

The Concept of Hope in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatization

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Abstract

Hope is intrinsic to the work of psychotherapy yet it remains implicit in much of what we do as psychotherapists. The concept of hope is discussed in this article in relation to the vicarious traumatization literature. I reflect upon an example from my practice with a description of the wider field of the community in which I work to illustrate an approach to balancing hope and despair. In situations of apparent 'no hope' illustrated in my practice with a middle aged woman and her family, I draw upon the underlying optimism and perseverance in Gestalt therapy as the key to staying present and in the moment with the client. The underlying optimism and courage of Gestalt theory, when operationalised, I conclude, is a vital component of clinician effectiveness and self care when working therapeutically. In particular, hope and an attitude of 'optimistic perseverance' are essential when working with clients who are living in situations of material deprivation, trauma and whose presentation raises complex, existential themes and dilemmas for the therapist.

Alfred the Great

'Honour and magnify this man of men

Who keeps a wife and seven children on 2 pounds 10

Paid weekly in an envelope

Yet he never has abandoned hope.'

(Smith, in Mac Gibbon, 1978, p24)

Introduction

Reading this poem again brought to my mind an important ingredient in my work with clients who live in under-resourced communities. Hope in the face of despair, deprivation and trauma. Last year I worked alongside the general medical practitioners at three suburban practices whose patients are amongst the lowest income earners in suburban New Zealand. My brief in this community was to establish and provide with a small team, a confidential and free mental health service that improved the access to service for residents who could not afford to use private services and yet did not fit the criteria for eligibility to the hospital psychiatric services.

As a high proportion of our clients were Maori and Pacific Islanders, but did not have ready access to culturally appropriate services, our 'Well-being' service comprised a kai-awhina, a registered nurse who works with traditional Maori healing methods, and a Pacific Peoples' counsellor, fluent in two Pacific Island languages and cultures who used narratives from Pacifica to heal. The practice employed two advocates: a kai-mahi for Maori and a matai from Western Samoa, who helped families experiencing financial hardship to obtain the housing and benefits they needed to live.

As two rival gangs have headquarters in the region, domestic and gang violence was an everyday reality. Hope and courage were essential qualities in our relationships as colleagues working alongside residents of this community. As a Team we were committed to engaging with one another and with our clients to 're-moralise' which according to Frank (2002) is possible through the quality of our relationships we have with one another. In this aim, we were drawing from Buber's (1970) notion of 'I-Thou' and what it means to be human which, for me, is the foundational idea in Gestalt theory and practice. Buber's idea of being with the other in solidarity within which moments of being in connection arise spontaneously, creates the context within which the process of healing and 're-moralisation' (Frank, 2002) can begin. In this article, I draw material from my work with clients who bring to me their hope and despair about their life circumstances and I describe how I balance their hope and despair now that Gestalt theory is informing my practice. On the surface, the concepts of hope and despair appear polarised or paradoxical. However, in working with them in complex situations, they

become a gestalt. I will draw from the literature on vicarious traumatisation (Pearlman & Saakvitne, 1995) and compassion fatigue (Figley, 1995) to suggest that Gestalt psychotherapy contains the tools to staying well in engaging with materially deprived and traumatised clients. In particular, I 61 Hope in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatisation

will refer to the work of various Gestalt therapists and theories that have inspired my optimism in Gestalt theory as a guide to my practice in this setting. I will suggest that aspects of Gestalt therapy can be used fruitfully to ameliorate vicarious traumatisation.

I use the term 'Gestalt theory' to refer to the core concepts underlying my practice. These concepts such as field theory (Parlett & Lee, 2005), the paradoxical theory of change (Beisser, 1970), the dialogical relationship (Hycner & Jacobs, 1995) and embodied practice (Kepner, 2003) to my way of thinking are all part of the same gestalt as they are grounded in practice and they inform theory in their operation. Therefore, for me they are two parts of the whole. In this way, I conceptualise Gestalt theory as both informing and enhancing practice with learning from my practice impacting upon and influencing what I do in an action-reflection process. I see the bridge between Gestalt theory and practice as being Buber's (1970) conceptualisation of 'I-Thou' as it is through the quality of relating and of the process of being in relationship from which all Gestalt theory and therapy originates.

Background

In the first two months of commencing work in this community, my personal belongings were stolen from the workplace and I witnessed a violent assault between a group of youths outside the rooms which provoked me to make an emergency call to the police. From this time, trust and safety issues became a day-to-day reality. I began to lock my possessions away everyday in my filing cabinet as was the suggestion from the police. I was aware of feeling traumatised by the lack of security and control I was experiencing in my work environment.

This recent experience triggered a similar traumatic experience from my first social work position. When I graduated from university during the mid 1980s, my first experience of social work was within a community mental health clinic. At this time, there was a burgeoning awareness of the psychological impact and legacy of childhood abuse, reflected in the growing number of people referred to the agency to deal with past traumatic experiences. Whilst the presenting issue was usually stress, depression or anxiety, the current distress very often stemmed from some form of traumatic event in the past. I felt ill-prepared for a caseload that was largely comprised of adults who were disclosing childhood abuse histories. Early in my career, as I began empathetically engaging with clients in the process of disclosure of past traumatic events, I began to Gestalt Journal of Australia and New Zealand 62 notice a transformation in my own thinking and being. I wondered if this was evidence of some denied memory or fragment of trauma from my own personal history, though I could not recall any such incident from my own childhood. I now realise that I was suffering from vicarious traumatisation.

The exposure to client narratives had heightened my sense of vulnerability and fear of loss of control in the world. I joined a women's self defence course in response to these shifts in thinking and feeling, however, I found that this only served to increase my feelings of physical vulnerability. In retrospect I was over-identifying with client narratives. I was travelling a parallel path to the traumatised clients to whom I had been listening. I was so confluent with clients that I failed to maintain awareness of my own process whilst empathetically engaging with the client. To cope with the weight of traumatic disclosure, I was alternately merging with and distancing myself from the angst in the field created between us. As Zinker (1977) and many of the authors of the vicarious traumatisation literature (Fox & Cooper, 1998; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Pearlman et al, 1996) point out, this is a dangerous over-identification as it robs the therapist of her own space in which to process material brought to her from clients.

Disruptions to the self and identity of the therapist: linkages to the literature on 'Vicarious Traumatisation'

Pearlman and Saakvitne's (1995) concept of 'vicarious traumatisation' seemed to be the most directly relevant to my experiences in the workplace. This concept refers to the process of self

transformation that occurs when the helper witnesses and engages empathetically with traumatic disclosures from clients. This theoretical 'lens' provided a useful conceptual framework to begin exploring the diverse experiences I was witnessing in my day-to-day work. Those existential aspects of the helper's self that are impacted upon by vicarious traumatisation include one's identity or the inner experience of self in the world, one's world view, spirituality or meaning, beliefs and relationships, safety and trust (Ibid).

The literature on compassion fatigue (Figley, 1995) and vicarious traumatisation (Pearlman & MacIlan, 1995; Pearlman & Saakvitne, 1995; Pearlman et al, 1996; Fox & Cooper, 1998) suggest the way to remain well and functional in working with trauma is through maintaining self care strategies and awareness of self. Fox and Cooper (1998) use vicarious traumatisation as a framework to investigate the effects of client suicide on social workers working as therapists in private practice. They suggest ways to remain well in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatisation

in which social workers deal with overwhelming case scenarios in reference to the literature on vicarious traumatisation and burnout (Fox & Cooper, 1998). Drawing on two extended case vignettes, Fox and Cooper believe that the support of colleagues is pivotal in enabling psychotherapists to cope with suicidal clients. They recommend that those working with suicidal clients form group practices for education, support and sharing. These formal and informal networks assist in ensuring accountability and quality assurance and a working through of often painful feelings that arise for the worker (Fox & Cooper, 1998).

I believe that in Gestalt psychotherapy, the support of colleagues assists the therapist to maintain a sense of connection to self and others and so remain 'contactful' (Clarkson, 2004; Joyce & Sills, 2001). Furthermore, it is participation in a professional community that enables therapists to connect to and embody their practice as a way of being (Kepner, 2003). My experience is that connectedness enables me to both engage empathetically with the client's trauma, to recognise the parallel process of dissociation I sometimes experience in relation to traumatised clients and to recover from the 'contagion of dissociation' (Herman, 1992) and thus to be more present with the client.

Therapist self care

An important theme in the literature on vicarious traumatisation is the need to ameliorate the effect on the psychotherapist of work with clients as survivors of trauma and deprivation (Figley 1995; Folette et al, 1994; Herman, 1992; Grosch & Olsen, 1994; McCann & Pearlman, 1990; McCarrroll, et al, 1995; Martin, et al, 1986; Pearlman & MacIlan, 1995; Pearlman & Saakvitne, 1995; Pearlman, 1997; Saakvitne et al, 1996). Coping strategies that were mentioned most frequently as increasing resiliency include: education related to abuse, supervision, consultation, 'optimistic perseverance, avoidance and wishful thinking', seeking social support and inner peace; and humour (Mederios & Prochaska, 1988). Training and supervision as ways of normalising psychotherapists' responses to the nature of the work, and enhancing the existing coping strategies of psychotherapists, have been suggested (Figley, 1995; Folette et al, 1994; Grosch & Olsen, 1994; Herman, 1992; Pearlman & Saakvitne, 1995; Saakvitne et al, 1996).

The literature on therapist resiliency and self care assisted me to understand what I was witnessing in engaging empathetically in client narratives of deprivation, abuse and depression and the impact of these Gestalt Journal of Australia and New Zealand 64 narratives on me. Disconnection with oneself, with one's family and friends and colleagues produces a sense of disjuncture which is the hallmark of vicarious traumatisation (Pearlman & Saakvitne, 1995; Saakvitne et al, 1996). I had noted this theme in researching the experience of sexual abuse therapists and their significant others in the New Zealand context (Pack, 2004). After experiencing periods of such disjuncture, I now valued and proactively used my own clinical supervision, personal therapy, social networks and sense of humour to increase my resilience to vicarious traumatisation.

A story of practice

The case that has inspired this article is one of the most hopeful and the most vicariously traumatising in my twenty year history as a social worker and mental health professional. The client, Elizabeth Jones (pseudonym) was referred to the Well-being service by her general

practitioner with a diagnosis of clinical depression. Thirty nine year old Elizabeth, daughter of Bob, married and a mother of two children, had been supporting her parents throughout the long struggle of her father's depression. The Jones family had been referred earlier by the local crisis psychiatric team as their father, Bob, had been hospitalised during a suicide attempt that had nearly ended his life. This was Bob's sixth attempt at suicide. Elizabeth had resuscitated her father whilst waiting for ambulance assistance on one occasion.

On this occasion, the overdose of anti-depressants had left her father on life support systems. The family had asked the medical staff to turn the life support systems off as their understanding was that there was damage to the brain stem and the extent of his recovery was unknown. The family wished for his suffering to be over as they had witnessed his desire to end his own life since his unemployment in the late 1980s following an accident that left him in chronic pain with a back injury. Whilst surviving on welfare payments for many years, he was assessed as fit to return to work but could not find work and became chronically depressed and suicidal from that point onwards.

What I experienced as traumatising in this situation was that the family wanted the life support systems switched off and had lost all hope of recovery through what I assessed as compassion fatigue or vicarious traumatisation. I found it difficult to support their decision due to strong beliefs I hold about the preciousness of life and because his prognosis was still unclear to the medical professionals. Thus, I was still holding out some hope in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatisation hope of recovery for Bob and the family. Whilst Elizabeth's presenting issue was clinical depression, I was also aware of taking a field theoretical position, or systemic position, in understanding my client in the context of her wider family issues.

The clinical specialists would not agree to switch off life support due to medico-legal ethical dilemmas so would not agree to the family's wishes. Elizabeth and her mother were planning to give up their employment to care full time for their father/husband. This impending loss of employment and the prospect of full-time care giving for Elizabeth and her mother seemed to add to and to compound the family's anguish which I found painful (though understandable) to observe.

My responses to working with Elizabeth

In my individual sessions with Elizabeth, I began having physical responses in her presence. I wondered if there was something too awful for her to express. I experienced this response as a tightness in my solar plexus area that resulted in a kind of 'dread-filled' feeling when I sat with Elizabeth, noticing her smiling, dissociated face talking about her father's progress (or lack of progress) over the week. I hypothesised that she was suffering from post traumatic stress disorder that limited her range of affect to her frozen, smiling, demeanour, that greeted me on a weekly basis. Also informing my practice was my experience in relation to the client. I experienced anxiety, anger and powerlessness that I further hypothesised may have been denied or repressed by Elizabeth. Becoming acquainted with Jacobs' (2007) conceptual framework for understanding the psychological sequelae of trauma as being the event and the disruptions to subjective experience - 'TSM (Traumatic States of Mind or Traumatic States of Being)' resonated with what I was experiencing with Elizabeth. The hall marks of 'Traumatic States of Being', (Jacobs, 2007) such as the loss of complexity of emotion, the past being contemporaneously experienced in the present with client being triggered into organising her world around survival, were themes in my contact with Elizabeth. The predominant feelings I experienced in relation to the client were dread and despair, mirroring the intensity of her anguish of living with a shattered world that had compounded over many years.

At this point, Elizabeth brought me a gift of chocolates to thank me, which added to my guilt at secretly wishing her father would recover. I believe I had supported her position, (to turn the life support systems off) and I imagine she felt supported. This may have been because I had Gestalt Journal of Australia and New Zealand 66

bracketed my responses to the life versus death decision that the family were facing. I found it difficult to support the decision of Elizabeth and her family as I felt that their decision was giving up on Bob. Giving up is not an option in my world view until death intervenes and connection (at least in this realm of existence) is then only possible amongst the living and the

memory of the person who has died. At the same time my sense was that Elizabeth was more optimistic about the future and I felt that I was helping her through the crisis by listening empathetically to her narrative and supporting her decision to switch the life support systems off. I experienced my own rejection of the family's wishes and my guilt about having a different view and desired outcome. I knew that if I offered hope that this was important to the family, so I did not challenge their idealisation of me as 'the helper' but privately I felt like a fraud.

I believed, as Clarkson (2004, p117) does, that it is an 'error' to 'hand back to clients' their idealised view of the therapist too early in therapy, in case it deprives them of hope. My sense was that I needed to have the courage to tolerate the ambiguity and complexity of the situation and what might happen to allow the family to define the way forward in their discussions with the medical professionals. I felt that I needed to acknowledge Beisser's (1970) paradoxical theory of change; that within each individual there is a uniquely individual theory of change awaiting discovery. I felt that I needed to explore with Elizabeth what her theory of change was by attending to her in the present moment.

'Optimistic perseverance': Applications of Gestalt theory

Gestalt theory was helpful in untangling this paradox of hope and despair in my practice with the family, and in understanding transference and countertransference phenomena. Kepner (1987 & 2003a) discusses countertransference responses or the co-created field between the therapist and the trauma survivor as affecting the body of the therapist. Clients are frequently triggered into traumatised states by current events within the therapeutic relationship which often mirror themes from the past. It is not uncommon for the therapist to take these repressed or denied feelings to supervision to be understood and worked through due to their having a symbolic representation in the field of the therapeutic relationship (Kepner, 1987).

To understand my reactions to the client, I referred to the bodily signs that had become familiar to me over the weeks to 'track' my process with Elizabeth with my clinical supervisor. I became aware that my sense of hope in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatization

dread became more tolerable as I built enough rapport with Elizabeth to be able to lean toward the meaning she was making from the tragic events surrounding her father's life. This approach enabled me to 'optimistically persevere' (Mederios & Procaska, 1988) to support Elizabeth, out of which more insights came. I reflected to her that living under the constant reality of seeing her father suffer with his depression might inspire a fear that she might follow a similar path. Articulating this unspoken fear for the client opened the floodgates to grieving for a loss of her hope for herself, in the face of her own depression linked to her father's recent suicide attempt.

This was the 'creative process' Zinker (1977) refers to in his suggestion of staying with client's uncertainty until there is a creative insight and a time to offer this to the client. I wondered how she had lived with such a high level of despair for most of her adult life and I reflected upon the heroicism of her struggle. Zinker suggests that 'a sense of wonderment' enables therapists to experience the special or unique qualities of their clients. He proposes that 'by staying with the situation, no matter how difficult, many factors emerge'. The skill of the 'creative' therapist is to 'track' these themes 'to maintain a sense of thematic direction', and to avoid becoming overwhelmed by the client's despair (Zinker, 1977 p47). In my view, the skill is to have confidence in the relational process and my part within it so that I know that through my own self awareness that there is a regulatory process in place that protects us both. It is through self awareness that I can know also when I am becoming overwhelmed by despair triggered by my empathetic engagement in the client's story of tragedy and to recover from it more quickly to be more available to her.

As I continued to persevere optimistically, I was able to track the source of the client's own traumatization. In the course of sessions, Elizabeth disclosed that she and her siblings had been sexually abused by a close family member over many years. Her father had confronted the alleged perpetrator but this disclosure was met with denial. Her process of dissociation was a way of protecting herself both from this denial and from the flashbacks of abuse over many years. As Kepner (1987, p20) suggests: '*when the truth of violation is denied the*

solution is to detach from her body and its reality'. Her four years of therapy had been of some assistance in healing from the aftermath of childhood sexual abuse, but the damage from her experiences was ever-present and to a large extent, expressed non-verbally. The co-created field of our experience picked up on these memory traces which I noticed as principally bodily responses. Through her anger at her father's recovery, she began to access some of her body awareness. For the first time, she confronted her father's clinicians about the lack of Gestalt Journal of Australia and New Zealand 68 preparation and follow up services for his discharge from hospital. She appeared animated and more alive.

I reflected to her the enlivening process that proceeded as she took charge to co-ordinate her father's care at home. The depression she had been experiencing lifted as she moved into a more powerful and active mode of self expression. I witnessed and reflected to her what I noticed about her process - that, through the vehicle of anger, she appeared to be liberating herself from depression. My dread-filled responses dissipated. I theorised that the vicarious traumatisation I had been experiencing diminished as increasing hope balanced the earlier despair.

Conclusion

For me this case is an example of the 'creative process' (Zinker, 1977) possible in Gestalt therapy whilst simultaneously illustrating the path through vicarious traumatisation. By staying with the client's process, the present and what is, however grim, I was able to hold on to my own sense of hope. In an 'I-thou' moment in relationship with Elizabeth, I had an insight of a paradox or polarity in my practice: that when I am working with despair and tragedy that hope is also present in the field. Balancing my own hope and despair and the client's hope and despair, enabled me to stay more present with her. Elizabeth was able to use this space created between us to access more of her own feelings to interact with her environment and so to ask to have her needs met.

I also learned that the more I am aware of the need of some clients to organise their lives around trauma and survival, the more I am able to understand their process. When Elizabeth's coping façade was lowered due to fatigue in the care giving role, I could more easily see how her original trauma (childhood abuse) compounded with subsequent traumatic events (her father's accident, injury, unemployment and depression), alongside the triggering of accommodation strategies to the original traumatic event. In my attempts to navigate the complexity of engaging empathetically with the client's process following years of traumatisation, I was aware of a connection with an unspoken and intense mixture of feelings which translate most accurately as despair.

For me, the feelings evoked were accompanied by a physical sense of dread. Paradoxically, when I was able to recover from my own discomfort with the feelings evoked in my experience in this empathetic engagement, the more easily that I was able to tolerate ambiguity and to hold onto the uncertainty of travelling this path with compassion. I believe the willingness to be in solidarity with the client to undertake a search for meaning to attach to their experience is the part that truly heals. The client's awareness of my solidarity with her in this mutual search for meaning supports the possibility that another version of events reality exists even if it is only a glimmer in the distance.

To my way of thinking, my practice with Elizabeth is an example of paradox and of the paradoxical theory of change (Beisser, 1970) in action. The process of holding hope and despair, my own and that brought to me by Elizabeth, formed a complete gestalt. Maintaining an awareness of my own process and untangling the apparent paradox of hope and despair freed me from over-identifying with the client to risk travelling again the path of vicarious traumatisation. This path, once feared, is now well known, well-trod, and successfully traversed.

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