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Chapter 19. Working with Trauma: Mindfulness and Compassion

John Briere

The past is never dead. It's not even past.
—William Faulkner

As the Buddha taught, the joyful and fulfilling aspects of life are inextricably intertwined with experiences of pain and loss. Some people's adversities are especially hurtful and destabilizing: many children have been abused, unloved, or abandoned, and many adults have endured disasters, war, assaults, torture, or traumatic deaths of loved ones. In fact, at least half of people in North America will undergo one or more major adverse events in their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Although the dividing line is somewhat arbitrary, these more extreme experiences are referred to as *psychological trauma*.

Traumatic Reactions

When a traumatic event or loss is of sufficient magnitude, it pushes the individual into an emergency state, activates biological systems associated with survival, produces great anxiety, and usually narrows awareness to immediate survival (Charney, Friedman, & Deutch, 1995; Siegel, 2005). Memories are formed, carrying with them emotions, cognitions, and sensations that become associated with the trauma, and that can be triggered and relived as flashbacks, intrusive thoughts, painful feelings, and other aspects of posttraumatic stress (Briere, 2004). In some cases, these memories may be continuously activated, leading to chronic anxiety, depression, or anger. Trauma can also breach the assumptions most of us carry about ourselves, our safety, the future, and, sometimes, the goodness of other people (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; McCann & Pearlman, 1990). Finally, trauma can involve existential confrontation. A rape, heart attack, or traumatic loss can rip the fabric of consensual reality, leaving the affected person feeling entirely alone, irrevocably changed, and flooded with awareness of the fragility of life and wellbeing.

Faced with overwhelming experience, many trauma survivors are understandably motivated to avoid thoughts, feelings, and memories about what happened to them. This may be especially true in Western cultures, with their tendency to pathologize extended sadness or fear, blame the victim, and encourage emotional numbing and externalization in response to painful experience. As a result, a traumatized person may engage in chronic suppression of thoughts, feelings, and memories, or behavior such as substance abuse or harmful acts toward oneself and others (e.g., Briere, Hodges, & Godbout, 1010). These responses are often associated with further suffering since they not only produce additional problems but decrease the extent to which pain is processed and/or accommodated (Briere, 2002).

Human compassion, which is as ancient as trauma itself, can help address these issues. In this chapter, I'll explore the role of compassion in treating trauma. I will suggest that unconditional caring, attunement, and acceptance, in combination with the therapist's overall mindfulness of self and the client, can provide new experiences that support both emotional and cognitive trauma processing.

Therapeutic Approaches to Trauma

Western clinicians generally view trauma-related memories and emotions, negative self attributions, and defensive avoidance strategies as symptoms of psychiatric disorders, for which a range of therapeutic interventions have been developed. These include exposure therapy (Foa & Rothbaum, 1998), cognitive therapy (Resick & Schnicke, 1993), and relational psychotherapy (Pearlman & Courtois, 2005). The first two of these include techniques that have been shown to increase the client's emotional and cognitive processing of trauma memories, thereby reducing their intrusive and painful qualities and diminishing their capacity to motivate problematic avoidance responses. The latter intervention, relational psychotherapy, stresses the importance of the therapeutic relationship, especially therapeutic attunement and nonjudgment, in addressing posttraumatic difficulties. All three of these approaches typically overlap: exposure therapy usually includes cognitive processing (Foa & Rothbaum, 1998), cognitive therapy usually involves exposure (Resick & Schnicke, 1993), both exposure and cognitive therapy may work best within a positive therapeutic relationship (Cloitre et al., 2010), and relational therapies implicitly include emotional and cognitive processing (Briere & Scott, in press; Fulton & Siegel, 2005).

Interestingly, a major finding of the psychotherapy outcome literature is that a positive therapeutic relationship and an attuned therapist may be the most helpful components of treatment—often exceeding the effects of specific interventions (Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). In fact, it appears that these therapist attitudes and qualities—first described decades ago by Rogers (1957)—have special ameliorative qualities in the treatment of traumatized individuals (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004).

Compassion

The value of a compassionate and nonjudgmental attitude has been described from at least two different perspectives: in the context of relational psychotherapy (as described above) and in the spiritual or contemplative domain, including (but not limited to[1]) Buddhist psychology. These approaches have been combined in the last several decades, especially as Buddhist principles and practices are integrated into secular psychological interventions ranging from psychoanalysis (e.g., Epstein, 2008; Bobrow, 2010) to cognitive-behavioral therapy (e.g., Hays, Follette, & Linehan, 2004; Segal, Williams, & Teasdale, 2002).

Compassion can be defined from a Buddhist perspective as nonjudgmental awareness and appreciation of the predicament and suffering of others (and oneself), with the felt desire to relieve that suffering and increase well-being. Although a similar construct, *empathy*, entails expressed understanding and appreciation of the client's experience and difficulties, compassion includes a positive emotional state, involving feelings of unconditional caring, kindness, and warmth that are directed to others regardless of the actual or presumed qualities or "lovability" of that person (see also Chapter 1).

When adopted into western psychotherapy, compassion is often seen as grounded in *mindfulness*: the capacity to sustain moment-by-moment focused awareness of—and openness

[1] Themes of compassion and nonjudgmental love, although sometimes intermingled with the reverse, can be found in many other traditions, including Christian, Judaic, Hindu, and Islamic faiths.

to—one's internal experience and immediate environment, without judgment and with acceptance (see Chapter 2). Mindful awareness helps the clinician maintain an unusual level of attunement to the client (Germer, 2005; Morgan & Morgan, 2005), as well as allowing him or her to better understand the subjective nature of his or her own thoughts, feelings, memories, and reactions, so that they can be placed in proper perspective before they result in significant countertransferential judgments or behaviors (Briere & Scott, in press; Shapiro & Carlson, 2009). In combination, these learnable capacities to focus benign, loving, and non-countertransferential attention on the client, while feeling and communicating acceptance and nonjudgment, may be critically important—if not essential—for the trauma survivor to fully engage his or her history and pain, while, at the same time, appreciating his or her own innate value and abilities (Goldstein, 2010).

Benefits for Trauma Survivors

Although compassionate attention surely has positive effects on everyone, anecdotal experience suggests that its impact on trauma survivors is particularly noteworthy. Trauma, especially interpersonal victimization, often results in alienation from others and oneself, expectations of further maltreatment, and other lasting breaches in the normal connections and relationships between people. Because compassionate attention encourages the redevelopment of these connections, it may be of great benefit, even though it is sometimes hard for the survivor to accept (Gilbert, 2009a).

There is relatively little empirical literature regarding the effects of compassion on traumatized people, nor do most discussions of compassion refer to the specific concerns of trauma survivors (Gilbert, 2009a, 2009b). The remainder of this chapter draws on the general compassion literature, and on my (and others') clinical experience, to discuss the often observed, but not well-documented, relationship between caring, attuned therapist's responses and increased well-being for those exposed to adversity. I'll try to show how the therapist's compassionate attitude may have both direct effects on the traumatized client, and indirect effects arising from the therapist's increased clinical effectiveness.

Direct Effects

As noted earlier, trauma survivors have experienced one or more events that have altered their subsequent experience of self, others, and the world at large. Such events typically produce terror, horror, or helplessness at a level rarely encountered by nontraumatized individuals (American Psychiatric Association, 2004). The horror associated with, for example, torture or rape can dramatically change the survivor's experience of reality, propelling him or her into a state of consciousness characterized by extreme fear, uncontrollably painful memories, and radically altered expectations of people and the future. The distress and pain associated with extreme trauma may or may not diminish with time, but typically is reexperienced when the survivor is reminded of the trauma by reminiscent phenomena in his or her current environment. In this way, the hyperaccessibility of horrific memories means that, as Faulkner (1951/1975) noted in a different context, "The past is never dead. It's not even past" (p.80).

Although the sustained anguish associated with trauma can be seen as evidence of psychological disorder, in some ways the survivor suffers not from a distorted sense of reality, as much as an unwanted awareness of what, in fact, can happen. The torture victim knows what authority figures can do, the rape victim cannot forget some people's capacity to violate and destroy, and the incest survivor or battered woman has intimate knowledge of how badly one can be hurt in a supposedly loving relationship. Thus, trauma-related perspectives and expectations are not always distorted understandings; they can be more accurate—although often

overgeneralized—revisions of previous beliefs about the intrinsically benign nature of the world. Further, the survivor's insufficient and temporary solutions to trauma-related distress, such as denial, substance abuse, or self-injurious behavior, make good sense to him or her; they are not illogical, and perhaps not even pathological, but rather coping responses to externally invisible but internally overwhelming experiences (Briere, 2002). This is good news, as it suggests that the survivor's "maladaptive" behaviors are reality-based, reflecting problem-solving and adaptation, and therefore potentially responsive to new learning.

Emotional processing. The powerful emotional effects of a caring, trauma-antithetic relationship have been discussed by many theoreticians and practitioners, both in psychodynamic contexts (e.g., Fonagy, Gergely, Jurist, & Target, 2002) and by trauma specialists (e.g., Courtois, 2010; Dalenberg, 2000). Generally, it is suggested that the therapeutic relationship, by virtue of its superficial similarity to aspects of the original trauma (e.g., the client-therapist power imbalance, the therapist's characteristics, or the likelihood of vulnerability), activates the client's trauma-related memories, relational schema, and conditioned emotional responses.

Once these phenomena are evoked, disparate experiences of compassion and safety in the current relationship can serve to weaken painful emotional associations to previous trauma. Such emotional processing may occur through a multi-step process: the therapist's visible sustained, noncontingent caring (a) engages the client's inborn attachment system, which is sensitive to, and triggered by, loving attention from important relational figures (Bowlby, 1988), which (b) activates biological self-soothing circuitry that downregulates the activity of threat recognition systems (Chapter 18; Gilbert, 2009a), leading to (c) the eventual counterconditioning and extinction of classically conditioned anxiety associated with trauma-reminiscent stimuli (Briere & Scott, in press). The anxiety/stress-reducing effects of compassion, in fact, may extend beyond trauma-processing to include positive impacts on neurobiology (e.g., Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008).

Cognitive processing. Compassion also appears to work on a cognitive level, providing the trauma survivor with new information that can update his or her assumptions and subsequent behavior. By offering unconditional caring, acceptance, mindful awareness, and attunement, the compassionate clinician becomes the antithesis of, if not the antidote to, the client's initial traumatization, providing input for changes in the survivor's perception and response systems. The therapeutic relationship itself becomes a nonverbal cognitive therapy instrument, heightening awareness of the disparity between then and now. Whereas others have hurt, violated, or rejected, the therapist actively supports, cares for, and accepts; where once there was danger and violence, now there is safety; where the survivor was exposed to chaos and powerful negative emotions, the therapist projects stability, calm, and non-egocentric loving attention.

Although the survivor's tendency may be to avoid interpersonal attachments[2], he or she inevitably needs them due to our evolutionary heritage as social beings (Gilbert, 2009a; Schore, 1994) and as a result of previous personal deprivation (Bowlby, 1988). The survivor is caught in a predicament: avoidance and isolation are protective against being hurt in intimate contexts, yet such behaviors are associated with emptiness, loneliness, and depression, and interfere with the self-esteem and well-being associated with relatedness (Cacioppo & Patrick, 2008; Chapter 12). By demonstrating caring, positive regard, and a willingness to connect at whatever level the

[2] Although attachment is problematic in the Buddhist sense, the current use of this word reflects the notion of interpersonal relatedness in the context of intimacy, which is a positive phenomenon. The specific point at which relational attachment can become what Buddhists refer to as attachment (e.g., involving grasping, obsession, or possessiveness) is a subject of some debate. I believe they are separate phenomena.

client can tolerate, the compassionate therapist becomes an exception to trauma's lessons. For example, in contrast to a woman's sexually abusive father or violent spouse, a male therapist might be regarded as someone who likes and cares about her, will not exploit or transgress, and is, in fact, not dangerous. And if such exceptions exist, then all men are not necessarily perpetrators and conclusions drawn from earlier horrors can be tentatively revised or limited.

Many survivors of interpersonal traumas were devalued, rejected, or shamed in the context of victimization and, as a result, have come to believe that they must be unacceptable or deserving of maltreatment (Briere, 1992; McCann & Pearlman, 1990). The survivor's trauma-related responses (e.g., posttraumatic stress, depression, or relationship issues) and coping strategies (e.g., substance abuse or dissociation) are also typically stigmatized by society, with the result that he or she is seen as pathological or bad. Fortunately, the therapist's noncontingent acceptance of the trauma survivor can significantly impact these difficulties. As the therapist conveys by behavior and words his or her unconditional positive regard and acceptance, the survivor has the opportunity to undergo trauma-disparate experiences that gradually undercut negative conclusions about her or himself associated with victimization. Shame, for example, involves assumptions about personal badness that must be kept from others—a response that tends to decrease in the context of therapeutic compassion and acceptance (Gilbert, 2009a). As the survivor's history and posttraumatic responses are gradually expressed, normalized, and accepted, there is less for him or her to judge as unacceptable, and thus less to keep secret and avoid—ultimately leading to greater cognitive and emotional processing.

Acceptance may involve two components: the therapist's visible noncontingent acceptance of the client as a person, entitled to happiness and well-being (although the therapist may not necessarily accept the client's self- or other-destructive behavior), and the client's therapist-supported integration of especially overwhelming and potentially stigmatizing traumatic material into "mere" or "just" painful memory. This unencumbered recollection of painful events of the past (i.e., with less activation of associated cognitions and emotions), occurs as trauma is remembered and recounted in the context of the therapist's willingness to share—and bear nonjudgmental witness to—the survivor's experience. As therapeutic compassion and acceptance reduces the stigma and personal badness associated with trauma memory, such recollections slowly lose their power to shame and motivate avoidance, thereby facilitating further cognitive and emotional processing.

Indirect Effects

Compassion also assists trauma survivors by creating conditions that support the therapist's effectiveness in his or her work. As the clinician extends loving-kindness towards the survivor, he or she engages warm and positive feelings that, especially in the context of mindfulness, allow him or her to be exposed to considerable pain and suffering without being disarmed, distracted, or personally activated. Since trauma therapy often is most effective when it facilitates the client's direct, verbalized, experience of distress, the therapist's ability to be less reactive while hearing otherwise painful and upsetting things increases the client's opportunity to process emotional pain in the context of more complete attunement. A mindful stance also allows the therapist to more clearly view expressed emotional pain as just emotional pain—not as intrinsically negative, nor as a trigger for countertransference, but rather as a process wherein the client can metabolize her or his history and ultimately experience reduced suffering (Briere & Scott, in press). In this sense, the client's pain is not perceived as "bad," and therefore the clinician is not impacted in the same way, nor is she or he as likely to be vicariously traumatized.

The effects of compassion are not limited to the client. Engendering this relational state produces real benefits for the therapist, allowing him or her not only to become a better therapist, but also to grow as a person and experience increased well-being (Gilbert, 2009b; Salzberg, 1995; Siegel, 2010). HH the 14th Dalai Lama (2009) notes, "If you want others to be happy, practice compassion. If you want to be happy, practice compassion." As many have described, compassion involves not only a felt experience of love and acceptance toward others when they are in pain, but also similar feelings towards oneself. So what goes around does appear to come around, and the compassionate practitioner may come to experience a sense of peace and (seemingly paradoxical) non-egocentric appreciation of self. The non-selfish aspect of this experience appears to involve the slow remission of the perceived duality of self versus others as individual objects of caring, such that self is valued in the same way that others are. However accomplished, and from whatever tradition, noncontingent, non-egocentric caring for others may have the side-effect of grounding the clinician and increasing his or her well-being in a way that, reciprocally, may then allow the helper to help all the more.

Finding the Center

As many have noted, writing or reading about mindfulness and compassion is quite different from experiencing it directly. Per the editors' request, the following brief section describes my personal experience of trying to cultivate these qualities as a trauma specialist and teacher in a large public health care system.

Most of the people my colleagues and I encounter are struggling with some combination of poverty, homelessness, drug addiction, or severe mental illness. Many present to emergency services following sexual or physical assaults, major losses, overdoses, or suicide attempts. Some are dealing with HIV/AIDS, are patients in burn units, or come with histories of political oppression or torture. Others are described as prostitutes, gang members, or criminals.

The clinical and spiritual issues in this work often converge: Can we inhabit a mode that allows objective assessment and intervention, yet, at the same time, supports compassion and receptive attention? And, how do we address or relate to our own experience in the face of such suffering?

I seem to be most helpful when I access a state in which empathic connection with a hurt person is possible, even desirable—partially because the presenting issue has been reinterpreted. From this position, I am less likely to view the client's pain as intrinsically negative, but instead as an objective fact—in some cases, even as an opportunity for recovery or growth. This does not mean that I dismiss the trauma survivor's distress in any way. Yet, rarely is it helpful to accept—and therefore reinforce—the stigmatization, hopelessness, and demoralization that people can infer from horrible things. Instead, the challenge is to acknowledge the sometimes incredible hurt that has occurred, while, at the same time, communicating that the individual's ongoing presence signals implicit strength, adaptive capacity, and hopefulness for the future. In this way, his or her difficulties and suffering are "just" that, not evidence for the labels that he or she may collect (and that I, ironically, may later write in a chart). The survivor becomes more than the sum of his or her wounds, and I cease to be a detached clinician, but rather someone who's job is to provide a space and context for the client's immediate experience and future recovery—a process that may require the client (and me) to sit with the fragility and impermanence of life.

I typically spend a few early minutes not only evaluating the immediate needs of the person in front of me, but also checking my own internal experience, noting feelings, thoughts, and impulses that arise and seek to dominate. I hope to see the person as he or she actually is: someone who, at this point in time, is in trouble or in pain—a scenario that, but for random circumstance, might be true for me as well. Were things to have gone differently, I could be my most injured or "disturbed" client—or even the person who may have hurt him or her. This reflection helps break the delusion that, as a therapist, I am essentially different from, or somehow better than, the person I am trying to help.

From one perspective, the trauma, psychosis, or substance abuse is the problem. But the problem is not the person, and the pain, in one way or another, will eventually change or depart. In fact, the experience of the pain often turns out to be the route out of pain. When I am able to engage that view, I can intentionally focus on caring in a way that is both involved and not. I do not want the person to suffer (although I may have little impact on that), and I know that we are all in the same boat around this "feeling bad and hurting" business. Compassion grows if one pays attention to it. As it expands, it allows the client (and me) to increasingly confront, engage, and accept upsetting feelings and thoughts, until, slowly, the painful aspects change and diminish from lack of sustenance.

Cultivating Compassion

Since compassion seems to have significant positive effects on the trauma survivor, as well as the clinician, how can it be developed?

Western clinical training programs expect that therapists should be objective, empathically attuned, and to the extent possible, unconditionally positive in their regard for clients—yet they usually do little to help trainees to accomplish these goals (Fulton, 2005). It seems that the assumption is often that (a) the clinician can learn, intellectually, how to do these things, such that merely being told to do so will suffice, or (b) nonjudgment and attunement are natural characteristics of some therapists, and only they should practice psychotherapy, or (c) if one doesn't feel compassionate, accepting, and nonjudgmental, one should learn how to fake it. Unfortunately, none of these approaches are necessarily correct or effective. Although there appear to be "natural therapists," clearly many other practitioners cannot immediately access these psychological capacities merely by being told that they should do so, and yet may have the potential to be effective clinicians with sufficient training. And, it is often the case that clients (perhaps especially trauma survivors, given their interpersonal hypervigilance) can detect inauthentic caring or attention in others, leading to distrust of the therapist rather than reassurance. Finally, misrepresenting one's caring on a regular basis requires unusual effort and energy, and is likely to have negative emotional impacts on the therapist.

Fortunately, the insights and methodologies of Buddhist and other spiritual traditions can be helpful here, since the development of compassion and mindfulness are common themes in those literatures. Most suggest that although some degree of compassion probably exists as part of the human condition, its expansion is a learned skill that can arise in the context of extended introspection, discussion, and discernment.

Meditation and Mindfulness Training

From most Buddhist perspectives, the primary pathway to the development of compassion and unconditional regard is through meditation. As described in other chapters of this book, a regular meditation practice, and exposure to a teacher, or books and CDs on

meditation, can accomplish several things for those who are able to sustain this approach. First, mindfulness is a common outgrowth of meditation, since the latter typically includes learning how to concentrate on a single process (often one's breath), paying attention to the present moment, and allowing thoughts and feelings to come and go without attachment to them (see Chapter 2; Germer, 2005; and for another perspective on this process, Siff, 2010). Among those things allowed to arise and fall away are judgments about oneself and one's internal experiences, such that the meditator becomes increasingly able to attend to ongoing experience without viewing it as good or bad.

As described by Teasdale, Segal, and Williams (1995) and others, an emergent phenomenon during this process is *metacognitive awareness*: the growing ability to observe and reflect upon one's thoughts and feelings, and to learn that such internal processes are, most immediately, products of the mind, and not necessarily evidence about the true state of reality. As metacognitive awareness grows, the individual begins to discern the transient nature of even very compelling cognitive and emotional processes, and discover that emotional reactions, intrusive experiences, and cognitions or beliefs are not necessarily "real:" they may be more relevant to the past than the present. From the meditating therapist's perspective, the result is increased attunement to the client's experience, as the clinician is better able to pay attention with less internal distraction and less interference from his or her own history.

Together, these components of meditation-based mindfulness allow the therapist to perceive and respond to the client in a more attuned and nonreactive way, producing many of the requirements of an optimal therapeutic relationship. These outcomes are largely in the cognitive and attentional domains, however. They reduce distraction and judgments; they do not specifically engender the caring associated with compassion. Fortunately, meditation can be of use here as well. First, it is the experience of many meditators that, as mindfulness grows, compassion arises as well (Shapiro & Carlson, 2009). The nature of this often co-emergent process is unclear. However, the capacity to experience caring for others and oneself appears to be naturally existent, probably as a function of psychobiological attachment processes, whereas the full expression of this response may require reduced interference from personal history and cultural training—including the need to judge experience and imbue it with egocentric needs and concerns. Some suggest that mindful awareness brings to the forefront a realization of the non-dual nature of reality, such that one's own happiness and the happiness of others are viewed as inextricably coexistent (e.g., Dalai Lama, 1995; see Chapter 4). Although this insight may not engender caring, per se, it supports the intention to transfer feelings from self to others and the reverse.

Finally, some meditation practices are specifically targeted toward the development of non-egocentric love and positive regard for others. For example, the Theravadin practice of *mettā bhāvanā*, or loving-kindness (Salzberg, 1995; Germer, 2009), and the Tibetan practice of *tonglen* ("sending and taking") (Chödrön, 2000; Chapter 7) are centered around the meditational cultivation of love and compassion. In mettā meditations, the practitioner locates and intensifies loving feelings toward himself/herself (although Westerners seemingly have more difficulty accessing self-love than individuals in some other cultures), and then applies these feelings, sequentially, toward a valued other, more neutrally-valued people (e.g., acquaintances or co-workers), difficult people or enemies, and, finally, all sentient beings (see Chapter 3). In tonglen, and its Western variations, the meditator "breathes in" pain and suffering from the world and specific people, and "breathes out" love, compassion, and happiness back to them (see Chapter 7). From an experiential perspective, such exercises allow the practitioner to locate, identify, and

"grow" loving feelings, which are then applied to others. With practice, this exercise of focusing and encouraging loving affects—even independent of its spiritual or religious intention—appears to make such feelings more experientially salient and easily generated, perhaps especially when mindfulness is also present.

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Reflections for the Helper

- Sit for a minute or two, with your eyes closed. Allow your mind to settle down a bit. Focus on the breath, letting your tasks and concerns fall away for just a little while.
- Bring your attention to what you do for a living. All the people you see who suffer, the work you do to help them, whether through therapy, medicine, clergy, the law, or being a parent or friend to someone struggling with life. Reflect on your intentions for these people: that they suffer less, that they be happy, that they have some sense of peace in their lives.
- Allow your compassion to grow -- all these beings, caught in painful circumstance, in one way or another doing the best they can. Send caring feelings to them. And to yourself, as someone not that different, although perhaps more fortunate at this moment.
- Bring one of these people to mind, someone whose difficulties are especially significant to you right now. Let yourself feel what he or she feels, see what he or she sees. Try not to get lost in this person's suffering; watch it from the grounded, caring place that you have established. Allow yourself to feel the pain, but not get caught in it.
- Reflect on this person's experience. Note that it is not a bad thing to hurt when you have been hurt. This person's distress is part of recovery, part of being alive. It is ultimately transient; it will, inevitably, change or depart. Feel the honor that you can be present with this person at this moment in time, in all the complexity of pain and caring.
- Embrace any gratitude that arises. How lucky you are, to be where you are, doing what you are doing. Your occupation or relationship is a special gift, although it may not always seem that way. See if you can directly experience the honor of being able to intervene in the suffering of others. It could have gone differently, you might have ended up doing something less meaningful or beneficial. Remember how you've always wanted to help, how lucky you are that you can.

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Non-Meditative Compassion Training

Outside of (or in addition to) meditation, certain aspects of compassion can be learned more didactically. In compassion-focused therapy (CFT; Gilbert, 2009a, 2009b), for example, an entire therapeutic philosophy and intervention approach has been developed to treat clients who suffer from significant shame, self-criticism, and depression (see Chapter 18 for a detailed description of CFT). Gilbert contends that compassion is a learnable skill-set, and provides the clinician with ways to foster a range of compassionate attributes (e.g., caring for well-being, empathy, and non-judgment) and skills (e.g., compassionate attention, compassionate reasoning, and compassionate behavior). It is likely that these attitudes and skills may be especially helpful in work with trauma survivors—especially in light of CFT's attention to adults with childhood maltreatment experiences (Gilbert, 2009a).

In a less structured way, compassion also may be increased by helping clinicians to appreciate the existential validity of phenomena such as suffering, impermanence,

interdependence, and nonegocentric love. In many Buddhist traditions, this occurs as the student interacts with his or her teacher, and studies, reflects, and meditates on various aspects of *dharma* (the true nature of reality/existence, typically as explicated by the Buddha). In our culture, this may also take place within the context of books, CDs, and DVDs offered by traditional teachers such as HH the 14th Dalai Lama (1998) or Western writers such as Tara Brach (2004), Jon Kabat-Zinn (1994), or Jack Kornfield (2008).

Such didactic and exploratory exercises are often especially helpful in explicating *dependent arising*, the notion that experience and behavior arise from concrete conditions and causes (Bhikkhu Bodhi, 2005), as opposed to doing so independent of causality (e.g., through an act of a deity, or the Aristotelian notion of a spontaneous First Cause; see Chapter 9). This exploration frequently leads to the realization that people are the way they are because of prior causes and influences, as opposed to inherent psychopathology or evil. As the conditioned and etiological aspects of previously unacceptable or "sick" behaviors are examined, it becomes harder to blame (and, perhaps, to label) individuals, leading to less judgment of them. This insight often is not that difficult for the clinician to appreciate, at least intellectually, since the science of psychology assumes that there are specific reasons why people behave the way they do. Especially in trauma, the conversation between the teacher/consultant and therapist often highlights the notion that "disordered," "acting-out," "dysfunctional," or "bad" client behaviors arise from predispositions, coping responses to trauma-related pain and suffering, and lack of information or options regarding better ways of seeing or doing things—much as Buddhist psychology suggests. Such discussions also facilitate the notion that individuals who commit violence against others, ranging from abusive parents to rapists to murderers, are not intrinsically evil, but rather are responding to causalities and vagaries of the human condition—including, in some cases, trauma[3] (Briere, in press).

In more directly clinical contexts, the teacher, consultant, or supervisor may use the therapist's reports or videotapes of sessions to continue this discussion. As the clinician explores his or her inevitable (dependently arising) countertransferential responses to the client, there are multiple opportunities for the teacher to point out the conditioned/historical aspects of the client's behavior and the therapist's reactions, hopefully increasing the clinician's metacognitive awareness and decreasing his or her judgments. In many cases, there will be opportunities for the teacher to give permission for the clinician to care about the client, perhaps in ways that existed when the therapist began his or her career, but that lost their power through clinical training to be "objective." Therapists are sometimes able to rekindle their compassion when compassion is considered a valid clinical goal rather than an expression of naiveté or lack of clinical sophistication. This may especially occur when the consultant or supervisor models the same attitudes and responses the clinician is encouraged to apply to the client.

The Suffering of Others

Some therapists grow in compassion during the course of their careers because of an implicit aspect of our work—the voluntary decision to be with people who are undergoing especially difficult times. By working with individuals who are greatly challenged or *in extremis*—for example those who are confronting impending death or who have been traumatized in major ways—the clinician may come to see more clearly the components and etiologies of suffering, as well as the subtle opportunities that can arise from chaos and crisis. Such work exposes him or her to impermanence in a real way, and can engender a growing

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[3] This perspective may be especially helpful on occasions when the therapist discovers that his or her survivor client is also a perpetrator of abuse or violence against others.

realization that we are not only fragile, but also worthy of appreciation and love; that we are not here long, yet we are involved in a compelling and, in some ways, awe-inspiring process. As we assist and accompany people who are experiencing what we, in our culture, tend to deny or discount, there is the chance to access deepening levels of caring for others and ourselves, as we realize that we are all in this together.

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