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A phenomenological exploration of the impact of a traumatic incident (death of a child) on Social Services Staff

Abstract

The research article is a phenomenological exploration of the effects of a traumatic event (death of a child) on Social Services personnel, the meaning they constructed from it, and the their perception of what was missing in terms of support. Implications for social services and for Gestalt therapy and practice are critically discussed.

Key Words

death, trauma, vicarious traumatisation, Gestalt psychotherapy, support, shame.

The research topic

I am a gestalt psychotherapist running a counselling service for staff who work for a Local Authority Social Services Department. I researched a traumatic event at work; the death of a three-year-old child placed for adoption, who died of a sodium overdose and whose adoptive parents were subsequently charged with his murder. I explored the impact of the event on Social Services staff and its implications in terms of gestalt psychotherapy theory and practice.

Choice of topic and research aims

Three factors governed my choice of topic:

1. I have a long-standing personal interest in trauma. My own life has been shaped by trauma in ways that I did not recognise for many years. My family is of Eastern European Jewish origin. The Holocaust was seldom mentioned directly in my post war childhood, yet, as an invisible force, it influenced my early years profoundly. I had a vested interest in how people survived trauma that was entirely outside my awareness.

2. I wanted my research findings to be useful both to myself and hopefully other practitioners. Social Services staff often present for counselling as a result of a traumatic incident e.g. the death of a service user, being assaulted at work. Such incidents can affect a team or several teams; the death of this child being one such incident, with many staff clearly devastated. Previously I had provided staff support in a number of different ways, in conjunction with colleagues. However, I was uncertain how helpful our interventions were as they had never been evaluated. The identification of best practice in responding to traumatised staff would yield practical benefits.

3. Gestalt psychotherapy theory says that what is missing from the field may be as important as that which is present. The absence of a gestalt theory of trauma constituted for me a lack of professional way marker. Counselling and psychotherapy theory seemed to me changeable, unclear or contradictory in terms of what traumatised individuals would find most helpful.

I was interested to explore phenomenologically, and thus in a gestalt compatible way the effect of a traumatic event on Social Services staff and elucidate with them the meaning they constructed from it. I wanted to reflect from a gestalt psychotherapy perspective what was helpful for individuals and what was missing from the field by way of support for them. I also wanted to consider implications for gestalt psychotherapy theory and practice; and finally to see what might come into awareness that might be helpful to the organisation.

Choice of Methodology

A phenomenological study describes the meaning or the lived experience for several individuals about a concept or phenomenon. I felt this was the approach best suited to my research. Phenomenology is one of the underpinning concepts of gestalt. (Yontev, 1993). Gestalt, as a phenomenological approach, has as its main goal the heightening of awareness. Each individual gestalt session might be likened to a mini research session in which an individual's awareness is raised. (Barber, 2002, p78.) A gestalt approach sees the researcher as simultaneously being part of the field of study. I intended to use my responses as researcher as part of a heuristic enquiry. (Moustakas, 1990). I

noticed my questions evolving during the research process as I refined my focus. This seemed to me healthy and in keeping with the tradition of phenomenological research.

Gathering data

I was aware that I could not undertake the research without organisational agreement. The Personnel Manager encouraged me to write a research outline for the Child Care Management Team. They agreed this, judging that the research could be beneficial.

I hoped to interview a minimum of six staff from the three main teams affected by the incident; the social work team, the adoption team and the family centre. The main criterion was that staff should have been closely involved with or directly impacted by the incident. I hoped for a good mixture of staff in terms of gender, ethnicity, age etc, but this was not figural in selecting co-researchers.

I made initial contact with co-researchers by writing to them. Several staff were understandably defensive and declined involvement. I located six willing participants, from four different work bases, four female, two male. Five were white European / UK, one was Caribbean. They formed an excellent cross section of the organisation from an unqualified worker to a senior manager.

I undertook a series of semi structured hour-long interviews with respondents. I met with them at a venue of their choosing and tape-recorded each interview. In order not to bias the research all co - researchers were asked the same set of initial questions. I tried to bracket any preconceptions I might have. Following each interview I immediately transcribed the tapes myself as a way of immersing myself in the material and reflecting on the content. Participants were offered an opportunity to debrief after the interview, and a majority chose to. I kept a diary of my own responses throughout the process as a form of heuristic research, and found this to be of immense therapeutic value.

My research felt it had joint ownership; some co-researchers had as much interest in the outcome as myself. This is unusual; usually co-researchers would be anonymous and probably more indifferent to research outcomes.

After I had transcribed the interviews, participants were sent a copy of the transcript to comment on and make any amendments.

Co-researchers were informed that I would produce a separate report for Social Services outlining key findings and any proposals for the future organisation of psychological support following major incidents. Several participants commented that they appreciated this.

Defining Trauma and Post - Traumatic Stress

Recent years have witnessed a rapidly expanding literature exploring the phenomenon of trauma. The American Psychiatric Association first recognised Post -Traumatic Stress Disorder (PTSD) as a psychiatric condition in 1980 (American Psychiatric Association, 1980).

DSM defines the nature and degree of trauma; the individual must have experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone.
I.e. a serious threat to life or well - being (American Psychiatric Association, 1980). Such incidents probably occur more frequently than many imagine and include sudden death, assault or road traffic accidents (Joseph, Williams & Yule, 1997).

DSM1V defines three main clusters of symptoms:- (American Psychiatric Association, 1994):

1. Re-experiencing the event e.g. in terms of flashbacks or nightmares

2. Avoidance or numbing responses

3. Symptoms of increased arousal

A Gestalt Psychotherapy Perspective

"Completion and integration are achieved when life before the trauma, the traumatic event itself, its meaning, the responses to it and life after are perceived as parts of a meaningful continuum, rather than as fragmented, disconnected segments." (Alon & Levine Bar -Yoseph, 1994, p452)

Gestalt psychotherapy, rooted in existential philosophy and gestalt psychology, has always acknowledged our need to self-actualise. Making meaning of our experience, and our lives is central to this search. (Perls, 1947/1969/1992). From a gestalt psychotherapy perspective we can understand the effects of trauma as "unfinished business." (Korb, 1984.)

A traumatic event is so frightening that it may paralyse an individual with anxiety. The trauma may be a "one off" event or something that occurs over a longer period of time. The individual seeks to complete processing the material emotionally,

cognitively and physically, but finds closure impossible to achieve. Unfinished situations from the past can drain us of energy and stop us living life to the full in the present, leading to the formation of fixed gestalten (Perls, Hefferline and Goodman,1951/1990; Zinker,1978; Polster & Polster,1974).

Melnick & Nevis (1997) are the only writers who present a gestalt theoretical model on the effects of trauma. They suggest that in diagnostic terms PTSD is most likely to occur at the end of the gestalt cycle of experience, (Clarkson, 1989) that is, in the demobilisation phase that incorporates both the resolution / closure and withdrawal phases of the cycle. Their model consists of four sub–stages to demobilisation; turning away, assimilation, encountering the void and acknowledgement.

Several writers lament the absence of gestalt perspectives in the current debates about post-traumatic stress and exhort others to engage more fully and critically with the issue (Fodor, 2001; Cohen, 2003; Avery, 1999). Cohen argues the case for gestalt being the treatment of choice for working with trauma, naming both phenomenology and I -Thou dialogues as effective therapeutic components; both approaches are integral to gestaltpsychotherapy.

There are a number of case studies in the literature demonstrating the efficacy of gestalt therapy in achieving completion of unfinished business following trauma. Accounts include empty chair dialogues in particular, but also role - play, dream work and guided fantasy. (Serok, 1985, Sluckin, 1989). Gestalt approaches including bodywork appear key to successful treatment (Kepner, 1987; Clarkson, 1989).

Acute Psychological Interventions Following Trauma

A significant segment of the current literature focuses on the usefulness of early psychological intervention following trauma and whether it can prevent the onset of PTSD.

Debate centres on the helpfulness of debriefing, (Dyregrov, 1989) also known as Critical Incident Stress Debriefing (Mitchell, 1983). Debriefing can occur in an individual or group setting within 24 – 48 hours of the trauma, and all the models share the same intrinsic characteristics.

Whilst debriefing is not counselling, the method is an acute intervention, designed to minimise psychological distress following trauma and the boundaries between the two are not always clear. Some have claimed that debriefing prevents the development of chronic post-traumatic stress disorder.

Rick & Briner, (2000) argue that debriefing meets many needs: the needs for survivors to articulate what has happened, understand it and thereby regain control; the symbolic needs of workers and management to aid those who suffer and display concern; the needs of those not directly involved to master vicariously the traumatic encounter. Critics claim that there is no firm evidence to prove debriefing is beneficial (Raphael et al., 1995; Rose, 2000; Rick & Briner, 2000).

Bauer and Toman (2003) explore debriefing from a gestalt psychotherapy perspective. The authors note that a number of useful parallels can be drawn between the gestalt cycle of awareness and debriefing, claiming the process helps those who have experienced a major trauma to move through the cycle at points where they might be stuck, by bringing issues into awareness. However, they do not acknowledge the risk of re- traumatization if the client confronts prematurely material that they are not yet ready to process.

Fodor (2001) argues a contrasting view from a gestalt perspective, questioning the usefulness of crisis intervention and mandatory debriefing. She feels individuals have an overwhelming need to talk and make sense of their dislocation following traumatic events, but that this is best done by talking within their own community to friends, family or their therapist if they are already in therapy.

One of the most interesting questions for me remains why there is such scant literature on trauma from a gestalt psychotherapy perspective. With regard to acute interventions following trauma, the present picture is a complicated and controversial one. A majority of individuals will recover from trauma with or without the help of debriefing or therapy, but the question still remains: what is most useful to individuals in the short term - a key question for my research to address.

Identifying themes that emerged

The interviews generated a huge amount of data, which was hard to summarise in a way that does co-researchers' experiences justice. I organised the findings into clusters.

The scale and impact of the event; a major disruption to the field

The impact, scale and uniqueness of the event were paramount. Co – researchers frequently

used words such as “disaster” “shell shocked” and “catastrophe” to describe their experience. The death of a child placed for adoption was an extraordinary occurrence unheard of among co-researchers despite their lengthy experience of social work. “It was like a trap door had opened and you was falling through, it was such a shock.”

Feelings of anger, self doubt and anxiety

Anger was deeply felt by the majority of co-researchers. Anger was expressed towards the birth parents for not trying harder to rehabilitate C back into family life when they were given numerous opportunities. There was anger toward the adoptive parents who were under suspicion of murder.

Co-researchers all displayed self-doubt and a lack of confidence in their personal responses and professional judgements as a result of the trauma. Workers who had been extremely confident in their professional judgement previously, were now hyper-vigilant and fearful to make decisions. They lacked trust in their own assessments and their ability to do quite mundane tasks such as record information accurately. "I think people here were literally frightened and were saying well how can we do our job then? How can we place children? How can we assess anybody? "

Whilst there was no hint of a blame culture in the organisation, concerns were expressed on a personal level about being judged and being found lacking. Feelings of powerlessness, helplessness, exposure, self-blame and paranoia were also reported. “You were thinking well I’m the manager in charge of this service when they do investigate and if things are untowards then it’s my head that’s on the block”. Anxiety was widespread about facing a court case, the need to give evidence and what the outcome would be.

Physical Symptoms

There was a marked absence of physical symptoms. When mentioned reference was usually as some form of desensitisation (blocking) or retroflection (holding back). Some staff deliberately chose to block out their feelings. "I sort of myself, personally, emotionally, I had to block it out.....I just blocked it out and I thought, I dealt with it that way." Others described the immediate aftermath of C's death as "surreal" and "being on auto pilot."

Co-researchers also coped by deflecting. One described how they removed all the photographs of C on display in the Family Centre after the funeral. "I suppose really we was trying to forget him in a way. It's a bad thing to say really but myself I felt if you couldn't see him perhaps you could deal with it better."

Four co-researchers referred to wanting to cry because of their feelings of sadness, but holding back because of their professional role. A number of introjects (Clarkson, 1989) were verbalised that emotions were not allowed within organisational life, or they would get in the way of the professional task. One co-researcher described feeling constricted, as if she was wearing a tight girdle, and fearing she would explode. Another said “You can’t be this wooden person who sits there and doesn’t react, but neither can you…. What you really want to do is say “Oh shit” and you can’t do that.”

Another cluster that emerged from the research was that of wanting justice for C, a feeling that he was owed that.

Personal Factors

Some personal factors were seen as having strengthened coping abilities: previous experience of the death of a friend's child; length of experience as a social worker, and having undertaken training in trauma.

Impeding factors included over identification from being a parent. Both of the male co-researchers commented how hard it was to allow themselves to experience their feelings and cry. These findings seem to support the views expressed by Hossack & Johnson (2002), who argue that because of the way they are socialised men are less likely to seek and utilise support networks to reduce the impact of trauma. Two co-researchers were “acting up” in management positions, and the need to “get things right” was extremely acute for them.

Meanings constructed f rom the event

The early gestalt psychologists (Wertheimer, 1944; Koffka, 1935; Kohler, 1947/ 1970) taught of the human need to strive for completion, to make a whole even where one does not exist. Organising our experience in order to make meaning from it is a fundamental concept of gestalt psychotherapy.

Figural for me in conducting the research was my own need to make meaning of my research topic. Three times during interviews I noted individuals wanting to go into filing cabinets and pull out files to confirm with me the exact date something had occurred. Whilst I indicated this was not necessary, I understood this as evidence of a continuing and urgent need to make sense of their experience, to tell their story in the greatest detail

and locate it within a time frame that would make a coherent narrative from which meaning could be derived. This supports the writings of a number of theorists about the need in trauma to make a meaning that can be integrated (Creamer, 1995; Levine Bar-Yoseph & Witzum, 1992; Melnick and Nevis, 1997).

Meanings co-researchers constructed were entirely individualistic, dependent on their own personal history, personality processes and what was figural for them. They included: the huge loss of C's physical presence and his future potential; going to the mortuary to say goodbye to C; a feeling of having failed; and a feeling Family Centre workers, many of whom are unqualified, were overlooked and not treated with the same importance as other qualified staff. One joint meaning that emerged was the dedication staff displayed to being professional, getting on with their job, and doing their best no matter what was asked of them.

Support

In terms of self support, quiet reflection was useful, as was positive thinking and counting your own blessings, a belief time would heal and maintaining a sense of perspective. Going to the gym helped dissipate negative thoughts for one person. Two co-researchers consoled themselves with thoughts that C had gone to a better life or was now at peace.

Environmental support was provided by friends and family and colleagues. Peer support was judged the most valuable. There was an overwhelming sense of being in un-chartered territory, but that talking and offloading were beneficial, as was hanging on to a sense of humour however desperate you felt.

Organisational Support

The Director visited two of the affected teams in person and also offered the opportunity for individual debriefing. Only one individual took up on her offer, but there was a consensus of staff really appreciating the visits and offer, which appeared to take on a symbolic meaning of being cared for.

Managers clearly felt a responsibility to support staff by encouraging them to talk and to grieve, take time out when they needed to, and to share their memories of C as part of the healing process. Staff valued their managers keeping them informed and also offering both emotional and practical support. e.g. accompanying them in person to do something particularly difficult such as visiting the mortuary. Staff who went to the funeral found this helpful as a symbolic way of saying goodbye to C.

All co - researchers mentioned spontaneously the availability of counselling from the Staff Care Service. Two of them used the facility to attend group counselling, which they found very helpful. The two main benefits were perceived to be; it enabled the sharing of feelings so staff were aware of each others experience; and it validated their responses, helping them to understand normal responses to trauma.

Three managers raised with their teams the option that individual counselling was available. No one took this up immediately. Two co-researchers commented that they would have attended counselling if they had felt the need.

What was Missing from the Field

Overwhelmingly, staff felt everything possible had been done to support them. Two main clusters of caveats were apparent. Family Centre workers felt they had been overlooked as the Director did not visit them. Some staff felt they lacked information they needed to make sense of what had happened. "And we still don't know the reason why he died. And we also heard he had about 5 post - mortems and we were wondering well why?"

Discussion and Implications for Practice

Symptoms of trauma

All of the symptoms experienced by co-researchers fitted within the three main clusters of symptoms defined by DSM (1994), which were described earlier. Some were experienced to a greater degree than others.

A point emerged that I found interesting. The DSM definition of PTSD makes clear that part of the avoidance cluster includes:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.

2. Efforts to avoid activities, places or people that arouse recollections of the trauma." (DSM, 1994, p 428.)

Co-researchers did not avoid talking about their experiences, although clearly it was painful for most of them to do so. Instead, they made some effort to accommodate me. I felt there was an inbuilt advantage for me here as a gestalt psychotherapist working within an organisation; a prior relationship both with individuals and the organisation helped facilitate my research.

Several co-researchers spontaneously attributed their participation to an altruistic wish to help improve the situation for others in the future. However, I was surprised in retrospect that anyone had been willing to participate in the research. I suggest the gestalt psychotherapy view of our need to make meaning of our experience had been greater than the need to avoid? I also suggest that staff who wished to avoid talking about the event would be more prone to developing PTSD, whereas those who were willing to talk would be more likely to integrate their experiences and heal more quickly? Certainly this seems to reinforce the importance of underlying personality process in terms of tendency to develop PTSD (Williams, 2001).

Shame and the Professional Role

None of the co-researchers said directly that they had experienced a sense of shame. Several mentioned a sense of failure. However, with some individuals I approached for interview who declined involvement, I was aware of a sense of righteous indignation. I felt wrong footed simply by asking them to participate. At various points, I was aware of carrying the feelings of shame, that we should not be talking about C's death and that in raising the issue I was breaking a taboo. Perhaps this is not surprising. Shame has been described as the hidden emotion, (Evans,1994) often experienced pre-verbally, and co-researchers may not have been aware of its presence, projecting it outwards so I carried the feeling for them.

I felt there was a conflict between the professional attitudes of co-researchers that they must get on with the task they were employed to do and their personal feelings of distress. This was particularly evident around the feeling of wanting to cry and retroflecting tears. Hawkins & Shohet (1989) describe how those in the caring professions may get their needs met vicariously and project them on to those they are trying to help. I felt this process was evident.

Implications for Gestalt Psychotherapy

Gestalt psychotherapy theory is based on the notion that we seek to self-actualise. Our needs organise our experience (Perls, 1947/ 1969/1992). In an ideal world self-regulation will be undisturbed and we will be naturally healthy and balanced. In gestalt terms health encompasses not only physical and mental health, but all aspects of self functioning (psychological, physical, social, spiritual). If we are healthy we move through the complete contact cycle and make clear gestalten.

For most of us unfinished issues from the past may limit our ability to self regulate and fulfil our needs in the present. At the contact boundary we have the ability to take in and assimilate nourishment and reject that which is toxic. Several questions arise: how did co-researchers experience moving through the cycle of experience and at what points did they get stuck? What are the factors that impact on individuals' ability to move through trauma?

Given there was still a court case outstanding at the time I conducted the research I felt it was impossible for any of the co-researchers to have achieved closure, but there was clear evidence of individuals being at different stages of the cycle.

Four co-researchers appeared to have processed events and moved on to the later stages of the cycle. Two co-researchers who had gone to say goodbye to C in the mortuary seemed to have achieved the greatest degree of closure. I experienced two co-researchers as desensitised and still in the early stages of the cycle. One co-researcher attended for 10 sessions of individual therapy about a year after the event. Her hyper vigilance was causing difficulties for her in carrying out her everyday work. This seemed to reinforce the model proposed by Melnick and Nevis that most difficulties of post-traumatic stress will be encountered in the demobilisation phase of the awareness cycle. This is of interest to us as gestalt psychotherapists as it seems to imply clients are more likely to seek therapeutic intervention in the later stages when they are stuck rather than immediately following a traumatic event.

No two traumatic events will ever be identical. All those affected will require differing interventions, depending on the nature of the trauma and the point in the contact cycle that individuals are stuck. This is part of the essence of gestalt psychotherapy; we work with difference and “what is”.

Post Traumatic Growth

I did not specifically ask co-researchers about post traumatic growth, but a majority spontaneously referred to the process. Benefits included a greater appreciation of their own families, and counting their blessings in life; a sense for some of feeling personally stronger through navigating adversity, and for others a feeling that staff had become a much more cohesive team as a result of their shared experiences. These findings support the available literature that post-traumatic growth exists, and that it is a continuous process occurring throughout a trauma and not just at the end of it. (Harris & Joseph (submitted); Linley & Joseph, 2002). This has important implications for gestalt

psychotherapy where the emphasis is on the minute by minute phenomenonological exploration of experience and the "staying with" in order to raise awareness. A questioning of the spiritual dimensions of life may well accompany post-traumatic growth. Gestalt psychotherapy with its emphasis on meaning making and spiritual well - being (Polster & Polster, 1977) is well placed to work with these concerns in those impacted by trauma.

Field Theory / Issues of Support

Gestalt psychotherapy theory as developed by Perls (1947/ 1969/ 1992) adopted some of the ideas of the early gestalt psychologist Lewin (1952), who argued that as individuals we are indivisible from our environment and can only be understood as part of the social / cultural field to which we belong. Perls believed the mature individual is one who can be self -supporting as well as take in support from the environment (Perls, 1951/1969). These ideas are important in therapeutic terms, as one of the tasks of the gestalt psychotherapist is to help improve both self and environmental support through awareness and contact.

I was surprised that staff felt so well supported through the trauma. I had expected a lot of anger to be disowned and projected out on to other people or processes. I had two thoughts about this. Initially, I wondered whether there was something in the personality structure of workers in the "caring professions" that perhaps they had low expectations of support. However, there is much in the literature to suggest that those who experience a traumatic event as part of a group will derive enormous support from peers (Hodgkinson & Stewart, 1991; Gibson, 1998; Pollard, Mitchell & Daniels, 2002). What was clear from co-researchers was the need for dialogue and contact to provide for the possibilities of creating a narrative and absorbing their experiences. There are obvious implications here for gestalt psychotherapy in terms of the possibilities of offering group therapy to victims of larger scale incidents.

Vicarious Traumatization

Undertaking the interviews impacted me profoundly in ways I felt unprepared for. At times I felt overwhelmed, despondent, despairing, deflated, tearful, agitated and immensely moved. Several times I felt mute. Although I had never met him I was also suffused by intensely vivid images of C, a large head of blond hair, both very alive and playful, and also lying dead in the mortuary looking very little and alone. I felt I was the conduit for all the disowned emotional material floating in the organisation. The potential for the vicarious traumatisation of therapists and trauma researchers is well documented. (Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995).

Working with trauma is emotionally demanding, and a long term process. As a therapists and researchers we have to contain the figures created and not push too hard, resist making a quick fix. We have to be able to "stay with" our own and our client's experiences however depressing the work. This demands a certain maturity on the part of the therapist /researcher.

Conclusion and Integrating the Research Findings into Practice

Over a period of years when traumatic incidents had occurred organisationally, I had experimented with differing therapeutic approaches; none of them felt entirely satisfactory, including debriefing, which I did not think sat comfortably with a gestalt psychotherapy approach. The opportunity to evaluate staff responses, previously missing, is precisely what has been so valuable for me in undertaking this research. The location of the Staff Care Service as internal to the organisation seemed advantageous to me in terms of being able to adapt creatively to the needs of this particular situation.

Being proactive in the early stages following a trauma feels essential. (Rick and Briner, 2000). There appears to be huge symbolic value for staff in being offered help at the moment of crisis, whether or not they take up the offer. Perhaps we can only offer and do our best. What has been reinforced for me, too, is that trauma is different from other forms of therapeutic engagement. Usually we wait for clients to self-present seeking therapeutic help; with trauma, if we are proactive in offering therapeutic help in the early stages there is more likelihood of the offer being taken up in the later stages, when perhaps help is needed more.

Gestalt psychotherapy teaches us of the need to come to each therapeutic encounter afresh, and work with "what is". My research findings have encouraged me to continue with an experimental approach that takes into account the particular variables in the field, rather than have a single, rigid formula to deal with differing events. One of the most satisfying outcomes of my research is that I am already engaged in this process of using the findings to further organisational training and development in relation to dealing with traumatic incidents in the workplace.

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