

## Self-Differentiated Caring

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### Introduction

The personal relationship in spiritual care is the very heart of the healing encounter. This relationship is generally perceived of as a meeting between care-giver and care-receiver – one who gives and one who receives. It is the economy of demand and supply where the presented need of the patient or client directs and organizes the flow of the caring interaction. But as caregivers we are usually not consciously aware of the needs that we bring to our practice of caring. Case studies attest to the fact that therapeutic encounters generally reflect the needs and aspirations of both care-receiver and care-giver. It takes disciplined personal examination to detect our motivations that have prompted and continue to shape our spiritual vocation to a caring profession. These motivations come out of hiding as we actually meet as care-giver and care-receiver. In Freudian terms this process is often referred to as countertransference: experiences that are evoked in a helping relationship but originate in the therapist's own history and stem from the therapist's own needs. From a Jungian perspective the same dynamics are described as archetypal helping images that we carry into our caring interactions – something that we cannot avoid but can be aware of.

*“The other person in a therapeutic encounter can serve any of these needs. His therapy therefore begins with my therapy, my becoming conscious of the various archetypal images which play through me and force the other into a role he may not be meant to play. For if I am a father, he must become a child; if I am a healer, he must be ill; and if I am enlightened, he must be benighted and astray. These images are part of the set, the scenic background into which, as on to a stage, the other makes his entry...The less I am aware of my personal needs and how they filter the forces playing through me, the more the archetypal aspects appear directly and impersonally. Counseling is then suddenly plunged into subhuman depths and the demands become inhuman from both parties.” James Hillman*

### For Reflection

- How do you react and relate to the above quote?
- What are ways that work for you to discern your helping needs?
- How do you see other-care relate to self-care?

## I. The Principle of Self-Differentiation

The ancient myth of the wounded-healer is often presented as an idealistic picture of the healer/caregiver who is in touch with his or her inner wounds and vulnerabilities and thus can meet the care-receiver in gentle and compassionate ways. In clinical training for spiritual care we emphasize the curious paradox that only the wounded can heal. Yet it is unfortunate that the wounded-healer paradigm is primarily applied to the caregiver. The fuller picture is that each person, whether care-giver or -receiver, has both wounds and an inner healer. When a person becomes wounded, the wound activates the inner healer. However, in a caring relationship the wounded person may turn to the caregiver as outside healer to replace his or her inner healer. At the same time the caregiver's own vulnerability can be activated by the contact with the wounded person and be projected onto the wounded person. The principle of self-differentiation requires that these mutual, interlocking projections between care-giver and -receiver are withdrawn for the inner healer to do its own work of healing within.

*Self-differentiated caring is a paradoxical concept that easily jars spiritual care sensitivities. Terms like “creative indifference,” “holy detachment” and “benign neglect” point to the paradox that distancing is a flexible and playful form of therapeutic care. Such playfulness, rather than callous disregard, pays serious respect to the troubled and wounded as capable and creative people.*

### Some Questions

- How have you experienced self-differentiated care in your own life?
- Do you see a growing edge for yourself in practicing “holy detachment”?
- Is self-differentiated caring but a different word for tough love?

## II. Two Models of Care

The therapies can be divided into the *person-oriented* and the *task focused* models of care. These two models of care can be distinguished from each other in variety of ways:

- the one modality of care is one of *being with*, the other is one of *doing for*.
- the one style of care is one of compassion, the other one of competence.

From a self-differentiating perspective these two approaches readily conform to projections active in two dominant countertransferences or helping archetypes:

- the one projection of the caregiver's *inner wounds*,
- the other projection of the caregiver's *inner healer*.
- the inner pull to be with the person in need and share the person's wounds, and
- the inner push to rescue the person from the pain.

This module will distinguish the two as the compassion and the competence model.

## 1. The Compassion Model

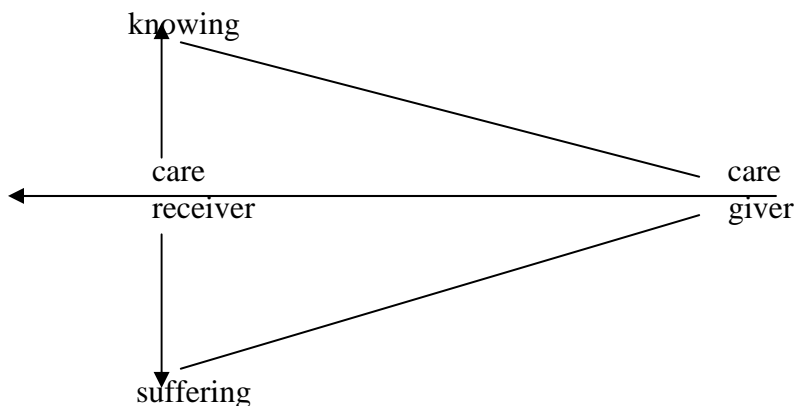
A uniquely caring response to human suffering can be captured by the word compassion. In compassion the caregiver is deeply touched by a person's pain and moved to sharing and alleviating the suffering. Through compassion the caregiver participates in and identifies with the suffering. Attachment theory (Bowlby) describes the innate dynamics observed in parent-child interactions where helpers are drawn close in proximity by those who signal their distress as they feel abandoned, threatened and insecure.

The compassion model rests on a powerful base in the wounded person's experience of pain that generates the gravitational pull that draws the helper through empathic identification. This baseline in the wounded person is represented by a line of interaction between *suffering* and *knowing* the wound. Knowing is found in the ongoing process of naming, interpreting and representing the wound through such narrative and symbolic expressions as story, lamentation, prayer, and symptom. The knowing and suffering interaction keeps the wound, though dated in precipitating events in the past, hurting in the present and projected through anticipation into the future.

The caregiver in the compassion model gets connected with the suffering primarily through what the wounded person knows and tells about the wound. The bridge of empathic involvement is the connecting link with the suffering person. The knowing and suffering are reciprocally related: the knowledge of the wound informs and shapes the suffering as much as the suffering informs and shapes the knowledge. Compassion is in knowing and feeling the wound. In compassion knowing is loving, with the erotic intensity that unites.

Figure 1

The Compassion Model



The traumatic dimensions in suffering dramatise both the intrinsic genius and the hazards of the compassion model. Trauma represents suffering in escalating intensity that increasingly cripples and disrupts the person's orientation and functioning in life. Trauma is the wound that multiplies itself through the persistence of intrusive thoughts, dreams, images and

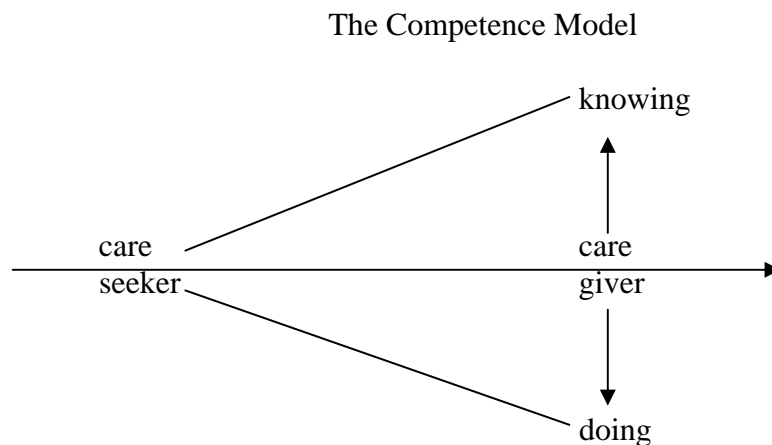
flashbacks. As wounding approximates traumatic proportions, the suffering person will lose the ability to name the pain, paralysed by what cannot be grasped or expressed. Trauma is the pain that breaks the connection between knowing and feeling the suffering. Greg Mogenson, in a book aptly titled *God is a Trauma*, describes how trauma in its overwhelming claims on the psyche functions as a God: "Just as God has been described as transcendent and unknowable, a trauma is an event which transcends our capacity to experience it. Compared to the finite nature of the traumatised soul, the traumatic event seems infinite, all-powerful, and wholly other"(1989,1-2). Trauma in this demanding, God-like impact creates and organises life after its own image.

According to a triangular diagram, as presented in Figure1, the more traumatically charged the suffering, the more compassion will be generated and the closer the caregiver will be drawn into the cycle of trauma incapacitation. The identification with overwhelming suffering in the wounded person will heighten the empathy countertransference in sensitising and activating the caregiver's own woundedness. This reciprocal process will increasingly put the caregiver at risk of the debilitating impact of what has been aptly labelled "compassion fatigue," or, with a theological ring, "vicarious traumatization."

## 2. *The Competence Model*

The second model of spiritual care, the competence model, shares with the compassion model a similar triangular diagram. The contrast between the two models is that the two triangles interact as mirror images. The compassion model focuses on the wounded person while the competence model focuses on the counsellor as the basis of gravitation which organises the energy field of therapy and directs the pull in the helping interaction. In the compassion model empathy propels the caregiver into the inner dynamics of knowing and suffering in the wounded person. In the competence model the lure of the counsellor's expertise propels the care-seeker into the dynamics of outer resources offered through the caregiver.

Figure 2



The competence model provides the wounded person(s), a point of connection outside the troubled and, in traumatized lives, flooded inner world of not knowing and the resulting hopelessness of mindless suffering. The caregiver offers outer perspectives and resources in order to facilitate the wounded to go beyond the confines of private suffering. As a trained professional, the caregiver draws from her or his helping image, spiritual and religious tradition, clinical wisdom and expertise to provide new and authoritative perspectives of knowing and doing in addressing the woundedness. The knowing in the wounded client is not just mirrored but expanded, confronted, or edited by the caregiver. In clinical psychology the knowing and doing of the caregiver is expressed in the link between diagnosis and treatment. Diagnosis presents the so-called "objective" knowledge of suffering, the knowledge that maintains clinical distance by reflecting extensive case study research with generalised profiles of the symptoms of distress. Treatment becomes evidence-based therapy as it is guided by the link that ties diagnostic criteria to the clinical research of preferred outcomes and interventions.

It is interesting to note the similarities between the classical method of pastoral care and the modern clinical model. Pastoral care and counselling in the classical tradition emphasises the contents of the objective message from sacred scripture and traditions of care while minimising the more subjective process of empathic understanding in the pastoral relationship. The ministry of preaching eclipsed the ministry of listening in the classical mode. Chrysostom, generally considered the greatest Christian preacher of antiquity, provides an example of a pastor who never really leaves the pulpit. In a "letter to a young widow," he excuses himself for not writing to her earlier on account of the fact that she could not hear him in the time of her acute grief, "but when the troubled water has begun to subside, and the fury of the waves is abated, one can spread the sails of conversation" (Volz, 1990, 157). In the same vein, classical grief counselling stressed moderation and control of one's grief. This pastoral approach stresses the primacy of the comfort of the gospel, and fears that our own private suffering may compete with the sufferings of Christ. Through a grieving process of de-privatising our own sufferings, our personal story is connected to the larger story of the faith community.

The value of the competence model is that it provides an external reference point for a closed system of suffering, and a boundary for the caregiver who is at risk of being incorporated and traumatised in the cycle of woundedness. The model's hazards, however, signal caution to most therapists. The role of the caregiver in the competence model is primarily one of the expert with the task of managing the wounded person's pain or saving his or her soul. The focus of the model is on the competence of a caregiver in complementary relationship with the helplessness of a care-receiver. Its toxic potential is dramatised in a rigid rescuer-victim scenario organised by power differences which collapse only when therapy fails, often when helper and client connect in both feeling victimised by the other.

### 3. A Scale of Contrasts

The two models, the one shaped by compassion and the other by competence, are often experienced and presented as diametrically opposed and mutually exclusive styles of therapy. From this polarized perspective, the therapist in the compassion model is the one who does not know and needs to listen to the client in contrast to the competence model where the client is the one who does not know and needs to listen to the therapist.

In clinical education programs, supervisors often experience this difference in students. One student (student A) enters a practicum program primarily on account of feelings of professional inadequacy, in search of good theory and techniques that work. In supervision A asks, with an urgent anxiety directly proportionate to the degree of difficulty in the case presented, what to know and what to do. Another student (student B) appears far more confident, to the point of arrogance, secure in the ability of developing close relationships with clients and claiming inside knowledge of what is going on with the client. While A looks primarily for the clinical expert, if not miracle worker, in the supervisor, B is more interested in a supervisory relationship that can support and parallel the relational dynamics of the counselling experience presented for supervision.

*A Table of Comparison*

<b>PERSPECTIVES</b>	<b>COMPASSION MODEL</b>	<b>COMPETENCE MODEL</b>
<i>pastoral paradigm</i>	relational pastoral/spiritual	classical pastoral
<i>"wounded healer" image</i>	the woundedness in the healer	the healer in the woundedness
<i>therapy mode</i>	"being with"	"doing for"
<i>power distribution</i>	horizontal	vertical
<i>therapist role</i>	companion	coach
<i>gravitation pull</i>	into the suffering	into the helping
<i>therapy direction</i>	towards client	towards counsellor
<i>therapy resources</i>	inner	outer
<i>counselling style</i>	facilitative	directive
<i>use of self</i>	personal empathy	clinical expertise
<i>countertransference</i>	the "empathizer"	the "rescuer"

Questions:

- *Where is your comfort zone between these polar ends?*
- *Where is your growing edge between these polar ends?*

### III. Self-Differentiated Caring

#### A. A Radical Model

From a radical self-differentiation perspective in Murray Bowen's family systems theory, expressed in Rabbi Edwin Friedman's classic *Generation to Generation* (1985), the compassion model and the competence model are not opposites but the offspring of the same parent of anxiety. Empathy, anxious to connect with the person in pain, readily dissolves into emotional fusion, and the seriousness anxious to offer competent help easily gets stuck in rescuing attempts. Such seriousness is contrasted with a therapeutic culture of playfulness that differentiates. This playfulness "has less to do with 'one-liners' than with the concept of flexible distance; it has less to do with good 'come-backs' than with the ability to distinguish process from content." (1985, 51)

Friedman applies the biological systems concept of self-differentiation to spiritual care. In an "emotional system" organised by pain the counsellor is easily drawn into a triangle consisting of the client, his or her woundedness or problem, and the caregiver's role to support (the compassion model) or to rescue (the competence model) the person. Rather than a spiritual care stance of joining with the client in support and comfort, Friedman proposes the self-differentiated approach of *challenging*: "it requires one to non-anxiously tolerate pain, and even to stimulate pain, thus forcing the other to increase his or her threshold (1985, 49)." Friedman presents *challenge* as a radical shift in therapy, appealing to practices in modern healing of injecting germs and viruses directly into an organism so as to stimulate its own immune system.

#### Some Questions about Supervised Pastoral Education

- Is a "non-anxious presence" something that can be learned in SPE?
- Is "forcing to increase one's threshold of pain" an appropriate goal in SPE?

#### B. An Integrated Model

By dismissing the compassion and competence models as two equally anxious ways of spiritual care, the differentiation model becomes a separate, third model of spiritual care. However there is a less radical option in self-differentiation that incorporates both compassion and competence in a balanced whole. This integrated model stresses an approach where the therapist can have recourse to both styles of care, without being identified with either one of them. It proposes a working alliance between the two students A and B mentioned above: an alliance based on the ability to differentiate between compassion and competence. By helping archetype, temperament and clinical experience, caregivers can approximate either a type A or a type B student, along a continuum going from the compassion model to the competence model. Type C characterises a caregiver not restricted to a fixed point on the continuum but who can self-differentiate and balance the two ends on the continuum according to what is appropriate in a particular helping situation.

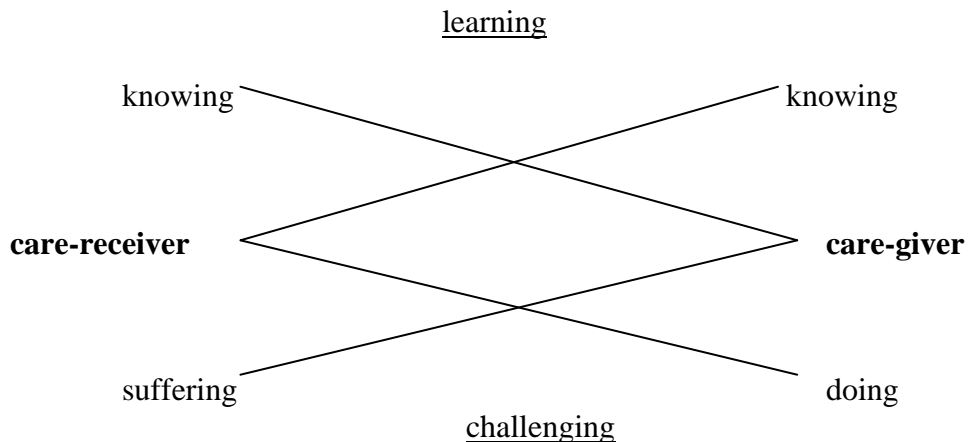
The integrated model of differentiation separates the two sources of knowledge, the inner, subjective source of the pain and the clinical research source represented in the outer response of the caregiver, and in so doing separates the wounded from their wound. This creates space for therapeutic conversations and critical reflection.

This differentiation principle informs constructivist and hermeneutic theories when prescribing a "not-knowing" stance for therapists. In order to learn from the client, the therapist becomes the curious listener who does not yet but eagerly wants to know. True understanding is not something to be acquired apart from the listening process and to be imported into the counselling session. The therapist's pre-understandings are not only irrelevant but will obstruct the helping process and thus need to be checked at the door. This "not knowing" emphasis, however, cannot be simply identified with the empathic presence of the compassion model. The therapeutic not-knowing stance does not mean that the therapist is totally dependent on the client for knowing anything at all. Rather, the counsellor's not-knowing is the stance which teases out unique bits of new and relevant knowledge and dares therapeutic competence to evolve in the helping dialogue itself. Healing happens in encounters that mutually enlighten client and therapist, opening up windows of understanding and hope, going beyond the restrictive and oppressive walls of blind suffering.

The Rogerian term *active listening* described the therapist's focus on understanding the client's inner world of feelings and thoughts. The term *active learning* may better fit a collaborative process where the therapist is responding both to the wounded person and to himself or herself in meaning-making conversation. Active learning is being poised for surprises, ready to pick up on what is novel and redemptive, what White and Epston have referred to as "unique outcomes" and "news of difference" (1985, 49) in stories otherwise saturated with doom and dominated by failure. In active learning, the listening ear is teamed with the playful pen of the reporter who can punctuate, organise, format the materials, and suggest a headline, possibly a cartoon, to go with the story.

Figure 3

The Integrated Differentiation Model



The differentiation model of a “balanced whole,” rather than rejecting joins the two triangles that represent the compassion and the competence model. The two triangles in interaction become a diamond which can contract and expand like an accordion as it balances each triangle in shifting therapeutic alliances between the two ways of knowing and doing.

### A Brief Conclusion

This module emphasises a *what to be* focus in spiritual care and therapy. It highlights the therapeutic relationship as the place where the therapist’s expertise in knowing and doing is negotiated. It is the place where therapy as a science is transformed into an art. In spiritual care and therapy, differentiation becomes evident in the interplay between *what to know* and *what to do* in a therapist’s flexible and playful ways of *what to be*.

*In the differentiation model, spiritual care is about the curious paradox that by learning from the other, the other can know, and that by defining oneself, others can find themselves.*

### Note

This module adapts sections from ch.6 - “What to Be: Therapeutic Relationships,” in VanKatwyk, Peter. 2003. *Spiritual Care and Therapy*. WLU Press.

### References

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- Friedman, E. 1985. *Generation to Generation – Family Process in Church and Synagogue*. Guilford.
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### Resources

- Reinventing Leadership*, Edwin H. Friedman. Video Cassette #0950, Guilford Publications. 1996.