DOCUMENT RESUME

ED 371 247 CG 025 352

AUTHOR Gilewski, Michael J.
TITLE The Use of Transpersonal Empathy with Child Abuse Survivors.
PUB DATE Aug 93
NOTE 14p.; Paper presented at the Annual Convention of the American Psychological Association (101st, Toronto, Ontario, Canada, August 20-24, 1993).
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Child Abuse; Counseling Techniques; *Empathy; Intuition; Perception; Psychology; Psychotherapy; Therapists
IDENTIFIERS Connectivity; Spirituality; *Transpersonal Psychology

ABSTRACT

Adult survivors of childhood abuse are some of the more difficult and challenging patients in psychotherapy. This paper applies a transpersonal model of empathy to therapeutic work with these individuals. The transpersonal model of empathy extends traditional humanistic models which strive towards "advanced accurate empathy" to the level at which, through intuition and personal spiritual growth, the therapist is able to create a profound unitary, healing bond with the patient. Basic and advanced levels of empathy may alleviate isolation and provide some emotional resolution for adult victims of abuse; the use of transpersonal empathy serves to undo in a present experience what the abuse served to accomplish--it helps the patient, who was disconnected as part of the abuse, re-connect to a deeper sense of self which is intimately connected with life outside itself. Several cases are presented to illustrate how the various levels of empathy interact with treatment of adult abuse victims. Two tables summarize the transpersonal model of empathy and the effects of transpersonal healing. (Author/RJM)

The Use of Transpersonal Empathy with Child Abuse Survivors. Michael J. Gilewski, Cedars-Sinai Medical Center, Los Angeles. Paper presented at the meeting of the American Psychological Association, Toronto, August 1993.

ABSTRACT

Adults survivors of childhood abuse are some of the more difficult and challenging patients that present in psychotherapy. This paper will apply a transpersonal model of empathy to therapeutic work with these individuals. The transpersonal model of empathy extends traditional humanistic models, which strive towards "advanced accurate empathy," to the level at which, through intuition and personal spiritual growth, the therapist is able to create a profound unitary, healing bond with a patient. Basic and advanced levels of empathy may alleviate isolation and provide some emotional resolution for adult victims of abuse, but the use of transpersonal empathy serves to undo in a very present experience what the abuse served to do--it helps the patient re-connect (disconnected as part of the abuse) to a deeper sense of self that is always and intimately connected with life outside itself. Several cases help illustrate how the various levels of empathy interact with treatment of adult abuse victims.

The Use of Transpersonal Empathy with Child Abuse Survivors. Michael J. Gilewski, Cedars-Sinai Medical Center, Los Angeles. Paper presented at the meeting of the American Psychological Association, Toronto, August 1993.

Adults with a history of child abuse--physical, severe emotional, sexual, ritual, etc.--comprise a large subset of psychotherapy patients. Often these individuals present themselves for other primary DSM-III-R diagnostic categories, such as depression, anxiety, substance abuse, and personality disorders. These patients are challenging because of how childhood issues compound current symptoms. The purpose of this paper will be to illustrate how a model of transpersonal empathy developed earlier (Gilewski, 1991) can be applied as a fundamental approach to treating abuse victims.

The transpersonal model of empathy is summarized in Table 1. The model develops and extends the concepts of "basic empathy" and "advanced empathy" (e.g. Egan, 1990; Rogers, 1980) to include a transpersonal level. I borrow Yogananda's (1953) three ways of knowing--sensory experience, reasoning, and intuition--and apply these modalities to the understanding of a patient. At the basic empathy level, a therapist is taught to introspect, understand and verbalize his or her experience. One's therapeutic skill becomes the strategic use of this experience to create a shared bond between oneself and the patient, e.g. that both are alcoholics creates the foundation of the therapeutic relationship between a long-time sober therapist and a newly sober or still drinking patient.

Table 1 About Here

Advanced empathy permits the therapist to transcend personal experience via the use of reason and logic. The therapist studies models of psychotherapy, research-based interventions, and psychopathology. The therapist is taught to integrate this knowledge with on-going vicarious clinical experience, hones clinical skills in the use of verbal and nonverbal

communication, and strives to create powerful empathic vicariously shared experiences. Thus, with sufficient knowledge and skill, a non-alcoholic therapist can relate to an alcoholic "as if" the therapist were also an alcoholic, and the lack of shared sensory experience is less relevant. At this level, the therapist can treat a much wider range of individuals than at the basic level.

At the transpersonal level, intuition becomes the mode of knowledge. I have offered strict criteria to differentiate this powerful form of knowledge from more loosely used terms that are clouded by imagination and wishful thinking. The criteria include always being correct, consistency with logic and direct sensory experience, and instantaneous perception. At the transpersonal level, the therapist must hone his or her personality and spiritual skills to strategically use the self to create a powerful, direct sharing experience. At this level the therapist transcends the illusory veil of separateness form the patient, and both experience a positive healing empathic force that bonds them. Both therapist and patient can transcend their own experience, whatever the therapeutic issue may be.

From a transpersonal framework, the ultimate goal of human/spiritual development is unity consciousness (Wilbur, 1977; 1980). The paradox is that children are born into this world with a primitive form of unity consciousness and lose it in the process of acculturation to the relativity of our world. The loss is apparent, though, because the link to it serves as the foundation for growth into higher levels of consciouness in adulthood. Child abuse in its many forms serves to close the door quicker and tighter on that sense of unity consciousness, making it more difficult for the individual to develop fully in adulthood. Through the deep impact of shame associated with abuse (e.g., Fossum & Mason, 1986), the child "learns" that s/he is inherently defective, that trust only leads to pain and betrayal, and that the world is not safe, reliable or controllable. As a result, problems of isolation, control and addiction dominate life when the child matures into adulthood, and the child seemingly loses the very thread back to unity consciousness that

would provide the essential solutions to life's core problems.

Adult survivors of child abuse are challenging patients because their problems are deeply rooted in their development, their defenses and skills at keeping others at an emotional distance are usually superb, and the very thing they need for recovery/resolution is what they lost in the first place--a personal connection with an "inner child," True Self," or whatever term is preferable to describe a connection to something "higher" or "greater" than oneself. With these adults, basic empathy may reduce the sense of isolation or provide information and validation of perceptions, but is insufficient to bring about a powerful corrective spiritual experience. Likewise at the advanced empathy level, the nature of the relationship is artificial and vicarious. At best a good transference might develop, in which the patient can experience feelings associated with the primary injury and experience them in a warm, caring environment.

A transpersonal empathic relationship aims to create a present relationship that virtually reverses the one associated with the abuse by following the principles listed in Table 2. The patient is again confronted with a true sense of self, but the experience is validated, not negated. Any accompanying emotional experience may be intense but it is relieving, not constricting. The therapist through the transpersonal bond serves all the instrumental functions that the patient did not receive from the parent or abusive adult. As the abuse blocked the door to the patient's sense of unitary consciousness, transpersonal levels of empathy can open those doors again. Spiritual growth which may have virtually been halted can proceed with a major obstacle removed. The following cases will illustrate the process in patients with various pain disorders.

Table 2 About Here

Case Examples

Jack F. was a 40-ish year old man who presented with recurrent

depression, chronic pain, relationship difficulties, and poor adjustment to a physical disability. He had been in therapy twice before--once for pain management and once for the depression and relationship problems. Both therapies were described as successful with cognitive and behavioral interventions from two different therapists, but poor adjustment persisted and symptoms re-occurred. It was about 6 months since termination of his last therapy.

The current therapy began at the basic and advanced levels of empathy, but traditional interventions were stymied by an extremely rigid compulsive personality. At a basic transpersonal level, it begged the question of what pain was he hiding, and therapy shifted to more intense efforts to develop trust. He was conscious of having an alcoholic and physically abusive mother and physically abusive father, but had no recollection before age 4 and a half. Ten months after therapy began, the first memories of satanic ritual and other severe physical and sexual abuse began to surface. Effective tools to communicate the transpersonal nature of the relationship were lengthier sessions, virtually unlimited phone access, reliance on interactive imagery and metaphors to re-play the memories, and validation of whatever actually happened. Within 13 months, he had filled the memory gap in with all the key dissociated memories. Currently, he is re-building his life in a slow, painful manner limited by financial problems, social isolation, and severe physical disability.

Grace S. was a woman in her mid-40's presenting to an interdisciplinary treatment program for fibromyalgia. She had years of psychodynamic therapy to uncover early childhood Satanic, sexual and physical abuse. Physical abuse continued throughout childhood, and she was involved in a non-Satanic religious cult for 10 years in early adulthood. Emotional and physical abuse persisted into adult relationships. Previous therapy had reduced her psychiatric symptoms, she was able to work, and spent considerable time helping and educating survivors of abuse. The fibromyalgia triggered a relapse of psychiatric symptoms, and she was "borderline" in appearance of her

pervasive anger and lack of control over emotions, relationships, practical problem solving and work capabilities.

She was seen bi-weekly for about five months to calm her down, assist the treatment team in their work with her, and provide some pain management skills. The transpersonal focus built on previous therapeutic work-- to pull her out of the emotional regression, to supervise and reflect her relationship and practical problem solving skills, and to explore avocational interests. A critical contribution was employing an American Indian metaphor to connect her with and develop her own internal spirit guide, a connection which was only through external ritual prior to therapy. Her depression and anxiety have been reduced the mild tolerable levels; she initiated and continues to develop the first positive, honest relationship in her life; she is more effective in her social interactions; she has traversed several difficult problem situations, extricating herself from virtually all abusive situations in her life; and she has returned to half-time employment, consistent with her physical capabilities.

Frances P. was an approximately 50 year old woman in the same treatment program as indicated above for fibromyalgia. She was abandoned at an early age by an alcoholic father and was raised by an co-dependent mother around other dysfunctional relatives. She was depressed, although her affect was restricted and blunted. Having only six months for treatment, creating the deep trust and getting through the defensive walls were improbable. In addition to the fibromyalgia treatment, the foundations were laid for work on the abuse issues by another therapist who could follow her over a longer period. Intuitively, the abuse was sexual and physical, and this was supported by circumstantial evidence of memory gaps, the "absence" of significant men in her early life, a secretive and evasive mother, and the patient's "plain" personality. Within the transpersonal framework, the foci of therapy were to: practice trust balanced with limits to the relationship; develop an external support system; practice assertion skills; begin reading about adult children of alcoholics issues; write and engage in other "letting

go" activities without a demand for results (let happen what happens); develop access to feelings; and have a gross map about what to expect and look for in a new therapist.

The patient completed the treatment program and was connected with another therapist. On follow-up the patient had begun to recall some abusive memories, and was still at the "discovery" phase.

Wanda E. was a woman in her late 50's who illustrates a "treatment failure" or one for whom the transpersonal approach was pre-mature. She was fully aware of very severe physical abuse and threats of violence by her father as a child. She had worked through some feelings with a psychodynamic therapist in the past, but abruptly left therapy when she did not feel understood. (The relationship was apparently also getting too intimate and threatening.) The patient was being treated for coping with pain following an injury and subsequent surgery, which interfered greatly with her normally very physically active lifestyle. Unstructured techniques were too threatening, she had virtually no conscious insight into her affect or the discrepancies in her speech and behavior, and the relationship was difficult to maintain. She could not focus enough to learn specific cognitive and behavioral pain management techniques within the therapy context. In a transpersonal context, we were able to do some brief, focused imagery work in which she became more clear about the issues confronting her. This was still too threatening, and we terminated therapy at the patient's request. She continued in the Biofeedback part of the program and obtained better symptom control. Perhaps the relationship with the "machine" was less threatening and thus more effective.

Stacy K. was a 30 year old woman with chronic pain and fibromyalgia from a lengthy but still nondefinitive physical disorder. She had been physically and emotionally abused as a child, and was only available for 3 weeks of treatment prior to a move across country. Treatment was precipitated by an episode of acting out, which was an apparent cry for help. She had a few sessions of unsuccessful marital therapy with another therapist, but seemed to

be ripe and anxious for help at the time of this treatment. Given the desire for help and the time constraints, the focus of transpersonal aspect of treatment was to accept the acting out as an innocent plea for help and to connect her with an image that served as her own inner guide. Virtually all the transpersonal work was done in the first two sessions, with the remainder of treatment reinforcing this gain and covering other aspects of fibromyalgia treatment. She was discharged after five sessions, is pursuing a more thorough diagnostic work-up at a specialty center elsewhere in the United States, and will continue with therapy in her new location closer to the stress of her family-of-origin.

Discussion

The therapist does not create empathy at the transpersonal level in session one. In fact, most therapy relationships never get to that level. Even when transpersonal empathy does develop, empathy proceeds from the basic through transpersonal level as the therapeutic relationship deepens. The level of empathy possible is dependent on time, situational factors, and characteristics of the patient and therapist.

In the case examples, Jack worked hard within a long-term therapy model. The transpersonal features made possible what prior advanced empathy could not create--an environment safe enough for him to recall extremely repressed and dissociated memories to enable a more positive disability adjustment. The transpersonal approach also quickened what is usually a process of many years in such a rigid individual. For Grace, the transpersonal approach was used in a short-term therapy to bring about a major personal and situational adjustment on the foundation of prior therapy, which most likely employed empathy at the advanced level. The connection with the spirit guide may also enable her to sustain her therapeutic gains.

Frances is clearly someone in need of long-term therapy in a short-term setting. The transpersonal approach guided the foundations for future treatment, but opening her up and discharging her would only be "abusive" and not aid her healing. This illustrates how the transpersonal approach,

although it is efficient, works within the constraints of practical realities. Wanda is also example of the practical reality, that although effective, not every patient and/or patient-therapist combination is ideal for the transpersonal method. Finally, Stacy illustrates how practical realities can only empower the effectiveness of transpersonal methods.

As was illustrated in Table 2, the application of transpersonal empathy, that is, the use of intuition and strategic use of the therapist's self, to abuse survivors can serve to reverse the effects of childhood abuse. The method is not magical, but rather scientific in helping individuals re-establish, foster and trust in their own inner guidance and sense of true reality. The therapist in essence re-parents the abuse survivor in the way that the patient needed in the original situation. A critical feature in distinguishing transpersonal from advanced empathy methods is the therapist's willingness and ability to transcend and discard relics from theoretical models of therapy to meet a patient's genuine needs. This includes length of sessions, duration of therapy, nature of session content, and the therapist sticking to some ideal persona. Rather practical realities, idiosyncracies of a patient's situation, and freedom of direction in the relationship and interventions are permitted to be as they are or develop to be. As such, the process then hooks in a very reliable and scientific manner to the normal inherent course that is inherent in healing and permitting the individual to resume a normal course of emotional and personal development.

The cases also illustrate how transpersonal issues are interweaved with other more traditional cognitive and behavioral interventions for chronic pain patients. The transpersonal focus addresses fundamental issues in the relationship or underlying emotional adjustment, while the structured interventions address the practical needs for pain management. Without the transpersonal approach, though, many of these individuals may have become "treatment failures." Finally, the cases illustrate the course and accumulative benefits of therapy across the years in such individuals. Transpersonal empathy can fit anywhere in the process as long as the patient

and therapist are able and willing to develop the therapeutic relationship to this level.

References

Egan, G. (1990). The skilled helper (4th ed.). Pacific Grove, CA: Brooks/Cole.

Rogers, C. R. (1980). A way of being. Boston: Houghton Mifflin.

Wilbur, K. (1977). The spectrum of consciousness. Wheaton, IL: Theosophical Publishing House.

Wilbur, K. (1980). The Atman project. Wheaton, IL: Theosophical Publishing House.

Yogananda, P. (1953). The science of religion. Los Angeles: Self-Realization Fellowship.

Table 1. Summary of the Transpersonal Model of Empathy

	Level of Empathy		
	Basic	Advanced	Transpersonal
Knowledge Mechanism	Sensation/Perception	Reason	Intuition
Communication Strategy	Strategic use of experience	Strategic use of language	Strategic use of self
Empathic Goal	Create shared experience	Create vicariously shared experience	Create sharing experience
Source of Empathy	Listening	Theoretical Model	Universal Principles
Type of Experience	Direct Separate	Vicarious Unitary	Direct Unitary
Learning Source	Teacher	Mentor	Spiritual Guide

Table 2. Transpersonal Healing of Childhood Abuse Victims

-- Reverses the abuse process

-- Present-oriented

-- Personal healing for personal injury

-- Re-establishes connection with something "higher"

-- Fosters development of inner guidance

-- Validates reality

-- Self used as genuine parent

-- Solutions balance compassion and discipline