In the Face of Trauma: Relationship, Ethics, and the Possibility of Presence

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ABSTRACT | Using Lévinas's ethical "commandment" as a starting point, this paper outlines some of the personal and relational dynamics in facing the extreme suffering of trauma. The polarities of alienation and identification illustrate some of the tensions and risks involved in becoming more present in the face of trauma. The therapist's personal relationship to trauma is positioned as a key factor in determining our ability to meet people who are traumatized, and the argument is presented that "therapeutic vulnerability" can be one of our resources.

KEYWORDS | trauma, ethics, presence, defenses, altruism

The phrase "In the Face of Trauma" in the title of this paper is drawn from Emmanuel Lévinas (1985, 39). I do not pretend to be a philosopher; in fact, I am pretty baffled by much of what I have tried to read, but still

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I appreciate that we have something to learn from Lévinas. First, though, what does this phrase evoke in you? A sensation, a thought, an emotion, a memory, an image? And what is your impulse to do with it?

My initial question in preparing my keynote address was: Would anyone want to listen to a presentation about trauma? In fact, why would anyone want to do this: to face extreme suffering, to hear stories of the worst atrocities that humans can inflict on one another? It is at best an odd choice to put ourselves "In the Face of Trauma," and at worst it is risky. But trauma is not something that any of us can avoid; indeed, Toronto has been visited by terrifying and shocking events in recent months, not so very far from the conference venue. I want to acknowledge people affected by those events and who may still feel the impact.

Before I turn to my main theme and offer some of my experience from my clinical practice, I would like to say something about my use of language. Terms such as client or patient, victim or survivor, all hold different meanings and can highlight implicit power in the relational field. Bonnie Badenoch (2018) gets round this issue by use of the terms "my people" and "the people who come to me." In this, I find deep and radical respect and choose to adopt these terms here.

So, I want to introduce you to one of my lovely people whom I will call Stephanie, though it is not her real name. Stephanie is one of those people whose dissociation is so extreme and enduring that they are hard to reach. Clearly, there are things she does not want to know about her experience any more than I do. This, she tells me, includes her fear of knowing that she is afraid. Her dissociated self-state is an example of *unformulated experience*: that which has not been symbolized by thought or language, and is not yet knowable. The experience cannot be reflected upon without threatening the integrity of her self (Strait 2013, 24).

On one occasion, a little way into our work, Stephanie was evidently triggered into a flashback during a session. Rather than work with a tight focus to guide her back into the present moment, I sat back in the chair and opened myself to the feeling tone of what was in the room. As I did so, wave after wave of nausea arose in me. Up until this point, I think I had been defending myself against this, but on reflection, it seemed as though our relationship was ready for it. Where my defenses had been up, I could now tolerate, allow in, some of Stephanie's experience, and,

I suggest, she was also giving me permission to share her feeling state. I gave my experience back to her: "It feels as though something really sickening is going on," at which Stephanie nodded and "came back" more into the room. The conversation that followed took us to new and more clearly articulated territory, more formulated experientially, one to which we could both be differently present.

This is but one example of what I want to highlight as a primary question in working with trauma, one I invite my students to reflect on and work with over time. I consider the most important question to be about our own relationship to trauma. This includes two aspects; first, our personal history, the backstories that tend to pull us in the direction of helping others. I want to pause and take in that there will be many such stories among readers, and I include the stories I could tell—my "#MeToo"—relating to my childhood and early adulthood. The second strand to this question is about our current fascination, compulsion, excitement, distance, contempt, disgust, and more, to trauma. I have felt most of those things at different times, and generally my own relationship in the face of trauma has changed over time. This question is important because it shapes how we either help or hinder the therapeutic relationship. Just as I tell myself I do not really want to know about this, there is also something about trauma that does not want to be known. It can be described as an absence, as something that we just cannot grasp; it is based on the *destruction* of coherent patterns. These are processes that often do not have any discernible experiential or sensory origin. I sometimes consider that trauma has the qualities of the Trickster, the shape shifter. And one of the roles of the Trickster is to fool me into believing that I am okay.

Here is an extended segment from Dori Laub and Nanette Auerhahn (1993), part of which appears as an epigraph at the beginning of my book (Taylor 2014):

> We all hover at different distances between knowing and not knowing about trauma, caught between the compulsion to complete the process of knowing and the inability or fear of doing so. It is in the nature of trauma to elude our knowledge, because of both defence and deficit. The knowledge of trauma is fiercely defended against, for it can be a momentous, threatening, cognitive and affective

> task, involving an unjaundiced appraisal of events and our own injuries, failures, conflicts and losses. (Laub and Auerhahn 288)

These are such very human responses, are they not? And when our defenses come up, as they will, whom are we really defending? Part of that defense is, I think, to do with the sheer energy that gets tied up, retroflected, in trauma, particularly in frozen people such as Stephanie, and with our implicit fear of this being unleashed in our face. The face of trauma is one that holds intense emotions.

Nancy Bridges (2003) speaks of "the difficulty that clinicians experience in maintaining attunement to affect, particularly traumatic affect, on the basis of what this stirs up in the subjectivity of the clinician's self, life and experiences" (as paraphrased by Strait 2013, 73). Our people's experiential worlds become very personal to us. This brings to mind my young person, Luke, whose story was the stuff of nightmares, and how I slowly became increasingly unsettled by his disclosures of extreme violence in his earliest years. I needed to slow right down and change some plans to attend to this, and so doing I realized that Luke needed me to process some of his story and give it back to him. I understood also that a fear-filled part of his story overlapped subtly with my own. It was only when I had identified this for myself as the source of my disturbance that I was able to formulate both his story and my own in the context of our relationship. British body psychotherapist Shoshi Asheri (2013) writes this:

> When a client enters the therapy room bringing with them their traumatic experience, in whatever disorganised or dissociated, physiological and/or psychological manifestations, they inevitably enter into a relationship with a part of the therapist that would rather remain dissociated than feel the unbearable feelings that an engagement with such trauma can evoke, particularly if the therapist carries a related trauma of his or her own. . . . To what extent can we undo the unconscious pact between therapist and client to remain dissociated, and what are the [. . .] therapeutic positions that can help us undo this unconscious pact? (73)

Looking through a Gestalt theoretical lens, one of the dichotomies I would like to highlight and perhaps deconstruct is that of alienation

and identification. Trauma leads us face on to splits and the problem of otherness—to alterity, to use Lévinas's term—that is, the disowned, including those aspects of experience that may be dissociated within ourselves. Malcolm Parlett (2015) states: "'Identification with' is to be aligned with, or to join together; while 'alienation from' involves distancing from 'the other.' And with this distancing goes a small, subtle, and yet discernible, reduction in the personhood of the other, or others. . . . All of us are part of this phenomenon of identifying and alienating. *It takes an enormous shift in consciousness to transcend this dynamic, to step outside it, to recognise it, and to avoid being caught in it*" (124, emphasis added). Paradoxically, however, when we want to create some distance, an inevitable and accurate dissociative attunement may be operating. Recognizing the difference between the unconscious alienation and the dissociative process is a challenge.

Marie Adams (2014) tells the story of one of her people who said on her first visit: "This will begin being about me, but will end up being about you" (80)—a smart, prescient comment indeed. Adams asks the question, "Why did you become a therapist?" (10). My answer to this might be along these lines: Because I care deeply about people who are hurt, because I am outraged by the damage that one person inflicts on another, and because I believe that the suffering can be alleviated. "But why did you *really* become a therapist?" (10) insists Adams. Well, here I have to be honest. Because I had an uncomfortable relationship with myself, with my body, with being in my own skin. Because of the millions of threads of shame that made the cloak I wore. Because I believed the lies people had told about who I was in the world. Like many of you in this readerly audience, no doubt, I had lived a hard life and hoped for something easier. What I have come to recognize is that by continually addressing my answers to the second question, I became less idealistic, less deluded by the Trickster that manifests in my answers to the first question.

Various writers attest to the complexities of working with traumatized people. For example, Kylea Taylor (1995) speaks of the particular ethics that are summoned in the presence of nonordinary states of consciousness in our people, such as dissociation, because those states seem to change ordinary pitfalls into quagmires (37). This rings true for me in my clinical practice, for example where things have "slipped" the memory of one party or the other. Laurie Perlman and Karen Saakvitne

(1995) address the personal impact of this work: "More than any other patients, sexual abuse and trauma survivors provoke deep emotional responses and raise unresolved issues in the therapist" (25). To resonate with such provocation is not—*is absolutely not*—a failure in that "our vulnerability to one another is an integral part of our biology, not a sign of weakness or lack of professionalism. . . . When we are in the presence of a traumatised person our brains become activated in the same ways as when we are traumatised ourselves" (Cozolino 2004, 192). Our response is as involuntary as the trauma responses of the people who come to us. James Kepner (2003) suggests that "our own body process is an intrinsic part of the transaction with the client" (11), emphasizing that intersubjective arousal is a primary transaction.

Troubling is a currency about avoiding vicarious trauma and secondary trauma in the helping professions. These concepts seem disconnected from a field perspective and reductionistic, as though one party is doing this to the other in the exchange, and as a shortcoming on the part of the therapist. I do not for one moment believe this situation to be the case. I am much more comfortable with Richard Gartner's (2017) notion of counter-trauma, which at least begins to move toward the idea of our own trauma responses having a part in our own inevitable embodied resonances. Taking Lévinas into account, we make a choice to experience these cocreations. Yet, as Perlman and Saakvitne (1995) remind us, "rarely do therapists enter the field of trauma therapy with full understanding of the implications of their choice" (279).

Lévinas (1985) asserts that there is a commandment in the face of the destitute, suffering or, in other words, traumatized Other, "to whom we owe everything" (89). We have to feel this, he seems to insist, and to bracket our own interests. This is a challenging ethic particularly because Lévinas intended it to be asymmetrical. Rabbinical scholars Thomas Zweifel and Aaron Raskin (2008) advise thus: "To raise a man from mud and filth. . . it is not enough to stay on top and reach down a helping hand. . . . You must go way down yourself into the mud and filth" (211). For some of us therapists, this is second nature, the relational ground on which we stand. One student told me: "Taking on responsibility for everyone else's suffering: that is the role I took on in a family that could not feel anything." Here lies the potential to overidentify as much as to raise defenses—a dichotomy we need to seek to overcome for ourselves if we are to meet in the mud and filth.

Set against this notion, Donna Orange (2011) questions whether our welcome of suffering is in fact (to use her term) an "unanalyzed moral masochism" (52). She asks: "Should we be setting better limits, for our own sakes. . . and for that of the client as well? Better limits according to whom, though? How do we decide which phone call not to take, which extra session to refuse, which patient to send elsewhere? How do we decide what is service to the other and what is masochism?" (52). To be honest, it hurts to see so many therapists suffer for their work, and I invite students and supervisees to think clearly and realistically about their limits, and about what nurtures them. Here is one example: A workshop participant, an experienced mature trainer herself, told me, "I had lost hope of ever finding nourishment for myself again," which left me concerned about how she could possibly sustain her work from a position of such deficit. What enduring relational themes (Jacobs 2017) were playing out in this, I wondered, and what were the implicit messages being held in the relational therapeutic field?

It is my honor to work with many therapists as a supervisor and trainer. All too often I hear stories about their shame, helplessness, fear, dissociation: the four primary organizers of traumatic experience (Taylor 2014). While these organizers may accurately reflect the processes of the people who come to us, and are part of the journey if we hold them in awareness, these are the ways I recognize the Trickster entering the stage. I frequently hear of a compelling sense of responsibility that takes therapists way beyond their limits: "Is it possible to ever end therapy with this person?" And in this, we deny the power and self-authority of our people (Perlman and Saakvitne 1995, 84). And thus, we recreate unwittingly the dynamics and dichotomies of the original traumatized relational field. This is a trap I can fall into. There is a pact I make with the part of me that is vulnerable, and the part of me that wants to help. My altruistic part nudges my wounded self out of the way and reduces my presence. That is a split I often want to disown, and in doing so I make part of myself "Other." I suggest that the Other reflected back to us in the face of the people who come to us is one we also must face in ourselves, and one to whom we also owe everything. I cannot state this enough: we equally owe our own vulnerable and wounded selves everything we can offer.

To reach toward another requires that we know our own center first. To do so needs a "balance between different consciousnesses, while

maintaining the capacity to be responsive from that place of internal and external connection" (Geller and Greenberg 2012, 55). Such a holding of different consciousnesses is containing and ultimately integrative. In order to do so, these writers call for us to cultivate a sense of inner presence ourselves first. And, paradoxically, we first may have to experience disjunction in order to realign more deeply (Strait 2013, 224). The Trickster runs in chaotic circles rather than in straight lines. Our need to withdraw may feel like a "misattunement," when it may in fact be an attunement to the dissociated states of our people, a dissociative attunement (Strait 2013, 233). It is helpful to know the difference in our bodies between reacting, resonating, and responding. (Readers: you may want to pause for a moment and check if you can tell the difference in your being).

Therapy, as mentioned earlier, can be risky; indeed, it can do violence to the therapist in ways we need to take seriously. I think here of a local outlet of the British National Health Service where therapists are paid by short-term results. The fewer the sessions (e.g., three) in which the work can be completed, the higher the rate of pay. Over six sessions is rewarded by the lowest rate of pay. Of concern here is that, in some ways, the therapists working for this service consent to this structure, and one may ask what personal or cultural conditions drive such a questionable ethic. It is my sense that, in less overtly oppressive ways, it is not uncommon for therapists to consent to working in conditions that are dehumanizing.

Louis Cozolino (2004) has something to say about the motives that bring us to this therapeutic work:

> We all come to training with some unconscious mission to fulfill: to find ourselves, preserve our sanity, or save someone in our family. Many of us grow up being told what good listeners we are, how well we mediate family conflict, or how we manage to regulate the emotions of those around us. Whatever it is, we can be better therapists when these missions are identified, understood, and factored into how we experience our clients. (14–15)

Without these missions, says Cozolino, we risk turning our career into drudgery. Many supervisees, trainees, and workshop participants often tell

complex, ambivalent, and overly responsible stories of their relationship to their work with traumatized people. This has led me to an interest in the subject of altruism, and how it plays into the relational dynamic in therapy. Interestingly, the word "altruism" shares it roots with alterity, Otherness, or *autrui*, as Lévinas would term it.

Joan Halifax (2018) positions altruism as one of five intersecting "edge state" experiences that can be positive and healing but can each tip into something else. (The other edge states are defined as empathy, respect, integrity, and engagement.) I have framed these edge states as the territory of the Trickster, the tipping point between complexity and chaos. I am in agreement with Halifax that pure motives rarely exist. She suggests that altruism's edge can easily crumble, leading to the possibility of destruction; and she talks of the fallout that comes from trying to solve problems—to fix, save, or to help—without acknowledging the underlying complexity (24). I suggest this as an example of the binary condition of trauma. But importantly, Halifax says, although most of us will fall over the edge, it is from that collapse that a new and more robust perspective can emerge (9).

Implicit is the suggestion that, when there is a cost to one side or the other, altruism may not always be as helpful as might first appear. Barbara Oakley (2013) has defined what she terms "pathological altruism"—pathological in the sense that it is excessive rather than disordered. According to her, this results in part from an inability to process the wide range of information necessary to make prudent decisions, and acknowledges the potential harm from the cognitive blindness that arises whenever groups or cultures treat a concept as sacred. Oakley also suggests that an excess of altruism is a dynamic process that may be invited by the beneficiary, leaning toward what we understand as cocreation. Returning to Halifax (2018), tipping over the edge into pathological altruism arises from losing a sense of the context: discomfort with ambiguity, Trickster states, and over-certainty. That I interpret as meaning: "Let's not know, be aware, and you can then go on looking after me." It is certainly probable that trauma calls forth the above like nothing else. Similarly, we can be fooled into ignoring alarm signals that our helpfulness has gone too far that time.

What we ignore, or hold out of awareness ourselves, may be picked up acutely by the people who come to us, and herein lies a key point:

"The inner state of the therapist strongly influences the response of the client" (Geller and Greenberg 2012, 59). My proposition is that greater awareness of implicit processes and the dynamics of Trickster states is in itself a major therapeutic intervention, increasing the possibility of presence. Geller and Greenberg link presence to mindful practice, not by teaching the people who come to us to be mindful, but by becoming more mindful ourselves (13). Here are two examples. Recently, Stephanie (discussed above) reported seeing me as a mindfulness teacher, though we had never talked about it.

Another of my people, Holly, came into the room one morning and was immediately on alert and saying that something was different. Nothing had changed in the physical environment, but she had instantly picked up on something in me. I had tripped and fallen the evening before; with no more than some impressive bruises, I was still shaken and was not taking enough account of that. Adams (2014) writes of the shame of needing support, of taking self-care seriously. If we feel threatened by the idea of needing help, recovery, or comfort we put ourselves above the people who come to us (125), a small and subtle alienation that reduces their personhood. Can I take the risk of my people knowing my vulnerability rather than my "defendedness"? I told Holly about my fall and that helped settle her agitation. What feels like an individual problem is isolating and needs to be reframed as relational. In that context we can make meaning.

The dominant narrative in some areas of the helping professions suggests that a personal trauma history is incompatible with the role of a therapist. How do we resolve the following dichotomy: If we have been broken by the actions of other people against us, and that trauma is unrecoverable, how do we still continue to work to restore our people to full recovery? This situation plays heavily into stigma and victim blaming which are also aspects of the narrative around trauma. This leans on an implicit narcissism of the helping professions, in which we therapists need somehow to be more-than-human. And, to the extent that we do not value our vulnerability, our trauma histories, and our need for support we objectify ourselves. This situation creates an environment in which some professionals are scared to speak out about their experiences of abuse. How have we allowed this to happen? My identity as a psychotherapist is not separate from that of victim or survivor: I cannot

cut off parts of my identity and still carry on working. Adams (2014) reassures on this point: "It may be from the position of vulnerability that we do our best work" (17). I cannot help but feel there are instances of such vulnerability in many of our professional lives. As in the example given of "Luke," we may only arrive at an understanding of our resonant responses because we have already known the place of suffering ourselves, and sometimes we have to dig deep into our own mud and filth to find it.

Although I was always open about the broad brushstrokes of my history, I clearly remember a time when, as a trainee, some aspects of my early experience felt unmentionable because I would surely be unfit to practice if they were known. The "un-askable" question on our training programs may be "How 'fucked up' can I get away with being?" Of course, trainee therapists need to be seen to be in good mental health, of course we need to be fit to practice, but how the line is drawn remains very unclear. Eventually, I felt unable to complete my training without telling a bit more of my story, because to qualify without being "known" would have felt fraudulent. It was a risky conversation, because from my perspective my future career hung on it. (I guess the answer I got is evident enough, or I would not be present here today! I am eternally grateful for that.) And I imagine that I am by no means alone in having had such concerns. In my experience, training often ignores the self-care of the therapist. There is rightly a focus on clinical resilience, but not on what I am calling "clinical vulnerability," which needs to be paired with it. Does clinical resilience exclude our histories of abuse and neglect and abandonment, or include and embrace them? Can clinical vulnerability be resourced and present?[1]

A Zen story gives a valuable perspective. Two acrobats were performing in the street, an old man and his granddaughter. Their act was for the grandfather to balance a pole on his head, up which the little girl would climb. He told her, "I'll watch out for you and you can watch out for me,"

1. There is, I believe, a psychotherapy training institute in Canada called Clearwater, which creates its programs around the life stories of its trainees. In doing so, they put recognition of relationality and cocreation as a foundational ethos and structure. I call that, too, radical respect. I have no idea how well it works, or how it fits into a more academically driven, competence-based culture, but the principle is interesting.

to which the girl replied, "No, Grandfather, I'll look out for myself, then you can look out for yourself, and then we'll both be all right." She was a wise little girl. The idea that, watching out for someone else in order to stay safe, is unbalanced and reflects a relational dynamic that often has its roots in trauma.

It is useful here to say a word here about self-care. In the popular discourse of these times, self-care gets rather glibly paired with vicarious trauma without sufficient critique. My take on self-care is as something that needs to go right to the heart of our relational ground and our vulnerabilities. The compassion and tenderness that we must bring to our own wounded places is not a quick fix or a luxury we cannot afford, but an *intrinsic intervention in the relational field*; it is about the therapist's capacity to look into the face of trauma. According to Halifax (2018, 134), respect for others is a reflection of the respect we have for ourselves, as well as for ethical principles. It can only be thus. According to Ronald Epstein (2017, 153), self-compassion is not an indulgence, but rather about restoring balance and making sure that we are not consumed by overidentifying with either emotional overwhelm or negative emotions. Importantly, Epstein claims that "*self-compassion is ultimately altruistic*" (emphasis added, 154). It is my contention that self-compassion, as a necessary dynamic therapeutic intervention, allows the possibility of integration of the dichotomies of alienation and identification. Patients need contact with the emotional core of therapists while they are in the throes of reliving their trauma (Perlman 1999, 27), and surely is it not best—ethical, indeed—that this core be a compassionate one?

Some eleven or twelve years ago, I undertook Sensorimotor trauma training, which changed the way I work and think. It was not only that I had a model for understanding trauma that was highly compatible with Gestalt theory and practice (Taylor 2013), but also that I found experiential learning about embodying resources to be transformative in my personal life and work. This gave rise later to my key chapter titled, "The Well-Resourced Therapist" (Taylor 2014). It is highly likely that my increasing access to a resourced state myself created a significant shift in my contribution to the dynamic relational field.

This is not a binary proposition of either vulnerability or invulnerability, as Lewis Aron (2016, 24) reminds us, but an indication that we need to ground our ethics in the experience of vulnerability. Here we have

a re-evaluation of Lévinas, in which attention is paid to the self of the therapist as part of the whole relational field. I apply the same principles to supervisees, trainees, and working therapists as I do to the people who come to me, by paying attention to the nuanced phenomenology of tolerance in the moment. This might translate into considering exactly how much vigilance, openness, distance, or closeness is appropriate in this here-and-now situation, and making choices accordingly. It is not defending ourselves that is the problem, but doing so uncritically, without awareness and "unchoicefully."

So why do I really do this work? I take to heart Lévinas' commandment. Yes, and for me, this ethic can at times feel burdensome. But the burden lessens whenever I embrace the ethic of self-care and self-compassion, and live my life accordingly. One of my most precious resources is my strong connection with the earth alluded to in my book (Taylor 2014), and expressed more explicitly in my workshops with Vienna Duff, called "The Well-Grounded Therapist" (Taylor and Duff 2018). The natural world has made a significant contribution in transforming some of my #MeToo moments. Following the 2014 Association for the Advancement of Gestalt Therapy conference at Asilomar, California, I traveled on to participate in a wilderness experience in the eastern Sierra. This was based on the Paiute peoples' practices of deep listening to the earth and the four directions of the compass. In their tradition, the east is understood to be the direction of the Trickster, associated with the crossing of boundaries into different states of awareness.

Two years ago, I made the decision to move to a region in the east of England known as the Fens. This is an area about thirty miles across; a liminal territory with indistinct boundaries between vast open skies and endless flat landscapes, where distances feel immeasurable and points of reference are fewer. It is a land of mists and water, as well as of generous fertility. There are strange stories about the Fens, of appearances and disappearances in the bog and the mists. I can have a sense of losing my edges here: open to expansive possibilities and, at the same time, uncertain, on edge, and disorientated. As this landscape reveals itself to me, it makes its home in me as I do in it, and I have a sense of coming home to somewhere I have always known. Because it holds up a mirror to different parts of me, this land grounds me; it makes the Trickster knowable and therefore less threatening. The landscape reflects back my

inner landscape. "Excluding any part of the larger landscape of our lives reduces the territory of our understanding" (Halifax 2018, 2), and therefore, I contend, our capacity to be present.

There are multiple other ways in which I embrace the vitality that the Trickster might try to deny. My choice—my ethic, if you will—is to live in order to sustain my work, and not the other way round. This is a radical departure, the Trickster tipping things on their head, thereby making more conscious processes that could not have be formulated previously. And yet, I can only be present to the face of trauma to the extent that I can tolerate it one moment at a time, incrementally widening my own window of tolerance, much as I hope to do with the people who come to me. I am resilient and present only as far as my vulnerability lets me be. And I start afresh with each new person who comes to me.

For Sharie Geller and Leslie Greenberg (2012, 9), presence is a reciprocal process which promotes a sense of personal well-being. But in addition to this, and importantly, I suggest, is the notion that our therapeutic presence becomes an invitation to our people to enter into a more present state within: "Client's presence can be activated by therapists' presence both by being deeply met by the therapist as well as by intersubjective sharing" (Geller and Greenberg 2012, 61). Presence becomes mutual when I include my own trauma and can stay in relationship to my peoples' trauma. And yet, being fully present to another's suffering can be a lot more challenging and perhaps emotionally draining than being half present or partially focused (Geller and Greenberg 2012, 153). Therefore, we must take to heart the imperative to take care of our own deepest and most vulnerable places: "The best yardstick for the enormity of the trauma lies in our own incapacity to bear witness to it; or in the level of dissociation that listening to it inflicts on the witness" (Sachs 2013, 25). The corollary here is that the best yardstick of healing trauma lies in our capacity to bear witness to it, and in the level of presence the witness can bring to the endeavor.

I suggest that in the therapist lies the first knowing of trauma, the recognition of the Trickster, when we are awake enough (Bromberg 2006), aware enough to know. Returning to my example of "Stephanie" above, waking up to her suffering was a risk I had to take in order to face her trauma with her. In that moment also was my recognition of several elements: an acceptance of my limits; that I cannot change her suffering or

the course of her life; and that she might meet me in return with gratitude, indifference, anguish, or anger.

I conclude with the words of Walt Whitman (2016 [1881]) in Section 33 of "Song of Myself": "I do not ask the wounded person how he feels, I become the wounded person."

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