

## **The Care Giving Personality by Karl LaRowe, MA, LCSW**

“Who taught you all this Doctor?” The reply came promptly: “Suffering.”

— Albert Camus, “The Plague”

### **Why We Were Attracted to Care Giving (It Wasn't the Money!)**

Care providers are unique people. We have the gift of being able to connect with others in ways that are difficult to explain and even more difficult for others to understand. Our unique ability to emotionally join with our clients that allows us a near first-hand experience of their inner world is perhaps our greatest gift; it is also our greatest challenge.

### **Personality and Profession**

Those personality traits that attracted us to care giving as a profession, are the very same traits that can render us vulnerable to stress, burnout and depression. For those of us who took the Strong-Campbell Vocational Interest Inventory (that long, boring test that tells us what we are supposed to be when we grow up), will recognize it as a type of personality test. Its validity is based upon years of trials that show a strong correlation between basic personality styles and the kinds of jobs those styles are drawn to.

As a care provider, it is my experience that most of us are drawn to the profession. We are drawn sometimes by strong emotions and beliefs as well as the desire to be of service to other people. There is something about being a care provider that has a strong attraction for us and we are as much “pulled in” to the profession as our making a long, thoughtful, intellectual decision.

Take a moment and reflect for yourself. Why did you become a care provider? It certainly wasn't for the money! In fact, I don't know of another profession that draws the number of highly trained and qualified people who are routinely challenged with large caseloads and expectations to produce results at a pay that may not be equal with the task.

So why did you become a care provider? Most people tell me they want to help other people and in the same breath gasp how hard it is and how little they feel they are really helping. Some providers will tell a long story about how many times they have quit the profession only to be “sucked back” into it. Why did you become a care provider? What attracted you to this profession?

One of the things I often ask providers is what personality traits do they think they share with their clients. Most providers are able to see a number of ways in which we actually “mirror” our clients.

For instance, in the State of Oregon report: “Listening to High Utilizers of Mental Health

Services” reports in one study of master’s level and above community therapists, 19% acknowledged they had been victims of Childhood Sexual Abuse. It is really no mystery that we are often providing comfort for the part of ourselves that we see in our clients.

If you can emotionally take a step back for just a moment and take a detached view (or as Thomas Crum, in his book “The Magic of Conflict” says, move from a point of view to a viewing point) and look at your profession as a care provider in the context of your whole life. Can you see some patterns and connections? Are there running themes that weave themselves throughout the fabric of your life? Do any emotions or memories surface? How do they fit in?

### **Repeating and Remembering**

Long ago Sigmund Freud made a statement that I personally believe is as accurate and true today as when he first said it. He said: “We shall repeat instead of remember.”

I believe he was referring to our internal scripts that have been written (mostly without our conscious permission) early in childhood. These scripts are often in the form of rigid, unquestioned beliefs that can form the basis of our individual perception and experience. As we “strain” life through our individual scripts we are bound to repeat those emotionally charged experiences that lurk in the blindness of our shadow.

The process of “remembering” including emotional healing, is the basis of therapy. When we have certain live issues that have not been resolved and laid to rest, they will create an attraction within us that will result in a repetition of the original script. Often our attraction to the care-giving field has some element of repeating our old, mostly unconscious life scripts.

### **Caring for Ourselves, Caring for Others**

Caring for others usually has some element of caring for ourselves and there is nothing wrong with this. From one perspective, there is very little difference between each of us and the concept of “boundaries” is abstract. From another and equally accurate viewing point, we are very different individually and individual boundaries are both very real and should be respected.

What ways can you think of in which we are all very similar? Where do all people share common ground? What are some of our universal needs?

Now think of and contrast the ways in which we are all very individual. Where do the boundaries lay and where do they lie? Which boundaries are necessary? How do you respect and care for those boundaries?

“Respecting boundaries” is a very real and necessary concept in care giving. One of the reasons it is an “alive” issue is because of the potential of psychological trauma for both client and care provider. Why this potential for psychological trauma?

The flip side of our being able to connect with others is our tendency to emotionally confuse empathy and sympathy. I say emotionally confuse, because most of us intellectually know the difference between empathy and sympathy. It's just that our emotions didn't read the same books as our intellect (or if they did, they got something different).

*"Judging from present trends, it is possible to envision a time when personality and behavior characteristics will be one of the first factors that health practitioners attempt to evaluate in assessing their patient's state of health or susceptibility to illness."*

— Kenneth R. Pelletier, *"Mind as Healer, Mind as Slayer"*

## **Empathy and Sympathy**

### **Accurate Empathy**

The capacity and ability for accurate empathy is the core competence for all care providers and all care giving.

The Oxford American Dictionary defines empathy as: "1. The ability to identify oneself mentally with a person or things and so understand his feelings or its meaning. 2. Do not confuse empathy with sympathy."

In his book "Emotional Intelligence," Daniel Goleman states: "Empathy builds on self-awareness; the more open we are to our own emotions, the more skilled we will be in reading feelings."

In other words, our ability to connect with others is closely tied to our ability to be open and honest about our own emotions.

Heinz Kohut, a Chicago psychoanalyst and author of the classic book: "The Analysis of the Self," defines empathy as: "...a mode of cognition which is specifically attuned to the perception of complex psychological configurations." Empathy and the ability to attune ourselves to the inner workings of our client's experience, is at the heart of every care provider's core competence.

Accurate empathy is also the cornerstone of Carl Rogers Client Centered approach to therapy. The pivotal word here being accurate. What is accurate empathy?

Again, Dr. Goleman provides some clues. He states: "For all rapport, the root of caring, stems from emotional attunement, from the capacity for empathy. The key to intuiting another's feelings is in the ability to read nonverbal channels...the benefits of being able to read feelings from non-verbal cues includes being better adjusted emotionally, more popular, more outgoing, and perhaps not surprisingly – more sensitive."

Accurate empathy is the process of developing rapport through emotional attunement, the ability to intuit another person's feelings and read non-verbal cues. Accurate empathy does not include feeling sorry for our clients or taking them home with us in our minds.

## **Sympathy**

The Oxford American Dictionary defines sympathy as: "1. sharing or the ability to share another person's emotions or sensations. 2. A feeling of pity or tenderness toward one suffering pain or grief or trouble. 3. Liking for each other produced in people who have similar opinions or tastes. 4. Approval of an opinion or desire."

So what is sympathy and how do we get it confused with empathy?

Accurate empathy is the result of a fundamental therapeutic skill that allows you to become a participant/observer during the process of communicating with your client.

The participant is the part of you that is open and receptive and joins with your client by developing rapport and alignment. It is your feeling-intuitive side. The observer is that part of you that is detached (not disconnected) from the content of what is occurring and is able to clearly and objectively observe the process of your relationship with your client as it unfolds.

The emergence of a sympathetic response to your client is an indication that the observer part of you is being drawn in and is losing clarity, objectivity and perspective. Something about what your client is sharing with you has hit a sensitive nerve and has precipitated a sympathetic response.

Sympathetic responses don't always result in a gush tender feelings for your client. They can often result in sudden anger, depression or repulsion. Whatever response you experience that response will have the qualities of being very intense, inappropriate to the situation, tenacious and ambivalent.

Take a couple of moments to think about how you identify the difference between empathy and sympathy. Identify which people (clients and/or coworkers) that you are more likely to have an empathic or sympathetic relationship with. Also try to identify what the context of that relationship is. Where are you, what are you doing, what is your purpose for that relationship? Also take a couple moments to examine your communication style in these relationships. What is your tone of voice? How is your body posture? What is the intent of your communication?

## **Transference and Counter-Transference**

### **What is Transference and Counter-Transference?**

Transference and counter-transference are psychoanalytic terms that are often used and rarely

understood. In 1895 Sigmund Freud coined the term transference as it applied to psychoanalysis. In 1905 he wrote an article called “Fragment of an Analysis of a Case of Hysteria,” where he defined transference as “new additions or facsimiles of the impulses and fantasies which are aroused and made conscious during the progress of analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician.”

As care providers we have all experienced this. Every care provider has a story to tell about the client who continually confuses them emotionally with some significant figure from their past. There are four major qualities to transference reactions, both positive and negative: Inappropriateness, Intensity, Ambivalence, and Tenacity

Strong transference reactions are noticed more often and more intensely in those populations of clients whose reality testing abilities are compromised. Particularly in nursing homes, adult foster care, inpatient psychiatric units and transitional facilities where the client’s sense of self may be experienced as weak or fragmented.

This represents a significant weakening in a client’s emotional and at times, cognitive boundaries. For those of us who have open or even healing emotional wounds, a client’s pain and helplessness may stir our emotions strongly. We may feel personally driven to take that person’s pain away, or, we can become angry and frustrated with why the client isn’t making better progress or is “acting out”.

### **Sympathy and Counter-Transference**

Even knowing better in our minds, we can slip into feeling sympathy for our clients and begin to shoulder their burdens as well. We will emotionally take our clients home with us. Even if we aren’t consciously thinking about them, they are often sitting right next to us on the couch as we try to forget about our day.

Have you ever asked yourself just how and why we take these people home with us, even when we don’t want to? We know it’s inappropriate. The intensity and tenacity of our ambivalent feelings toward them should give us a clue.

I believe counter-transference happens. It just happens. It’s not so much a matter of what we are or are not doing that is right or wrong, we are simply all connected. As the chapter on Parallel Process will show, it’s not a question of whether we are or are not connected it is the clarity and transparency of the connection that matters.

Identify one client who you believe is having a transference reaction to you. What does your client say and do that makes you believe they are having a transference reaction. Identify how they demonstrate inappropriateness, intensity, tenacity and ambivalence in their communication and relationship with you.

Now, identify a client with whom you are having counter-transference reactions – it can be the same client – and repeat the exercise identifying how you demonstrate inappropriateness, intensity, tenacity and ambivalence in your communication and relationship with your client.

## **The Need-Desire to Be Right**

What can cloud transparency and dull clarity is a self-image that requires other people to respond to us in a way that we expect will make us feel right, important and special. We are more vulnerable to seeking sympathy from others rather than providing empathy for others.

### **When Wanting Feels Like Needing**

When our desire to be thought of in a kind way by others is overshadowed by our need to be right, needed, important and/or special we are experiencing a state I call “need- desire.”

Need-desire is a want that is experienced with the same inappropriateness, intensity, tenacity and ambivalence as transference and counter-transference reactions. It is a desire that feels like a need.

The desire to be RIGHT for example can be experienced with the same force and intensity as our physical and safety needs. Those of you who work with battered women and their abusers have probably made the observation that one the central issues underlying the violence is the need-desire to be right.

For care providers, our need-desire to be right/special can trap us in the compulsion to give more of ourselves to our clients, our work and our co-workers than is healthy for us, or them. It can also cause us to react strongly and at times without our conscious awareness, towards our clients and/or co-workers in ways that supports division and conflict rather than unity and cooperation.

### **Trapped in Giving**

When we feel compelled to give our attention, time and energy we can experience ourselves as trapped in giving.

Trapped in giving is our experience of having to do more, be more (special to our client) that is characterized by the same qualities as transference and counter- transference reactions; inappropriateness, intensity, ambivalence and tenacity.

As we begin to lose the observer function of our perception we can begin to feel drawn into a relationship with our client where emotional boundaries become blurred, particularly if we are dealing with an issue that we have an emotional vulnerability to – and especially if we are unaware that we have a vulnerability.

As we become increasingly caught in the struggles of our client that will become repeated in the therapeutic relationship, we will continue to lose the observing function of our ego and begin personalizing those struggles with others, our profession and ourselves. As we shall see in the next section, "The Personal Cost of Care," being trapped in giving is very expensive in the personal cost of providing care.

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