

**“BACK FROM THE EDGE OF THE WORLD”:
RE-AUTHORING A STORY OF PRACTICE
WITH STRESS AND TRAUMA
USING GESTALT THEORIES
AND NARRATIVE APPROACHES**

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The aim of this article is to offer an ongoing reflection of the difficulties of working with trauma survivors within mental health agencies which provide brief models of intervention. The dilemma of how to work safely, respectfully, and collaboratively with clients who present with a history of trauma is highlighted. The author reflects on her own experience of vicarious traumatization through her practice with a long-term survivor of domestic abuse. The team and organizational narratives which are embedded in the medical and managerial models in the mental health services are reflected upon as constraining the environment in which the author is able to provide a context for the client's healing and collegial practice. By witnessing the abuse survivor's story of survival drawing upon themes in the "New Trauma Therapy," Gestalt and Narrative therapy practice frameworks, the author suggests that other versions of the "story" are made available for the client and for the worker that offer a greater sense of "personal agency." These "re-authored" narratives offer a way forward for the client, individual worker, and team.

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INTRODUCTION

Paradoxically, trauma is ameliorated when the re-telling of a story is located within broad philosophic frameworks in which the whole person is attended to. Experience, both one's own and vicariously lived through listening to client accounts, needs to be located in perspectives that give meaning to experience. This article explores, through my practice in a specific case of domestic violence, how I managed to evolve meaning to continue to cope with traumatic disclosures within the constraints of an agency. In my experience, this process was akin to a journey to the edge of the world. This example charts my return from the edge. This re-telling of the story of my practice is put forward in the hope that others may benefit from these reflections. Articulating themes from practice provides another level of understanding. Out of such defining moments of practice new and reformulated frameworks for practice emerge.

In this case a synthesis is made connecting Gestalt theories based in holism and phenomenological methods, and narrative to describe the wider "field" (Parlett in Woldt & Toman, 2005) with narrative theory. This reflection explores how we can become enmeshed in "dominant discourses" which are endorsed by powerful groups in society, that disrupt our sense of "personal agency" (White, 1995; White & Epston, 1990). Narrative therapy is defined by White and Epston as a process by which therapists "work collaboratively with people in identifying those ways of speaking about their lives that contribute to a sense of personal agency, and that contribute to the experience of being an authority on one's life" (White, 1995, p. 121). For White and Epston therapy's aim is to assist people to recover lost narratives and wisdom that have been marginalized and debased by "professional knowledges."

BACKGROUND

An example from my own practice demonstrates a defining moment in my emerging professional identity as a psychotherapist. This article is based on my memory of pieces of work that were undertaken in my practice as a team leader of a mental health service I had established, while I was also training as a Gestalt psychotherapy intern. This is a composite constructed out of a number of cases rather than one case. It contains themes and story lines that relate to "vicarious traumatization" (Pearlman & Saakvitne, 1995), "compassion fatigue" (Figley, 1995), and what ameliorates them. These concepts refer to the process of self transformation that occurs when the helper witnesses and engages empathetically with traumatic disclosures from clients. I also considered that it might demonstrate my praxis journey through my engaging in a critical-reflective process of a piece of my own work, in a way that is suggested in the writings of Gestalt psychotherapists (Yalom, 1989; Zinker, 1977).

Looking back, I realized I had developed a quality of relationship with the client, Freda (not her real name), that went beyond my “official” role as a mental health professional. Care in maintaining contact, trust, and respect meant that I needed to go beyond the confines of “the clinic,” and notions of what is customary practice within the psychiatric or medical model. This way of working enabled Freda to trust me with more of her personal narrative, as time went on. However, my colleagues saw her presentations to the service where I was working over the course of a year as constituting “a problem.” I wished to “externalize the problem” (White, 1995) through the opportunity of retelling the story of my therapeutic relationship to Freda, and in that re-telling, to re-author it. Returning to “unfinished business” (Joyce & Sills, 2001) in attempt to make a complete gestalt was another motivation to document this ongoing reflection.

I chose to focus on my practice in relation to one client who is a composite of many with whom I have worked, to avoid any breach of anonymity and confidentiality. A minimum of detail is included to tell this account of my practice. My working relationship with Freda, and many other women clients in similar circumstances, illustrates the differing viewpoints and multiple, shifting realities that constitute accounts of practice. I refer to these accounts as “stories” of practice because they reflect my reality of the events.

THEMES FROM WORKING WITH SURVIVORS OF ABUSE

As a result of repeating the development of the therapeutic relationship with each new client, psychotherapists draw upon an eclectic mix of theories to inform their practice. Given the transgressions of physical and emotional boundaries that have occurred for many clients, the central dilemma is: “how can I supply what the client needs without replicating what has happened before?” Second, if the client’s presentation is indicative of relationships in which power is or has been misused in the past, and the client has been denied his or her own subjectivity, the question becomes: “how can I assist in the retrieval of the client’s own voice?” Working for many years with sexual abuse survivors, I found that my initial training as a social worker provided few constructive answers to these dilemmas. Gestalt therapy with its emphasis on phenomenology, existentialism and holism, I discovered was more useful than the psychoanalytic tradition from which social work (my original training) and psychiatry (the site of my work) drew. However, how to approach a new way of being with clients that separated me from my original training was difficult. I felt a little like Coffey (1998, p. 163) who concludes that: “therapists who toss aside all psychotherapeutic tradition may also unwittingly and perilously toss aside its protections, forcing themselves to blaze unnecessarily chancy paths through precarious jungles.”

There is an element of risk and of trail blazing through such “jungles” that set

me on the path of finding other ways of working with clients to ensure that their well-being and my own health was maintained in the process. The New Trauma Therapy epitomized in the work of Courtois (1988, 1997), Herman (1992), Briere (1996), Coffey (1998), and Dalenberg (2000) offered some initial ideas. Within such theories there is an emphasis on the therapist's own awareness of self and relationship to self and other that are the keys to maintaining connections with clients who have been traumatized. The "blank screen" of Freudian psychoanalysis is replaced by a conceptualization of therapy as a collaborative endeavor in which the therapist is a witness who stands in solidarity with the client. Narrative and language are important in the healing journey of both the client and the therapist. With these themes in mind, I begin the story of Freda and our therapeutic relationship.

MY ACCOUNT OF FREDA'S STORY

The local Women's Refuge referred Freda to the community mental health services where I was working as a psychiatric social worker. The refuge worker, who provided Freda with transport to our initial session, said that she had not been sleeping or eating well and the workers were worried about her state of mind since her arrival there. The local Women's Refuge had provided emergency accommodation for Freda and her five children in the weeks immediately following a life-threatening assault by her husband after which he was arrested, convicted, and imprisoned. Freda is a first generation New Zealander whose parents had migrated to this country from China in search of a better life.

After the initial interview, I wrote and presented a bio-psychosocial assessment for presentation to the multidisciplinary Team. The purpose of the assessment and the case presentation was to formulate a plan of action. The Team agreed with my formulation that Freda seemed to be experiencing symptoms of clinical depression since the attack, and an appointment time was offered for her to see the consultant psychiatrist. The consultant psychiatrist confirmed the signs of depression I had noted in my assessment, prescribed medication, and then referred Freda back to me for "short-term counselling." The expectation from the Team was that I support Freda for six weekly sessions to assist her to recover from the immediate crisis. The Team thought that, in time, Freda would benefit from relaxation training to assist with her general level of anxiety stemming from posttraumatic stress disorder. The assessment and treatment plan was implemented and Freda responded in a way that led to her discharge from our service.

However, she returned after the contracted six sessions. Freda did not fit the existing profiles of psychiatric services' client groups, who either had diagnosed long-term mental illnesses, and so justified longer term care who were referred to as "chronics," or were those needing shorter term/acute services who were referred to as "the worried well." Brief models of intervention did not fit Freda's needs.

The dilemma was that she appeared to have “recovered” from the immediate crisis, was linked to community resources and, therefore, was no longer expected to need contact with mental health services.

She periodically returned to our community-based mental health center once she had achieved some stability. This relative calm in her life that she cultivated in the weeks following her engagement with our service enabled her to remember further traumatic events that she had endured. Freda began to look at these themes in her family of origin in a number of ways. She joined a longer-term psychotherapy group and a community-based women’s group that I had established in conjunction with the coordinator of a local women’s center. Looking back, these were attempts at contact and relationship when circumstances triggered a fixed gestalt from the past history of victimization within her marriage and family. My dilemma was that the Team expected me to be the “quick fix” change agent which conflicted with my understanding of the healing process for trauma survivors from a Gestalt perspective (Kepner, 1987, 2003a, 2003b; Mackewn, 1997), Narrative therapy (White & Epston, 1990), White (1995), and earlier learning from the “New Trauma Therapists” (Briere, 1996; Herman, 1992). My understanding was that listening to and engaging empathetically with the client and her narrative provides a space for “re-authoring” to proceed.

With this in mind, I return to my memories of my first meeting with Freda.

REFLECTIONS ON OUR FIRST MEETING AND EARLIER CONTACT

At the first meeting I found Freda’s presentation confusing. I found working with Freda overwhelming in the first contact, due to the weight of unexpressed, conflicting, and contradictory emotions of which I was aware. I related these feelings, mistakenly in retrospect, to the latest attempt on her life. I realized, as our work together progressed, that the extent of the traumatization and her need for a different experience of relating were the probable reasons for her wish to re-present to our service.

My relationship with Freda over the time in which I knew her inspired many feelings, including revulsion at the way she had been treated, the anxiety that surrounded her day-to-day life, righteous anger toward her perpetrators, and guilt/relief that I had been spared such horrors. I experienced the terror that went unexpressed by Freda and, at times, felt fearful that I, too, was at risk of violence by virtue of being a woman living in relationships and institutions based on patriarchal power dynamics.

Freda’s survival became a source of wonderment to me, which I reflected to her. In the early months of our contact she discounted her resourcefulness. Eventually her desire was to take her driving test as a way of contributing to her growing independence.

MAJOR THEMES IN THE NARRATIVE OF MY PRACTICE

The metaphor of Freda wishing to be in the driver's seat of her own life became an enduring symbol of her growing independence, with the result that she took her driver's licence and purchased her own car. From this time onward, I used the metaphor of Freda being in the driver's seat of her life. This goal created a context or "experiential field" that made more available the process that I was interested in supporting (Kepner, 2003a). Her success at passing her driver's test foreshadowed her release from a marriage in which she had a "spoilt identity" (White, 1995) attributed to her. White uses the term "spoilt identity" to refer to the limited definitions of ourselves which we come to live by, through a process of internalization of what others call us. By the term: "spoilt identity," I refer to the tendency for Freda to make herself invisible as a means of coping with the domestic violence she had endured.

Through the use of metaphor, Freda created a vision of her future that differed from the images of her that were promoted by her interaction within her family of origin and with her own children. Our "re-authoring" involved inventing other versions of Freda and her story. Her car remained a potent symbol of her newfound sense of self that had been rendered invisible over 20 years of marriage. We drew upon the achievement of passing her driver's licence, to challenge the versions of her story that were based in lack and in deficit. In retrospect, the celebration and declaration of these new versions of her story, in line with White and Epston's (1990) work around performance and ritual in the presence of wider audiences, could have assisted in this "re-authoring."

The public display of her car to the Team may have provided such a context in which her success was witnessed and celebrated by trusted others, albeit by her professional caseworkers. Experimentation with ceremony, ritual might have strengthened Freda's re-authoring of her narrative, as she had the paperwork to accompany her right to be in the driver's seat, via the attainment of her driver's licence. However, her personal narrative did not provide the scope at the time for acknowledging let alone celebrating such achievements.

REFLECTIONS ON MY WORK WITH FREDA

We looked at earlier events within Freda's family of origin as mirroring the events within her marriage. Freda was successful at changing her history by climbing back into the driver's seat of her life, despite invitations to remain firmly in the passenger's seat. My work with Freda involved listening to her stories, expressing wonderment at her endurance and persistence, working with her key desires and the metaphors they evoked. The stories Freda told to me supplied the "sparkling facts" and "news of difference" that seemed to spur her into upward cycles of success begetting success (White, 1995; White & Epston, 1990).

White and Epston use the terms “sparkling facts” and “news of difference” in the sense of being examples of exceptions to the predominant narrative that bring people to therapy. These narratives are often enmeshed with problems that relegate the client to an identity that is related to, or synonymous with “the problem.” To assist the person enmeshed in pathologizing discourses to gain space from being the problem, White and Epston encourage their clients to contemplate and recall the instances that fall outside the predominant discourse. They sometimes personify the problem that is threatening to take hold and give the problem a personal identity.

It was appropriate in my working with Freda to focus on the “tellings and retellings” of her story as it brought into our awareness the possibility of working from other versions of the predominant story with which Freda had become identified and enmeshed.

THEORETICAL UNDERPINNINGS OF MY WORK WITH FREDA

Such practice generates a process in which the client can recall and use skills and personal resources that have been obscured by the predominant narratives. From a Gestalt perspective, the therapeutic relationship is the “vehicle” of healing. As Kepner (2003a) suggests:

It is not our personality theory, nor our empty chairs or our creative techniques . . . the core of what is healing in the Gestalt approach is our contextual, relational and experiential conditions that make for growth. It is the creation of a person/environmental field as the interactive whole in which growth may take place, just as it is the conditions of the field which create the “mental health” problems which the client is bringing to us. (p. 8)

Sometimes it seemed important that I was simply there as a physical presence, to witness Freda experiment with her rediscovered abilities. Once Freda became familiar with her newfound talents, it became easier for her to access and use these abilities in her everyday life. Other trauma theorists have termed this process as “witnessing” (Dalenberg, 2000; Herman, 1992). I became the person who was the witness in the background until the process of integration of this knowledge of herself had been internalized. The importance of believing in Freda’s talents and capabilities was the most foundational, guiding principle in my practice and continues to be so. From a Gestalt perspective, if I lose the ability to see the resourcefulness that my clients bring along with the defined “problem,” I lack the frame of reference for forming a relationship in which the client can begin to have a different experience.

This work, given the history and transgressions of boundaries of the past, is of necessity carefully paced, evolving in slow, small incremental steps. Becoming

acquainted with Jacobs's (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 Freda. The hallmarks of "Traumatic States of Being" (Jacobs, 2007), such as the loss of complexity of emotion, the past being contemporaneously experienced in the present with the client being triggered into organizing her world around survival, were themes in my contact with her.

PATHOLOGIZING DISCOURSE IN MENTAL HEALTH

My experiences with Freda and other women, whom the team found complex, difficult, and hard to reach, provided the impetus to find other options besides those offered within the confines of psychiatric services. In so doing, I became aware of the stigmatizing influence of being a client within an institutional/psychiatric setting. The problem was that I had engaged with a client who kept representing which in itself constituted a "problem" to the wider clinic. Such clients were often traumatized and so required longer-term care that was not at that point in time recognized within the wider mental health service. I wanted to provide an alternative pathway for clients who were in the process of healing from traumatic events, from a career as a "psychiatric patient." Due to Freda's numerous representations at the outpatient clinic, the Team I worked with suggested to me that I present my work with Freda at our monthly problem case conference.

THE "PROBLEM" CASE CONFERENCE

The focus of the therapeutic endeavor within the wider multidisciplinary team of psychiatric services in which I worked, assumed many forms. The hospital service offers individual psychological interventions, family therapy, nursing, psychiatric assessment and review; the provision of practical rehabilitation such as occupational therapy; the coordination of inpatient/community/day program facilities; and social work. Reintegration into community life is the primary goal or outcome of contact, following hospitalization or treatment.

The provision of practical services such as advocacy to obtain income maintenance and housing is central to the multidisciplinary team's perceptions of the social worker's and so my role within the mental health service. As a qualified, experienced, and registered social worker within the services that are primarily responsible for diagnosing and "treating" clients, I was aware that I was also working as part of a system that, at times, seemed to be preventing clients from healing, despite my well-intentioned efforts to the contrary.

My role primarily consisted of assessing and "treating" clients. "Treating" meant two to six sessions of individual or group sessions following initial assessment

and the formulation of a treatment plan, by the Team. This plan was a standard format detailing the presenting issue to the history and social circumstances of the client. The plan ended with a “formulation” or summary that consisted of what the worker had surmised to be the key issues to be addressed. A range of services were then suggested, often in combination, with the intention of addressing the needs identified. What the plan lacked was a clear statement of what the client wanted, the absence of which led to the team unintentionally excluding the client from the development of the plan.

Such well-meaning efforts often involved the consumers of our service becoming what we referred to as “chronics,” who came and left the service in a revolving door fashion. This group of longer-term clients was expected to spend varying amounts of time in contact within our services, so their presence did not constitute a “problem” in the same way as Freda did. The clinic, or the context in which we worked defined, therefore, who or what was “problematic.” Due to the challenges of such clients as Freda, the Team implemented a monthly “problem” case conference which all psychiatric staff in the greater area could attend, to deal with cases that were defined by the team as “difficult.”

Much to my dismay, Freda had become known as a “chronic” within psychiatric services. I felt blamed for failing to both reduce her re-presentations and demands on our service and for creating what the Team implied was a dependence on me that could be thwarting her independence. Freda had refused to see any other staff member when she referred back to our service on a number of occasions. Over the year in which I knew Freda, she did, however, work with many different staff in a variety of roles, but would only see them after first seeing me. I became the first “port of call” when she referred. As such, I was the one who then introduced different staff and team recommendations for Freda’s consideration.

POSSIBLE EXPLANATIONS FOR FREDA’S RETURN

In retrospect, I could surmise the reasons for Freda’s so called “dependency” on me as her caseworker. From a client-centered perspective, my personal qualities, which could have been perceived by Freda as being consistency, dependability, and trustworthiness, might have compensated for the disruption caused by trauma that she had experienced over many years. Freudian psychoanalysts might have concluded that I was a “transitional person or object” while Freda reconstituted her life. The new trauma therapists (Briere, 1996; Herman, 1992) might have thought my approach in going at Freda’s pace and dealing with practical skill building before memory work, might have been deemed useful to Freda.

From a managerial viewpoint, I represented the whole of the multidisciplinary team in my person, and therefore, the means of accessing a range of people and services and providing continuity of care. As Opie (2000, p. 5) suggests, as a

representative of the multidisciplinary team, I provided “the actual and conceptual point of intersection at which the multiple fragmented representations of the client’s body are reassembled.” Narrative therapists might surmise that Freda was able to access alternative narratives in our sessions and thus, re-author her personal story. As these new versions of her personal narrative became known to Freda and therefore accessible to her, I became the audience of one that witnessed Freda’s performance of these alternative stories. My being witness to Freda’s recounting and working from these alternative narratives might have led to the recovery of her stories and an enhanced sense of “personal agency” (White & Epston, 1990, p. 17).

From a Gestalt perspective, I could be seen as co-creating and holding a “field” (Kepner, 2003a; Parlett & Lee, in Woldt & Toman, 2005) in which Freda was rediscovering her lost aspirations and dreams for the future. In this salvaging of her lost narratives through carefully attending to and supporting her process, her own resilience could have been recovered, the knowledge of which could then be integrated into her day-to-day life.

“RE-AUTHORING” FREDA’S AND MY NARRATIVES: REWRITING THE WAY AHEAD

Freda and I both became immersed in pathologizing discourses (Hart, 1995; White, 1995). The Team minimized Freda’s achievements and she found herself labelled as a “patient” within psychiatric services. Increasingly I began to be aware and uncomfortable about the structure in which I worked, that seemed neither to appreciate the needs of traumatized clients such as Freda, nor the professional expertise that psychotherapy offers. What was a normal response to abnormal events in the case of domestic violence over many years became ensnared in psychiatric labels and discourse that added further injury to insult.

However, based on my Gestalt training and personal awareness, I knew that to connect and generate a field for supporting Freda’s process into creating new ways of being was one of the pathways to assisting her healing from trauma. Ironically, our service’s failure to appreciate the needs of clients such as Freda seems to have been part of the reason why she and others regularly re-referred and became a “problem” to our services. Unfortunately, I had experienced many clients who were recovering from trauma over my 20-year career in mental health who became labelled as “depressed” which led on to a career in mental health services, often lasting some years.

REFLECTIONS ON TEAM DISCOURSES

I reflected on the various discourses that had developed among my peers within the case conference. Through this kind of negative feedback, I began to doubt the

skills and abilities I had developed as a fledgling Gestalt therapist. I began to think I did not have a theoretical rationale for practice. Now, I recognize that the discourses I had been involved in while working in mental health had separated me from the basis of my practice, leaving me feeling disempowered and alienated from the theoretical grounding which had previously sustained and guided my work.

Part of the paradox was that not only was Freda typecast as a “bad” or “disobedient” client in child-like terms, but as the worker attached to her care, I was similarly stigmatized for creating and maintaining the “problem.” The creation of pathologizing discourses surrounding me created a professional millstone around my neck from which I felt I could not escape until I left the service. Such conditions were conducive to creating a climate in which vicarious traumatization was very much a fact of my life and a daily reality. This experience inspired in me the need to find creative modes of liberation by looking at the wider “field” including the Team and the organizational context.

VICARIOUS TRAUMATIZATION: A TEAM PERSPECTIVE

In further contemplating the case study, I wondered if the interaction described among the multidisciplinary team reflected their collective and individual experiences of vicarious traumatization epitomized in a parallel process to the client’s process. I considered the persistent search for additional services to “fix” the problem that Freda represented. This was a discourse of vicarious traumatization in two senses. The first of these sources of vicarious traumatization is the wider organizational context in which the managerial “time is money” ethos, contrasted with the altruistic discourses of the Team as an entity and as individual members. Both as individuals and as a Team, it was not possible to provide the continuation of resources to support Freda’s healing in her own time. Rather goals, tasks, and a desire to fix and discharge seemed to reflect the enmeshment and conflict among the team, individual, and organizational discourses.

Opie (2000) argues for clarity in the face of wider organizational narratives where teams in similar situations and contexts are seen to constitute “discourses of survival” and “of failure.” Teams and individuals may take on other related discourses that are “heroic,” “oppositional,” or if based in feelings of powerlessness, may defer to “discourses of defeat.” According to Opie the existence of multiple discourses grounded in multiple perspectives provides points of reference for teams and individuals to make meaning from their diverse experiences on the job. Opie recommends attending to the discourses at the individual, team, and organizational levels in order to move out of the impasses caused by enmeshment in the more negatively framed discourses.

With the benefit of hindsight and the luxury of knowing what I know now, I return to reconsider my practice in relation to Team discourses.

RE-AUTHORING MY PRACTICE

In retrospect, I could surmise that one possible reason for the Team's impatience with Freda and the need to problematize her stemmed from the wider discourses of the hospital system and field at that time. As part of the wider psychiatric service, we were increasingly under pressure as individuals and as a Team to collect statistics on client turnover, length of time of clients being in the system, and itemizing the use of our time on the job. The increasing managerialism that viewed public health as a commodity like any other in the business world might have conflicted with the altruistic ideals of individuals and teams working within mental health. The previous emphasis on client satisfaction was increasingly supplanted by efficiency, defined in terms of client turnover within specified timeframes.

The vicarious traumatization that might have coalesced around the agendas of the wider organization of which we were all a part—to move clients swiftly through—produced “discourses of failure” when our statistics were compared across other units within the hospital (Opie, 2000). “Chronics” such as Freda, came and left our service in a revolving door fashion which was identified as problematic to the definition of an “exit” to the service. Instead of remaining unspoken, these issues could have been collectively and openly discussed as informing our patterns of impatience with Freda. This would have changed our focus to what was happening within our agency rather than labelling the client with what was essentially our problem rather than hers.

“RE-AUTHORING” THE TEAM NARRATIVE: THE WAY AHEAD FOR CLINICIANS

If I had been able to bring awareness to the group the process of what was occurring within the multidisciplinary team, I could have reflected my own involvement in the discourse of failure that was not all my own making, although I felt like I was that discourse, at the time. Collectively, we could have discussed ways of responding to the gap between how we worked, both individually and as a Team alongside the wider organizational imperatives of economic retrenchment within the health services. We could have analysed the power differentials of the discourses we were espousing. The “problem case conference” might then have been reformulated as narratives of individual survival and success despite various obstacles.

Stories of client resilience and worker or Team creativity might have been discussed as engaging us in new discourses, some of which might have assumed a distinctly heroic appeal. We might then have been a Team that invested time in exploring the wider organizational “field” conditions that includes the environment of mental health workers, the clients, the team and the organization. The

creation of a range of narratives within this “field” of experience might have enabled our teams and individuals to author a range of narratives within the wider organization.

Having the space to choose one’s own narrative among multiple discourses would have been a powerful mediator to the vicarious traumatization that I and no doubt others experienced individually and collectively within the team and wider organization at that time. The increased sense of “personal agency” (White and Epston, 1990) among the workers would then have been more likely to have flow on effects to the quality of interaction with clients and co-workers in the workplace, in an upward rather than downward spiral.

CONCLUSION: AN AWARENESS OF “DISSONANCE”

Paradoxically, discussing this sense of disjuncture in working within a therapeutic relationship which lacks a fit between the service and the client’s needs connects with the potential for exposure, shame, and vicarious traumatization for the worker. In working with trauma, this dissociation can be a “field” condition of working with sexual abuse and other traumatic disclosures in terms of the potential for vicarious traumatization and burnout that are routinely experienced on the job (Grosch & Olsen, 1994; Pearlman & MacIan, 1995; Pearlman et al., 1996). Shame and a parallel process is produced between the client and worker as “victim” of a system that purports to care yet in its operation fails to promote the conditions for healing. It is best described as an experience of disconnectedness or dissonance.

Thus, dissonance occurs on two levels simultaneously: the discomfort of knowing that the work is outside the “known” in the case of working with traumatic disclosures, coupled with working within a system that requires working in a way that challenges the need for a dialogic or collaborative relationship with clients.

In writing this reflection, I discovered creative ways of traversing the path “back from the edge of the world.” Gestalt and Narrative therapy are informing my practice now with trauma survivors. I am aware of the concepts of hope and despair in this reflection as being an apparent paradox or polarity on the surface. However, in working with traumatized clients in complex situations, they become a gestalt (Pack, 2007). Freda’s depression could have been re-authored as demoralization requiring re-moralization (Frank, 2002). My “dependence” inducing practice could have been re-authored as functional dependability leading to engagement toward a safe container for healing from injustice and abuse.

In this way I am re-authoring my own personal narrative in ways that encompass the personal and professional growth I experience through my work with trauma survivors. The journey “back from the edge” was a defining moment in my development as a psychotherapist and remains a work in progress.

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