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ORIGINAL PAPER

Trap of Conflicting Needs: Helping Professionals in the Wake of a Shared Traumatic Reality

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Abstract Many professionals working in the wake of communal disasters are doubly exposed to the disaster, both as professionals and as members of the stricken community. Yet most studies of widely reported distress of these professionals examine manifestations like compassion fatigue, secondary traumatization, and vicarious traumatization, which do not take this double exposure into account. Moreover, these measures reflect the assumption that their distress is rooted in empathy with their clients or helpees. This paper argues that at least some of their distress derives from a self-perceived lapse of empathy. It contends that professionals living and working in a disaster stricken community are caught in a trap of conflicting inner needs stemming from the defenses they mobilize to cope with the heightened mortality salience aroused by communal disasters. Furthermore, it proposes an etiology of their distress.

Keywords Double exposure · Shared trauma · Conflicting needs · Communal disaster · Mortality salience · Helping professionals

Introduction

It is by now widely recognized that helping professionals working in the wake of communal disasters that they themselves experienced often suffer considerable emotional distress. Such distress has been repeatedly documented after both natural (e.g., hurricane, earthquake) (Faust et al. 2008; Marmar et al. 1996; Matthews 2007) and manmade (war and terror) (Eidelson et al. 2003; Lev-Wiesel et al. 2009; Seeley 2003; Wee and Myers 2002) disasters, among both professionals who provide emergency services immediately following the disaster (e.g., Boscarino et al. 2004; Shamai and Ron 2009) and those who conduct ongoing psychotherapy before, during, and after it (e.g., Frawley-O'Dea 2003; Keinan-Kon 1998; Kogan 2004; Saakvitne 2002; Tosone 2006). Since September 11th, the distress of both sets of professionals has been described as rooted in the 'shared trauma' or 'shared traumatic reality' experienced by both helper and helpee and/or therapist and client (Kretsch et al. 1997; Saakvitne 2002).

The phenomenon, variously termed "shared reality," (Kretsch et al. 1997) "shared trauma," (Tosone 2006) or "shared traumatic reality," (Keinan-Kon 1998), refers to situations in which helper and helpee/therapist and client are exposed to the same communal disaster. These situations are characterized by two central components: 1. Both the helping professional and the person receiving the assistance or therapy belong to the stricken community. 2. The helping professional suffers double exposure: as an individual member of the stricken community and as a professional providing services or psychotherapy to persons adversely affected by the disaster. In recent years, it has been recognized that professionals working in a shared traumatic reality, in which they are doubly exposed to the disaster, may suffer from both primary and secondary trauma: the first stemming from their direct exposure to the disaster, the second from their work with traumatized or distressed clients (Saakvitne 2002; Tosone 2006). Nonetheless, there has been very little exploration of the implications of the double exposure.

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Need for an Additional Perspective

Most studies of professionals working in a shared traumatic reality examine emotional responses like compassion fatigue (Figley 1995; Tosone et al. 2010), secondary traumatization (Figley 1999), or vicarious traumatization (McCann and Pearlman 1990). These outcomes, by definition, refer only to the effects of professionals' work with clients or helpees, not to the effects of the double exposure characteristic of a shared traumatic reality. Both these concepts and the instruments used to measure them were initially developed to study psychotherapists and other professionals who hadn't experienced the same disaster as the person(s) they cared for, such as psychotherapists working with war veterans (Figley 1995, 1999), victims of sexual abuse (McCann and Pearlman 1990), or intimate partner violence (Pearlman and Saakvitne 1995).

Indeed, several scholars question the adequacy of these concepts for understanding professionals' responses in a shared traumatic reality. Tosone (2006) points out in the wake of September 11th: "While vicarious traumatization is a relevant explanatory concept, the constructivist self-development theory…cannot adequately convey the experience of psychotherapists who were directly impacted by the 9/11 tragedy" (p. 91). In similar vein, a group of New Orleans psychologists who provided emergency care right after Hurricane Katrina, declared: "…These concepts alone do not capture our experience, as we were all directly impacted by the storm, returned to provide professional services to other survivors, and continue to be adversely affected on an almost daily basis…" (Faust et al. 2008, p. 4). These doubts are reinforced by the weak findings of the studies of compassion fatigue, secondary traumatization, and vicarious traumatization among professionals in shared traumatic realities. On the whole, these studies found that most of the professionals examined suffered from low levels of the examined outcome and that only a few suffered from high levels (Boscarino et al. 2004; Lev-Wiesel et al. 2009; Shamai and Ron 2009; Wee and Myers 2002). Thus, while the findings are informative, they raise questions about whether all aspects of professionals' distress in a shared traumatic reality are adequately reflected by these outcomes. Indeed, writing of their own research on these outcomes among social workers exposed to the same terror attacks as those they helped, Shamai and Ron (2009) suggest that the quantitative part of their study "was limited by the somewhat standardized character of the questionnaire and instruments used" (p. 34).

Among the problems with these outcomes is that they reflect the assumption that the professionals' distress derives mainly from their empathy with their helpees or clients (Boscarino et al. 2004; Lev-Wiesel et al. 2009; Saakvitne 2002). But it is not at all certain that this is the case where the person concerned is doubly exposed to the disaster as both an individual living in the stricken community and a professional providing services to persons under the same life threat as he or she faces. This paper argues that at least some of the widespread distress reported by professionals working in the wake of communal disasters, whether terror, war, or natural disaster, derives not from their empathy, but from a self-perceived lapse of empathy—from moments of not being fully available to their clients and not fully empathic with them.

Accounts of Lapses of Empathy and their Effects

Empathy refers to the capacity to share other people's feelings, to feel their pain, joy, fear, and other emotions in oneself (Hein and Singer 2008; Hoffman 1997). With respect to therapy, it has been defined as a spontaneous, intrapsychic, and preconscious experience within the therapist which has both affective and cognitive components. It is a key means by which the therapist may come to know and comprehend what the patient might be experiencing consciously or unconsciously (Book 1988). A thorough review of the publications in English which cover the subject of professionals working in a shared traumatic reality reveals indications of self-perceived lapses of empathy among both emergency workers who provide services in the acute phase of the disaster (Faust et al. 2008; Somer et al. 2004) and psychotherapists engaged in long-term psychotherapeutic relationships that started before and continued during and after the disaster (Batten and Orsillo 2002; Keinan-Kon 1998; Kogan 2004; Miller-Florsheim 2002; Saakvitne 2002). To be sure, many professionals in both situations experience the conflict of attention to self versus attention to the client as temporary and normal for the situation. Most also probably soon bring their full attention back to their clients. In addition, there is a growing body of literature that points to vicarious resilience (Hernandez et al. 2007) and secondary post traumatic growth (Arnold et al. 2005; Lev-Wiesel et al. 2009) or professional growth (Baum and Ramon 2010) among professionals working with victims of disasters. With this, reports also suggest that their lapses in availability and empathy cause at least some professionals considerable distress.

Reports by professionals suggest that their lapses in availability and empathy cause them distress by impairing their self-esteem and fostering feelings of guilt, shame, and inadequacy. Among emergency workers, group interviews conducted by Somer et al. (2004) with hospital social workers in Israel during a period of frequent terror attacks reveal the workers' shame, discomfort, and self criticism for their self-perceived failure to empathize with their clients at certain moments. Faust et al. (2008), who worked

with victims of Hurricanes Katrina and Rita, noted their own failure of empathy: "The experience has, at times, made us less active or open as psychotherapists, distracted or unintentionally selective in listening to the stories of our patients" (p. 5).

Among ongoing psychotherapists, similar findings are reported in qualitative studies and clinical reports on working in the wake of the Twin Towers attack. Batten and Orsillo (2002) report feelings of guilt among psychotherapists who reported that they were less effective than usual, that they were more oriented to their own needs than to those of their clients, or that they were so tired of hearing about the attack that they may have subtly and unintentionally discouraged their clients from talking about it. Saakvitne (2002) reported that she and her colleagues felt guilt and shame at their inability to be attentive to and empathic with certain clients. Tosone (2006) reports feeling guilty that she could not concentrate on her clients' problems. Guilt feelings, along with reduced self-esteem, stemming from a self-perceived decline in professional functioning were similarly reported by Israeli psychoanalysts who worked during the First Gulf War (Keinan-Kon 1998; Kogan 2004; Miller-Florsheim 2002), when Israeli cities were struck by Iraqi Missiles.

Temporary lapses in empathy and attentiveness are actually not uncommon in professional intervention. They can have a large variety of causes, ranging from experiences in the professional's own life to reactions to clients' contents (e.g., Gerson 1996; Goldblatt and Buchbinder 2003). Most clinicians experience them from time to time, and they rarely arouse major distress. The remainder of the paper will try to explain why and how lapses in empathy and attentiveness, even if only temporary, may impair the self esteem of professionals working in a shared traumatic reality and cause them to feel guilty, ashamed, and uncomfortable with themselves. More specifically, the paper suggests that temporary failure of empathy causes such distress because it is anchored in a trap of conflicting inner needs in which professionals working in a shared traumatic reality are caught.

This conceptualization rests on insights from *Terror Management Theory* regarding persons' reactions to "mortality salience" and is supported by evidence from the literature on helping professionals working in a shared traumatic reality. Terror Management Theory is a social-psychology theory (e.g., Greenberg et al. 1986) first developed in the mid-1980s to help explain the defenses (explained below) used by individuals and groups to protect themselves psychologically from the anxiety—that is, the terror—aroused by awareness of mortality. Inspired by the writings of Ernest Becker (1971), the theory is based on the idea that persons usually push the reality of death out of consciousness, but that it is made more salient, and frightening, by the imminent threat or actual occurrence of death, whether through war, illness, accident, or other potentially fatal event. The theory is supported by extensive empirical research (Burke, Martens and Faucher 2010).

Working in a shared traumatic reality is one of the many experiences that can raise mortality salience and the attendant defenses. Since the literature on helping professionals working in such a reality has not thoroughly discussed the inner processes that lead to the distress these professionals report, this paper is confined to a description of the processes hypothesized by the author, and does not presume to present a systematic theory. It should also be stated in advance that this explanation of the professionals' distress by the trap of conflicting needs does not necessarily mean that professionals working in a shared traumatic reality do not experience compassion fatigue, secondary traumatization, or even some vicarious traumatization.

The Trap of Conflicting Needs

Conceptualization

The trap of conflicting needs stems from the heightened mortality salience that occurs in the wake of experiences or events that stimulate thoughts of death and augmented death anxiety. Communal disasters, whether natural or man made, evoke usually dormant feelings of vulnerability deriving from intense awareness of the reality of death. They make those who are exposed to them painfully aware of the fragility of their lives and of the lives of their loved ones (e.g., Keinan-Kon 1998; Kogan 2004; Marmar et al. 1996; Shamai 2005; Somer et al. 2004; Wee and Myers 2002).

The conflicting needs in which professionals who work in the wake of disasters in their community stem from the defenses that are mobilized in work in a shared traumatic reality. According to Terror Management Theory, persons mobilize two orders of defenses in a temporal sequence against the fear of mortality (Pyszczynski et al. 1999). The first order of defenses (*proximal defenses*) is activated immediately in response to the salience of mortality. They include defenses like denial, avoidance, distancing, self-distraction, and suppression (Arndt et al. 1997; Greenberg et al. 2000). In the literature on helping professionals, these defense mechanisms are referred to as Type 1 countertransference (Wilson et al. 1994). They are activated in an attempt to remove thoughts about mortality from consciousness.

The second order of defenses is mobilized when proximal defenses, having provided a measure of protection, are

relaxed and the individual experiences an increase in the accessibility of thoughts related to death. At that point, symbolic defenses (*distal defenses*) are mobilized to deal with the fear. Among the key symbolic defenses posited by TMT is the enhancement of one's self esteem, defined as a sense of personal value that is obtained by believing that one is living up to internalized standards that are part of one's world view or, to put it somewhat differently, that "one is an object of primary value in a world of meaningful action" (Becker 1971, p. 79). A very large number of empirical studies provide converging evidence that self-esteem buffers the anxiety stemming from our knowledge of the inevitability of death (for review see Pyszczynski et al. 2004). Findings show that high levels of self-esteem lead to lower self-reports of anxiety, psychological arousal, and defensive distortions to deny one's vulnerability to an early death. Reminders of the inevitability of death, lead to increased self esteem striving in the forms of increased adherence to the standards inherent in long-standing attitudes and increased discomfort when performing behaviors that violates cultural norms. Proximal defenses are used to manage conscious thoughts related to death, whereas distal defenses are used to manage the unconscious thoughts related to death (Greenberg et al. 2000).

Among persons in the helping professions, the needs implicit in these two orders of defenses—the need to distance and the need to augment one's self esteem—conflict. The self-esteem of persons in the helping professions, as in other professions, is closely linked to their ability to do their work well, in accord with the standards and values of the profession. For social workers, psychologists, and others who provide mental health assistance, the key values include being present for those they help: temporarily suspending their own needs so as to be available to their helpees or clients, and being empathic with them. It is precisely these abilities that are undermined, even if only temporarily, by the proximal defenses—distancing, denial, avoidance –that are mobilized to ward off thoughts of death.

As stated earlier, temporary failures of empathy are not uncommon among helping professionals. Under ordinary circumstances they may be a cause for self-reflection, but they are rarely a source of substantial distress. The psychoanalytic literature observes that the "empathic tension" stemming from these defenses usually reduces the practitioner's anxiety, especially when the defenses are used only for brief periods (Figley 1999; Wilson and Lindy 1994). But in a shared traumatic reality the defenses, and the ensuing withdrawal of empathy, are a source of distress, because they undermine the very self-esteem that the professionals need to continue to defend themselves from the heightened mortality salience. This trap underlies the feelings of guilt and shame, and the decline in the psychotherapists' professional self esteem in a shared traumatic reality.

The following pages propose an etiology of the process, supported by clinical testimony drawn from the literature. Although the suggested stages are chronologically ordered, it is not always clear where one ends and the next begins.

Etiology of the Distress of Helping Professionals in a Shared Traumatic Reality

First Stage: Heightened Mortality Salience, Heightened Anxiety, and Impaired Ability to Attend to Helpees and Clients

In the wake of a collective disaster, mortality salience is generally heightened among all or most members of the afflicted or threatened community (e.g., Green 1985; Raphael 1986). Among professionals living in the community and working in the wake of the disaster, this already heightened mortality salience is further augmented by their encounters with their helpees or clients. Among those providing emergency assistance, the mortality salience is augmented by their encounter with victims of the disaster and families of those victims. McCammon et al. (1988) reported that among the sources of stress experienced by emergency workers is that their work reminded them of their own mortality. Among psychotherapists, mortality salience may be exacerbated by contents concerning the disaster that arise in sessions with clients (Kogan 2004; Tosone 2006). In both the emergency phase and in psychotherapy, the encounters that further exacerbate their already heightened mortality salience augment the professionals' anxiety and impair their ability to attend to their helpees or clients.

For example, hospital social workers interviewed by Somer et al. (2004) during a period of recurrent terror attacks in Israel reported that they were not emotionally available to provide the victims and their families with the necessary assistance until they made sure that their loved ones had not been harmed.

> What I remember is everybody in hysteria. I was on the ward, and I felt my own panic… First, I had to look for my children, … then I ran to [my post at] the hospital information center. (p. 1083).

Shamai (2005) reported that social workers she interviewed who provided emergency assistance to terror victims and their families continued to think about their own families during their interventions. Thoughts such as "I hope my family and friends are all right", "this could happen to my own family" or "how is my family coping with the horrifying news?" were constantly on their minds. The participants also reported that despite their strong

commitment to the role of helper, they were unable to focus solely on their duties, as they did under ordinary circumstances. Nuttman-Shwartz and Dekel (2009) reported that student trainees who worked with adolescents in an area exposed to repeated Qassam rocket attacks became less involved in providing assistance to them and more anxious about their own safety after a student in the local college was killed by a rocket.

Keinan-Kon (1998), a psychotherapist who continued to work in her regular practice during the first Gulf War in Israel, described the intense anxiety she felt when her client talked about his fear of the Scuds that were launched at the center of the country, and how his reality based fears converged with her own and made it difficult for her to listen to him:

> …as Moshe spoke, I fell into a nebulous anxiety that quickly grew and flooded me… Moshe's fear penetrated me and gnawed at me, and not primarily as an outgrowth of projective identification… but rather because the reality-based aspects of his fear met my own apprehensions about the real threat to existence. …I thought about how the material from our shared traumatic reality distorted my ability to listen to him … (p. 427).

Second Stage: Mobilization of the Proximal Defenses and Further Impairment of Professional Functioning

The heightened death anxiety evoked in encounters with helpees and clients arouses in professionals an almost instinctive need to defend themselves by denying the threat or distancing and emotionally dissociating themselves from it.

Somer et al. (2004) quote a hospital social worker who provided emergency services after terror attacks telling: "The most meaningful thing I do after [an attack] is that I emotionally disconnect…This emotional dissociation helps me not break down in front of the traumatized families" (p. 1087). Although the quoted social worker found the defense helpful, the researchers report that several social workers revealed "how the protective advantage of this emotional disconnection had later distanced them from their clients. Their descriptions were replete with examples of how this defense had hindered their wish to be more emotionally available to the clients" (p. 1087). Lev-Wiesel et al. (2009) point out that even though a certain level of emotional detachment is necessary for coping in an adverse situation, "higher functional levels of dissociation (emotional detachment) may lead to higher levels of distress" (p. 1169). Along similar lines, social work students studied by Tosone et al. (2003) reported that following September 11th, in their efforts to avoid feeling re-traumatized, they were at times not present in sessions and had had become somewhat desensitized.

Kogan (2004), an Israeli psycho-analyst, reflects that her countertransference responses to a client in ongoing psychotherapy were aimed at warding off her own heightened fears of death and destruction during the Gulf War:

> … The turning point for me in the treatment of Jacob was when I realized that my countertransference feelings were not induced only by the typical patient's transference and actions toward me, they were also the result of my own defense mechanisms in confrontation with death and destruction. (p. 745).

She asks: "… Is it possible that for a while I was unable to contain my patient's fear because I was denying my own?" (p. 749).

For the most part, the above citations indicate that even as the proximal defenses mitigated the professionals' death anxiety, they also impaired their ability to be present for their clients and to contain their fears. Kogan, in fact, wonders whether doing so is even possible in situations of terror: "Are we able to contain and modify the fears of our patients while we find ourselves confronted with death and destruction?" (p. 749).

Third Stage: Quest for Professional Self-Esteem to Reduce Resurgent Death Anxiety

Following relaxation of the proximal defenses after they have attained their aim, thoughts about mortality once again emerge, and persons turn to symbolic defenses, among them augmenting their self-esteem so as to reduce their resurgent death anxiety. A number of studies carried out in Israel provide indications that social workers who served victims of the same terror attacks that threatened them sought to augment their self esteem through helping the victims, and that their fulfillment of the professional injunction to help others not only made them feel good, but also gave them an almost magical sense of safety. Shamai (2005) quotes a social worker who provided services in the immediate wake of terror attacks saying: "I … hold a superstitious belief that by helping terror victims I am protecting my family" (p. 208). Lev-Wiesel et al. (2009) found that having to act, being responsible for others, acknowledging their necessity for their clients, and their sense of being needed and relied upon contributed to hospital social workers' feelings of worthiness. Shamai and Ron (2009) observe that many social workers reported that their work with terror victims made them feel good about themselves and alleviated their fears:

> The ability to help others gave me a good feeling…there was also a good feeling of being there.

> I felt that I was fulfilling my professional role….The sense that I had contributed to them eased my own fears regarding the terror attack. (p. 47)

The psychoanalyst Kogan (2004) observes her need to cling to her identity as an analyst during the Gulf War—"I was trying to hold on to my identity as an analyst, … I clung to what made me feel safe" (p. 746). In similar vein, findings among social work students indicate that following terror attacks in Israel (Baum 2004), September 11th (Tosone et al. 2003), and Hurricane Katrina (Plummer et al. 2008) indicate that helping others through their work was an important source of meaning for them.

Fourth Stage: Guilt, Shame, and Self-Reproach

Even as augmented self esteem alleviates the death anxiety of professionals working in a shared traumatic reality, it cannot but be undermined by the feelings of guilt, shame, and self reproach that arise from their distancing and withdrawal of empathy. These negative feelings are noted both among professionals working with the terror victims and among those providing ongoing psychotherapy. Somer et al. (2004) report that the social workers who told that they enjoyed the "protective advantage" of their "emotional disconnection" were "embarrassed" to reveal this, and adds that "[t]heir descriptions were replete with examples of how this defense had hindered their wish to be more emotionally available to their clients" (p. 1087).

Batten and Orsillo (2002) report that psychotherapists working in the wake of September 11th told of feelings of guilt stemming from their withdrawal of empathy and reduced effectiveness:

> … some psychotherapists reported feeling guilty in session because they did not feel as effective as usual, while others reported that they were so tired of hearing about the situation that they might have subtly and unintentionally discouraged their clients from talking about the events to meet their own needs (p. 36).

Kogan (2004) reproaches herself for clinging rigidly to her identity as an analyst during the Gulf War:

> "What made me adhere so blindly to the ordinary rules of psychoanalysis during such frightening times? Was my fear of losing my analytic function so great that I lost sight of reality?" (p. 749).

She further tells how her withdrawal of empathy from her client as a result of her denial reduced her ability to help him and made her feel guilty:

> "In this case, denial of external reality made me, to a certain extent, un-empathic toward my patient's fears and restricted my ability to contain and modify them so that he would feel supported. This hindered the analytic work. … My feelings of omnipotence and guilt, which were greatly increased by the fact that I was experiencing external reality as a threat, made it difficult for me." (p. 750–751).

Summary and Conclusions

Recent years have seen an upsurge in the publication of clinical reports and both qualitative and quantitative research studies on the feelings and functioning of helping professionals working in a shared traumatic reality. Two theoretical papers have also been published. One distinguishes between emergency work, consisting of short-term, crisis focused intervention in the immediate aftermath of the disaster, and ongoing psychotherapy, which starts before the disaster and continues through it, (Baum 2010), in a shared traumatic reality. The other discusses the challenges faced by social workers in a shared traumatic reality (Dekel and Baum 2010).

None of these publications, however, has attempted to systematically analyze the inner processes that the professionals undergo. The above conceptualization represents such an attempt, based on indications scattered in publications written for other purposes. Other conceptualizations—for example, a conceptualization based on Hopper's (1991) theory of encapsulation, defined as a defense against annihilation anxiety by means of enclosing, encasing, and sealing off the sensations, affects and representations associated with it (Hopper 1991)– may well be possible. It is thus important to acknowledge at the onset that a good deal of work remains to be done to ground the proposed conceptualization. Systematic, empirical examination is recommended to test the conceptualization.

With this, the above account suggests that the source of much of the widely reported distress among professionals working in a shared traumatic reality is an intra-psychic conflict between two conflicting psychological needs: the need to distance themselves from their helpees or clients and their need to raise their self esteem. Both these needs are defenses against death anxiety or, in terms of Terror Management Theory, heightened mortality salience. They are of particular significance to helping professionals in a shared traumatic reality, whose death anxiety is doubly intensified by their personal experience of the communal disaster and their encounter with their clients or helpees.

The conflict arises from the fact that even as their distancing helps the professionals to cope with their own death anxiety, it reduces their ability to empathize with their helpees or clients. While it helps the professionals, it reduces their ability to be present for their helpees and

clients and to contain their fears and anxieties. Indeed, Bauwens and Tosone (2010) found that reported feeling both vulnerable and ill-equipped to deal with the gravity of September 11. However, much of the identity and self-esteem of helping professionals is anchored in their ability to be empathic, present, and containing towards those they help. Hence, the guilt, shame, and self-reproach that are reported. As the helping professionals meet their need for distancing, they are unable to meet their need for heightened self-esteem. And not only that: their behavior, so contrary to their ideal, actually impairs their self-esteem.

Neither the behaviors nor feelings that stem from the trap of conflicting needs in which professionals working in a shared traumatic reality are caught are exclusive to this trap. Distancing and reduced professional self-esteem are components of compassion fatigue and vicarious traumatization among professionals working with traumatized helpees or clients (Figley 1995; McCann andPearlman 1990). But the processes involved are quite different: in compassion fatigue and vicarious traumatization the distress derives from the professionals' empathy with their traumatized helpees or clients, from the very fact that they contain the clients' pain. In contrast, the distress described here is generated by the professionals' perceived failure of empathy, as they give priority to their own needs—even temporarily—and only afterwards make themselves available to address their clients' needs.

The intrapsychic conflict stemming from the trap of conflicting needs should not be confused with role conflict. Much of the literature on professionals working in a shared traumatic reality either states or implies that their distress in the wake of a communal disaster stem from the role conflict between their obligations as professionals and their needs as individual members of the stricken community (Green 1985; Loewenberg 1992; Raphael 1986; Rosser 2008; Saakvitne 2002; Shamai 2005). There is extensive documentation of the stress and distress that professionals experience as they are torn between the needs of their families and their concerns for their safety, on the one hand, as their responsibilities as professionals working in a crisis situation (e.g., Faust et al. 2008; Hobson et al. 2001; Matthews 2007; Shamai and Ron 2009). There is also extensive indication that they are able to attend to their professional responsibilities only after they have assured themselves of the safety and well being of their loved ones (Loewenberg 1992; Rosser 2008; Saakvitne 2002; Shamai 2005; Shamai and Ron 2009; Somer et al. 2004). However, role conflict entails conflicting external demands or responsibilities. In the trap of conflicting needs, the conflict is internal: between opposing inner needs.

A question that arises from the explanation for the distress of professionals working in a shared traumatic reality is how they can be helped to cope with the trap in which they are caught. The usual means for aiding professionals facing difficult situations, such as debriefing, supervision, and counseling, are important. They may not be enough, however, to enable professionals to cope with the consequences—namely the guilt, shame, and self reproach—of their behavior in the wake of the double exposure and augmented death anxiety they experience in communal disasters.

A supplementary approach might be to try to compensate for the impairment to the professionals' self esteem stemming from their withdrawal of empathy. This approach is based on Hobfoll's (1998) Conservation of Resources theory, which claims that loss of resources in one area can be compensated for by gaining resources in another area. In line with that theory, it might be appropriate to compensate professionals working in a shared traumatic reality for the loss of self-esteem by enhancing their sense of belonging as an alternative resource. According to Terror Management Theory, an enhanced sense of belonging may serve as another distal defense that buffers anxiety and mitigates death concerns (Arndt et al. 1999). Indeed, findings in the United States and Israel show that the social support enabled by connection with family members, affiliation with the agency or organization where one works, and/or being part of a community can alleviate the distress felt by professionals working in a shared traumatic reality and facilitate their movement between the personal and professional realms (e.g., Baum and Ramon 2010; Plummer et al. 2008; Saakvitne 2002; Shamai and Ron 2009). Beyond enabling support and its benefits, these connections and affiliations can enhance the professional's sense of belonging. The agencies where the professionals work can encourage these connections by providing opportunities for them to share their experiences with one another. Group debriefings, supervision, and counseling can be expanded to include not only the professional issues that the workers face in a shared traumatic reality, but also the feelings and experiences that arise from their double exposure as individuals living in the stricken community. Such sharing can be expected to augment the common bond and sense of belonging among workers facing the same personal and professional challenges.

Further research is called for on professionals' double exposure in a shared traumatic reality. Empirical research is needed to understand the emotional processes that they undergo, as well as to verify the processes hypothesized in this paper. Empirical research is also needed to identify factors that may affect professionals' ability to sustain empathy in a shared traumatic reality and factors that may amplify or alleviate their distress stemming from lapses in empathy. Factors to be studied might include attachment styles, tendencies towards auto-regulation or bi-regulation (that is, control of affect by the self or with the help of an

other), need for distance, and ability to self-soothe. Clinical research is recommended to consider the role of reverie (e.g. Ogden 1997), that is, the capacity to sense and be a receptor for what others feel (Bion 1962), in a shared traumatic reality and the uses that therapists can make of it to improve the therapeutic process.

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