ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions [and] images emerging from states of half-sleep" (Ogden, 1997, p. 568). Heidegger emphasises the importance of this form of thinking, suggesting that it is awakened, facilitating deeper understanding, or the noticing of "what at first sight does not go together at all" (p. 53). Given the obvious significance of this thinking state, I feel it important to consider what can happen when it is interfered with.

Preoccupation

For me, when in the depths of adversity, it is easy to become preoccupied with those events raging in my personal life. Consequently, the clear, meditative, and psychotherapeutic thinking, previously mentioned, can become significantly more difficult. As I reflect on this experience, I am reminded of the popular use of the term "unthinkable" in relation to experiences of trauma (Foehrenbach & Lane, 2001; Ringstrom, 2014). For me, there was something unthinkable about my personal experience, and this fed into my professional life. Mendelsohn (2013) calls this unthinkability "preoccupation", suggesting traumatic preoccupation can reduce the therapist's ability to be cognitively present during times of crisis. Mendelsohn describes his sense that he had lost his own "clinical bearings" after the loss of his young daughter who had a congenital heart condition.

The concept of losing one's clinical bearings reminded me of a wayward compass (Lombardi, 2010). I imagine the adventurer encounters a great amount of despair when the compass, a utilitarian object, whose only purpose is to aid navigation, becomes useless. This despair is picked up on by Mendelsohn (2013), who remembers anxiety and self-interest emerging amid frequent hospital appointments, detracting from his ability to think psychotherapeutically. He recounts the turmoil of being told that his daughter would die soon only for her to recover, and then decline once more. He also recalls the constant feeling of fear while under the cloud of his daughter's inevitable yet unpredictable death. Over time, Mendelsohn worried that preoccupation with his daughter's precarious medical situation was impacting his clinical judgment.

Mendelsohn (2014) develops the idea of preoccupation in writings about his divorce. He describes his decision to separate from his wife of 29 years as both hopeless and hopeful—an act that risked long-term security and disrupted the familiar; yet one which was bold, offered the promise of new possibilities, and required facing into powerful and destabilising forces. Mendelsohn remembers this as a time of pain, loss, and grief; all of which

contributed to an overall preoccupation, making it difficult to think psychotherapeutically. He relates the experience of divorce back to the death of his daughter, suggesting that during this time he felt he was under a "shadow" that made it hard to think. This impacted his connectedness with clients and made him worry about his continued effectiveness and ability to think as a therapist.

Preoccupation is a concept that emerges elsewhere in the literature. Adams (2014), for instance, writes of the anxiety that followed a professional complaint that a client had made about her. At the time, she felt she could "bracket" her distress but, after the complaint had been resolved, many of her clients and supervisees advised her that they had felt something was wrong throughout this arduous period in her life. This led her to wonder retrospectively about whether, under stressful conditions, she could retain a level of thinking light enough to continue to spark connections and remain attuned to the needs of her clients.

I encountered a similar phenomenon when I read Flax's (2011) reflection on her experience of serious illness in the family. Her daughter experienced an unexpected seizure, leading to the discovery of a brain tumour which ultimately damaged her ability to speak. Flax's reflection on this time is underpinned by resentment toward her clients as she remembers the struggle to continue caring for others while being preoccupied with her ailing daughter. This resentment is a familiar sensation for me as I have sometimes wished that I could just be alone with my difficulties, rather than continue to make myself available to others.

The relational impact of therapist experiences of adversity

Trauma can evoke alien feelings, feelings of overwhelm, distraction, disturbance and, troublingly, occasionally it may provoke emotional deadness, causing those affected to feel nothing at all (Stolorow, 2008). Certainly, sitting calmly in my comfortable chair in my office while chaos reigns supreme in my personal life has presented multifarious challenges not present when the waters of adversity were placid. Some authors suggest that such disruption to the therapist's affective equilibrium can result in problems in the psychotherapeutic relationship (Colson, 1995; Goldstein, 1997). Others, such as Adams (2014), suggest that the experience of personal trauma can draw the therapist nearer to their client. Moreover, the contrast between experiences of affective chaos and subsequent feelings of numbness can unsettle psychotherapists (Morrison, 2013). Thus, what happens within the dyadic client–therapist relationship during and after the destabilising of the psychotherapist's emotional radar is a question worthy of pondering.

Countertransference and its disequilibrium

Countertransference is a fundamental tool in the work of a therapist and might be thought of as a therapist's 'emotional radar' (Racker, 1957). Historically, countertransference was understood primarily as an impeding disturbance within the therapist which needed to be worked through in personal therapy (Frank, 2014). Since then, however, countertransference has come to be thought of as the multiplicity of feelings and emotional

responses experienced by the therapist—everything that arises within the therapist (Racker, 1957). The therapist's feelings are no longer pathologised or thought of as detrimental to the therapeutic process. Instead, they are viewed as guidelines to understand more fully the client's experience and can assist in interpretation and intervention.

The scope of countertransference has been further broadened by the idea of "subjectivity"; the notion that the therapist is, in actuality, *completely* involved in the relationship (Gerson, 2013). In classical psychoanalysis, the patient divulges their mental content which is then interpreted by an analyst who serves a purely objective function (Mitchell, 2000). Benjamin (1990) critiques such approaches which essentially define "other" as object, suggesting that they deny both parties the full experience of their own subjectivity. Benjamin postulates "where objects are, subjects must be" (p. 184). As such, countertransference reactions have more recently been reconsidered and are now thought of as "essential and necessary aspects of who we are" as therapists (Gerson, 2013, p. 14). Therapists may respond to trauma in their personal life in ways which can disrupt "stability, tranquillity and equilibrium" in the professional environment (Morrison, 2013, p. 43). Morrison calls this "countertransferential disequilibrium", and suggests that upsetting the delicate and finely tuned emotional compass within the therapist can make the process of therapy difficult. He contends the therapist *is* the analytic instrument and, therefore, any instability in this instrument can have disastrous consequences for the work. Specifically, he points out that disruption to the "self-state"—or sense of self—of the analyst "shakes up the calibrations on that delicate appliance" (Morrison, 2013, p. 44). This makes it difficult to truly "hear" the client, appreciate their emotional states, and unpick and understand the subtle transferential elements of the therapeutic relationship.

Khan (2003), too, observes that "personal crisis... is a time of acute emotional disequilibrium in which the boundaries that people set up to protect themselves are bombarded by the presence of immediate situational stress" (p. 51). For Khan, the "explosion of regularity and dependability" (p. 51) in the therapist's personal life is only exacerbated by the anxiety of disruption to clients. This sensory bombardment can impact the way that the therapist perceives and understands their clients, especially given that therapists often rely heavily on emotional and bodily responses (Rytohonka, 2015).

Disclosure

Disclosure is a hotly contested topic also relevant to this discussion. It is interwoven throughout the literature on the implications of therapist experiences of adversity (Comstock & Duffey, 2003). Disclosure is a concept synonymous with countertransference, and there are many differing opinions on the subject (Foehrenbach & Lane, 2001). Several therapists who have written about their experiences of adversity refer to disclosure as problematic, recognising that the very act of writing about personal trauma is essentially disclosure (Chasen, 1996; Morrison, 2013). It seems, however, that writing is generally perceived as a safer and more grounded option than openly disclosing to clients in session (Mendelsohn, 2014).

There are some theoreticians who staunchly deemphasise any benefits of therapists disclosing difficult life events, inferring that this can only intrude upon the therapeutic relationship (Comstock, 2008). Ivey (2009), for example, postulates that disclosure of personal adversity contradicts "the analytic attitude and the very essence of psychoanalytic inquiry" (p. 86). For Ivey, such disclosures create narcissistic potential as they can become about the therapist's needs. Moreover, clients may find therapist disclosures of personal crisis to be burdensome (Morrison, 1997). They may feel that their own issues are trivialised by the difficult experiences of their therapist or may lack the tools to engage with such expressions by the therapist. This thinking appears to be underpinned by the notion that "one cannot determine... that self-disclosure is a manifestation of anything in the psychoanalytic moment" (Busch, 1998, p. 519).

There is also some argument that client knowledge of their therapist's personal crises can encourage transference and countertransference enactments that negatively influence the therapeutic relationship (Colson, 1995). Colson observed that his own clients fantasised about the catastrophic consequences that may occur if they did not protect him after learning of his wife's terminal illness. He concludes that this had a largely detrimental effect on therapy. Similarly, Morrison (1997) posits that client knowledge of difficulties in their therapist's life may foster the desire in some to care for their therapist, which can convolute the delicately balanced dynamics of the therapeutic relationship. Thus, the therapist's disclosure of challenging personal events can make them vulnerable to analysis by their clients (Mills, 2012).

Mendelsohn (2013) takes a different position, arguing that the self-disclosure debate comes down to "the question of acceptability, to both participants, of the analyst's emotional situation" (p. 39). Mendelsohn wonders whether it is appropriate to disclose aspects of the therapist's personal situation to some clients; while for others, it may be entirely inappropriate to disclose anything. Additionally, Comstock and Duffey (2003) suggest that as the role of the therapist is to assist the development of the client's relational capacities, by ignoring the influence of personal crises on their professional relationships, therapists may inadvertently teach clients how not to access their own emotional world.

Bemesderfer (2000) discusses the capacity of adversity and trauma to disrupt usual boundaries around self-disclosure. Upon learning of her son's cancer diagnosis, she experienced heightened maternal awareness and noticed herself becoming more reactive to anything that would stir this in her. Consequently, she found herself making more conscious and more inadvertent disclosures than she felt she would otherwise have done. In one interaction, she startled herself by responding openly to a client's constant questioning about her family that she was married and had four children. Bemesderfer concedes that while this was an unnecessarily full disclosure, it allowed her client to explore more deeply the dynamics around her own large family and stimulated the admission that she felt in competition with her therapist, which was ultimately useful for the therapy.

Greenspan (2008) discusses the benefits of disclosure as breaking "through the fiction of psychotherapy that the therapist is some kind of superhuman being and is there only as the total transference object" (as cited by Comstock, p. 184). Morrison (1997) also suggests that disclosure of personal adversity can augment the humanness of the therapist, thus fostering

a realness in the relationship. Through this lens, disclosure might be thought of as augmenting the therapist's genuineness and authenticity; helping the client to feel included and important, reducing the possibility of feelings of betrayal should they discover that an event such as a life-threatening illness has not been relayed.

Amy Morrison's (1997) account of her decade-long battle with breast cancer is a moving depiction of the challenge of unavoidable disclosure. Around the time of her diagnosis, she chose to disclose only to clients who asked, even when she wore a wig after treatment. An interesting dynamic that emerged was that the clinical material presented by those who did not directly enquire about her illness or feelings tended to centre on struggles with wanting to know, yet not wanting to know. Khan (2003), too, was diagnosed with breast cancer and, after a course of rigorous chemotherapy, also wore a wig. Khan notes that, around this time, frequent last-minute cancellations of appointments and fluctuations in health and energy levels were prevalent, which meant her clients came to know of her illness.

Unavoidable disclosure is a theme picked up on by Andrew Morrison (2013) in his discussion of "enforced disclosure" (p. 42). According to Morrison, enforced disclosure occurs when there is no way of concealing the event or its impact from clients. In Morrison's case, because his ailing wife's office was next door to his own, his clients inevitably discovered her illness. Morrison discusses struggling with pervasive shame and guilt around the imposition of his personal circumstances on his clients as he observed them become less able to freely explore their own associations and inner processes.

Shame and guilt

As I read more about the emotional impact of therapist experiences of adversity, and particularly Morrison's (2013) account, I began to think more about shame and guilt. These difficult emotions seem to emerge both when the therapist must decide whether to disclose difficult personal circumstances, and more generally within the experience of adversity itself. To make this point, I turn first to a personal vignette. A little over halfway through this project I was tasked with presenting the progress of my research to a room full of faculty members and peers. This was a difficult and interesting experience in which various criticisms and encouragements were shared. I was surprised by the responsiveness of my audience to the specific ideas of shame and guilt. After presenting, I was approached by several individuals, each very generously sharing their own experiences of divorce, difficult clinical encounters, and other challenging personal circumstances. Each narrative was underpinned, in its own way, by a pervasive sense of shame and guilt for not having "done enough", been "available enough", or been "attentive enough".

I felt it important to include the responses of my audience as they indicate to me that the experience of shame and guilt felt by therapists in times of crisis may, in fact, be commonplace. Each response was, of course, coloured in a slightly different way, revealing different aspects of each individual's experience of these potent emotions. Consequently, it was no surprise that shame and guilt are themes that also proved to be prevalent in the literature. Comstock and Duffey (2003) suggest that therapists are especially vulnerable to such feelings because they receive the covert message "handle yourself as a professional

regardless of what happens to you" (p. 77) throughout the course of their training and into clinical work. Mendelsohn (2014) captures this well, writing of his divorce, "my internal experience—particularly insofar as it is suffused by shame and guilt—works its way into the...field" (p. 195). Shame may emerge around lacking the energy and passion for the work, and guilt may be felt about continuing work while not knowing if we 'should' be doing so.

The challenge of facing shame and guilt when crisis emerges in the psychotherapist's personal life is acknowledged by Comstock and Duffey (2003). They observe that discourse within the broader psychotherapeutic community suggests "if... it does affect your work, know it's affecting your work and take time off" (Comstock & Duffey, 2003, p. 77). Comstock and Duffey also recognise a more insidious element of this discourse which implies "but take care not to take too much time off" (p. 77). I have felt this deeply in my own moments of crisis, an invisible motor driving worries about how much time I could take off, if any. What about my clients? When would my mind settle and clear? What if I could not meet mounting academic or clinical demands? As Henry (2009) writes "I can't keep [my client] afloat when I feel like I'm drowning. Yet I feel I can't abandon her while she is barely holding onto herself" (p. 296).

As beginning therapists, we are often not taught that a "good enough therapist" also experiences struggle and painful distractions (Comstock & Duffey, 2003). It can be difficult to know when to 'down tools' and when to continue working. Consequently, the expression of overwhelm, preoccupation, and countertransferential disequilibrium, all often underpinned by some form of shame and guilt, can be difficult, potentially leading the therapist into hiding (Schlachet, 2013). Miller and Ober (1999) point out that sometimes adverse experiences can be unspeakable, and leave the therapist "crouching in the shadow of [their] lives, unpredictable, a locus of rage, of despair, of fear, looking for an opportunity to be heard" (p. 21). Hirsch (2008), too, discusses the wish for emotional tranquillity in times of crisis, suggesting that conditions that disallow this can lead the therapist into an unspeakable realm. This unspoken, shameful realm seems almost "secretive", as if it must be kept hidden (Chasen, 2013).

Reading about shame and guilt in the face of adversity led me back to Pines (2014), who outlines the challenge inherent in processing and expressing shame in the wake of crisis. Pines writes that after experiencing a stroke she felt she *had* to return to work, a step that was complicated by the fact that she was now bereft of many of the skills that she had previously taken for granted. She found that she had to develop a new way of working with her clients while simultaneously having to process the shame and self-doubt associated with feeling that she was somehow now 'less' than her clients and colleagues. I was struck by Pines' desire, and ability, to 'press on' through the pain, and by her ability to acknowledge that things were different. Chasen (2013) eloquently summarises this hope for continuing on, writing, "the stabbing pain has turned to a dull agony. I am aware of the constant presence of an absence. I function. I more than function. I've changed" (p. 20).

Conclusion

Enquiry into the phenomenon of therapist experiences of adversity has revealed that many aspects of the therapist's world—the therapist's mind and the therapeutic relationship, the decision about whether to go to work, the emotional state of the therapist, and the therapist's personal and professional relationships—are touched, in some way, by personal crisis. Encounters with adversity have the potential to throw the finely tuned emotional equilibrium so critical to the therapeutic relationship into disarray (Morrison, 2013). Equally, however, such moments can deepen the therapeutic relationship by affording us a window into our client's experiences of distress and suffering. As Gerson (2013) posits "personal struggles with crises... sometimes enhance, sometimes limit but always affect our clinical work" (p. 13).

I feel that my approach to personal crisis now, both as a practicing psychotherapist with several more years' clinical experience and as a human being and a patient with more years on the couch, differs to my approach at the time of writing. As my understanding of myself has deepened, the way I have negotiated such moments has changed. In this way, perhaps the psychotherapist is actually particularly well-placed to deal with crisis, having often completed years of their own therapy, possibly already being in therapy when the crisis occurs or at the very least having ready access to supervision and therapy services (Adams, 2014). This unique position affords close proximity to resources which can help one deal with circumstances that might otherwise be devastating. As such, one avenue for future research may be to explore differences that may exist between beginning and experienced psychotherapists.

It is also true that however experienced, the therapist must notice when they become overwhelmed by personal adversity, paying "deliberate and focused attention to this dimension" (Morrison, 2013, p. 44). Retaining a degree of self-awareness both of the intrapsychic and intersubjective ramifications of such conditions may mitigate the impact of the intrapsychic tearing at the root that I have referred to, and the ensuing countertransferential disequilibrium that can arise. Ultimately, we must be true to who we are and attend to our unique needs, both as human beings and as therapists, whether or not life is going smoothly (Gerson, 2013).

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