British Gestalt Journal
2014, Vol. 23, No. 2, 28–37

Contact and despair: a Gestalt approach to adolescent trauma

Bronagh Starrs

Received 21 May 2014

Abstract: This paper aims to extend McConville's model of development and therapy with adolescents towards an understanding of the impact of trauma in adolescence. The author examines the adolescent's experience of trauma from a relational perspective, specifically focusing on the implications of parental influence on the adolescent as she attempts to lay claim to her life. The model identifies three qualities of contact within the adolescent–parent relational field, each with varying degrees of parental capacity to attune to the adolescent's developmental needs, ranging from supportive to traumatising. The phenomenology of adolescent trauma is explored and a cycle of despair is identified in the adolescent's self-experience. The application of this model for understanding and working with traumatised adolescents is demonstrated through the presentation of two case histories.

Key words: adolescent trauma, parenting space, receptive, non-receptive, hostile, trauma-without, trauma-within, adolescent despair cycle.

Introduction

We do not develop in isolation. Adolescence is more than simply an individual's journey from childhood to adulthood, characterised by puberty, cognitive development, moodiness, and greater investment in peer relations. It is a process of whole-field development, which is to say that the adolescent's environment also undergoes some sort of growthful transformation. There is a natural momentum in the capacity for the adolescent and those in her world to experience contact in a progressively differentiated and considered manner, which moves increasingly in the direction of mutuality over time (McConville, 1995). This developmental process is nowhere more dynamic and influential than at the contact boundary between the adolescent and her parents.

Attachment theory has given us one valuable mode of understanding human experience and motivation. During adolescence, however, the attachment lens may not provide us with a sufficiently clear and accurate description of contact boundary development. In my experience of working with adolescents and their parents, I have found little evidence of the correlation between attachment security status in infancy and the quality of attachment through adolescence. For example, 6-year-old Mary and her mother enjoy a close and loving bond; there is an ease in their relating and their connection bears the hallmarks of a secure attachment. Fast-forward ten years: Mary is a feisty 16-year-old adolescent. Communication between them almost inevitably results in tension and contempt, although Mary can be charming and responsible – usually when she wants something. The adolescent believes that her mother's agenda in the world is to make her daughter's life a misery; her mother feels that Mary's 'attitude' and new-found friends are the problem and laments the loss of her lovely little girl. Fast-forward another ten years and there is a good chance that Mary and her mother will experience an easier, more companionable relatedness.

Attachment and contact are different phenomena; and whilst Mary and her mother might well continue to have a fundamentally secure attachment, during adolescence the quality of their contact certainly has undergone dramatic change. So what happens to the child–parent connection during adolescence that can create such fraught and shaming interaction? Surely we cannot put it down merely to hormones. McConville has discovered that if we shift our focus to understanding the evolving contact boundary, the adolescent's behaviour and experience begins to make greater sense (McConville, 1995).

Adolescent development is the development of contact. Contact, for Gestalt therapy theory in general, and McConville in particular, is the cornerstone of psychological functioning, referring essentially to the way an individual engages and interacts with the world and with herself. In the magnum opus of Gestalt therapy, *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls et al., 1951), the concept of contact was postulated as the defining characteristic of the self,

in sharp contradistinction to the dominant intrapsychic, psychoanalytic models of the day. The authors spoke of the contact boundary as the concrete, experiential meeting place of self and other. It is the evolution of this meeting place, its organisation and functioning, that McConville offers as the critical issue for understanding adolescent development. McConville's model tracks the evolution of the contact boundary via recursive processes of differentiation of the adolescent in the family field. He contends that as the adolescent develops, her sense of differentiation in and from her environment increases and she begins to feel somehow different in terms of subjective experience of herself. These changes lead her to engage with her world in new ways.

McConville's model is decidedly phenomenological, and this shows through in his attention to the evolution of the adolescent's first-person experience. Because development is about this emerging capacity for contact, both with others and with oneself, then therapy for McConville is about the support and cultivation of this capacity. This is an important postulate, because it radically diverges from most contemporary assumptions concerning the nature of therapy with adolescents. Therapy for McConville is not about problem solving or conflict resolution, at least not primarily. The themes of therapy involve not so much an adolescent's behaviour change as the client's learning how to expand her awareness, sit with dilemmas, know where she stands, tolerate the 'what is', have the courage to speak her mind, acknowledge shortcomings without shame, etc. McConville is a proponent of Gestalt therapy's 'paradoxical theory of change' (Beisser, 1970) which holds that it is precisely *not* the therapist's task to change the client, but instead to assist the client in becoming more aware and accepting (without either shame or self-justification) of who she already is. With adult clients, this approach inevitably leads to change, though change is not the target. With adolescent clients, according to McConville, this approach leads to development.

McConville's model offers a radically relational lens through which to understand and support adolescents, particularly those adolescents whose developmental path might be described as 'normative'. His landmark text, *Adolescence: Psychotherapy and the Emergent Self* (1995), continues to have far-reaching implications for clinical theory and practice. This article aims to extend McConville's model of development as *development-of-the-contact-boundary* into the less explored territory of the impact of trauma on adolescent development, with particular focus on the adolescent's phenomenological experience.

Defining trauma

Trauma is experience which creates shock, distress, and dysregulation in people's lives. It creates profound disruption in three principal domains of experience: physiological, psychological, and relational. This trauma can be a single event, a cluster of events, or a chronic situation which is negotiated on a repeated basis. The experience falls outside the range of what is normative and it is not possible to process the experience in the present moment; subsequently the adolescent enters a state of alarm and overwhelm. The aftermath of trauma for any adolescent typically includes a detrimental impact on affect regulation, self-concept, and interpersonal relating. All of this will hopefully subside with sufficient support, both intrapsychic and environmental. Sadly, for too many adolescents, trauma is the ground of their lived experience. Their trauma happens within the home; within parental relationships. Their legacy includes despair, self-experience saturated with shame and powerlessness, and a deep-seated conviction that they are defective human beings.

PTSD symptoms, experienced by some adolescents, are long-term creative adjustments to trauma's impact and are an expression of unintegrated overwhelm. PTSD symptoms involve the ongoing dysregulation of psychological, physiological, and relational processes, which creates an additional layer of complexity and anguish in these adolescents' lives. Over the past number of decades, considerable research has been undertaken as we continue in our attempts to understand the impact of trauma and PTSD on the experience of being human. Recent developments, particularly in the field of neuroscience, have contributed significantly to our understanding. The various modalities, including Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy (CBT), Sensorimotor psychotherapy, and Psychodynamic psychotherapy have each developed approaches to treat trauma survivors. Divergent methodologies include emphasis on cognitive processing, behaviour modification and physiological experiencing, with varying degrees of appreciation of the highly complex nature of some trauma.

The Gestalt approach to working with people who have experienced trauma is rooted in the relational. Phenomenology, field theory, and contact are the guiding principles. Kepner's description of therapeutic intervention with adult survivors of childhood sexual abuse in *Healing Tasks: Psychotherapy with Adult Survivors of Childhood Abuse* (1995) has until recently been the only major publication which dealt with the specifics of trauma from a Gestalt perspective. In Taylor's newly published *Trauma Therapy and Clinical Practice:*

Neuroscience, Gestalt and the Body (2014), the author presents a comprehensively relational model for understanding and working with trauma, integrating the Sensorimotor approach into a Gestalt framework. In the specific domain of adolescent trauma, Oaklander's seminal publication *Windows to Our Children* (1978), rich with clinical strategies and descriptions, has provided the cornerstone for creating a Gestalt developmental–therapeutic model. Contributions have been made by various authors with regard to working specifically with adolescents who have experienced trauma, for example, as presented in *The Heart of Development: Gestalt Approaches to Working with Children, Adolescents and Their Worlds. Vol. 2: Adolescence* (McConville and Wheeler, 2001) and *Relational Child, Relational Brain* (Lee and Harris, 2011). However, a comprehensive theoretical framework for understanding and intervening with regard to adolescent trauma has yet to emerge. Working with traumatised adolescents requires the therapist to understand adolescent developmental process; to understand the experience of trauma; and to understand what happens when these two meet. This article aims to outline briefly a relational Gestalt methodology which has emerged from the ground of this understanding.

The parenting space

The nature and influence of the connection between adolescents and the adults in their worlds has considerable potential for support, and equally for adversity, as the young person journeys towards existential selfhood. For the adolescent, her principal environmental context is usually her parents. This relational context, which I call *the parenting space*, is a continuous interplay between the intrapsychic and interpersonal worlds of experience, with mutual influence and ongoing co-creation of self-experience occurring in the encounter between self and other. There are varying degrees of receptivity within the parenting space which impact the adolescent's emerging sense of self and manner of engaging with her environment. I have identified three general grades of receptivity which can be experienced in the parent–adolescent dyad. These include *receptive*, *non-receptive*, and *hostile* parenting. These descriptions are organised according to a parent's capacity to manage the transitioning contact boundary in an appropriately supportive, non-shaming manner, according to the developing adolescent's needs. These are not rigid categories of parenting experience: rather, one of these qualities of receptivity will usually emerge as the dominant style of contact within the dyadic encounter. The parenting space is a dynamic, fluctuating experience for the parent–adolescent dyad. The following is a broad description of each grade of receptivity within the parenting experience and its impact on the adolescent's development.

The receptive parenting space

The adolescent's emerging experience of 'self' is, in every moment, exposed to the environment in a dynamic process of living. To be wholly received by her environment means that the adolescent experiences a consistent, attentive, supportive, and responsive interpersonal world. This experience of being received, in turn, nurtures and encourages the construction and development of a rich intrapsychic experience. She grows by experimenting with and exploring her environment – hopefully finding that her experimentation and exploration are received and affirmed by that environment. This support and validation promote ownership of experience and the emergence of a firmly grounded sense of self and connection to others. Life is meaningful, interesting, rich with possibility: life is worth living.

Receptive parenting is the capacity to attend to the relational needs as well as to the more practical, functional needs in the adolescent's developmental journey. The parent ideally relates to her daughter in a manner which cultivates a sense of being cared for, of mattering, and creates the expectation of being received and supported by her environment. Throughout childhood, hopefully the parent has received and encouraged the development and expression of her child's inner world, which in turn supports the emergence of a strong, grounded sense of self for the child. During adolescence, the parent intuitively understands that the young person's inner world of private experience, which is deepening and expanding, is becoming more and more the adolescent's business. The parent's role now is to continue to influence her daughter by holding her accountable for actions and decisions in a way which is affirming and non-shaming of the adolescent's attempt to define who she is in the world. This is a developmentally healthy posture for parents of adolescents, though not always sustainable – particularly when Mary rolls in at 2.00 a.m., smelling of cigarettes and cider.

Non-receptive parenting

Non-receptivity as figure

A recursive and progressive process of differentiation and reorganisation occurs throughout adolescence, which frequently is played out at the contact boundary between the adolescent and her parents, particularly during earlier adolescence. This can result in running battles themed with responsibility, freedom, power, and

boundaries. When I meet with an adolescent and parent together, for whom conflict has become a fixed gestalt within the parenting space, I very often find that difficulties have arisen not simply because the adolescent has become moody, hormonal, has fallen in with a 'bad' crowd, etc., but because the parent has not quite understood that her mode of parenting is failing to support her teenager developmentally. She is still trying to parent in a manner that worked with her daughter as a younger child and feels powerless to influence her now. Shame is sure to be present in the encounter; and it is not uncommon for me to hear a parent describe how she finds it very hard to like her daughter, and to issue (another) ultimatum – either behave or be gone. Parents surprisingly have little awareness of how devastating their impact can be on their adolescent children. The adolescent experiences a non-receptive parenting space and becomes artful at hiding this shame.

Non-receptivity as ground

No parent or caregiver can be receptive 100 per cent of the time. Life happens and it is beyond our capacity as human beings to maintain perfect relational connections. Sometimes the most well-meaning and supportive parents cannot 'be there' for their adolescent children. A parent can become distracted and preoccupied with his or her own life situation and the adolescent experiences diminished receptivity within the parenting space during these episodes. A parent, for example, might be hurting; or becomes distracted by the excitement of a new relationship; she or he may be intensively focusing on a work project to the detriment of family life; or the adolescent's parents are in the process of separating. As these experiences become less figural for the parent, the parenting space becomes increasingly receptive once more. However, in many cases, non-receptivity characterises the parent–adolescent relational space. Parenting is often agenda-driven, where the adolescent's life is closely directed and managed by the parent who has a desire for his or her son or daughter to be a 'success', e.g. the adolescent having a pre-determined, non-negotiable academic path and career. The agenda can emerge in a compensatory manner in respect of the parent's own life experience and the adolescent does not have much of a voice in determining the direction of her life. The parent fails to notice or fully take into account the wishes and sense of emerging self of the adolescent. When I meet adolescents whose lives are agenda-driven, I hold the image of a topiary tree while we work: a dedicated and thoughtful gardener has created a structure around which the plant will grow and take shape, and so each is perfectly sculpted. Adolescents are not topiary trees. In other experiences, absence or some experience of separation has created a lack of receptivity within the parenting space. Perhaps there is irregular, insufficient or no contact between an adolescent and her parent. This can be the case when, for example, the parent–adolescent relationship has faded after parental separation.

An adolescent who experiences a habitual lack of receptivity within the parenting space often describes feelings of insignificance and invisibility. Creating sufficient support to challenge her deep belief that she does not matter is the challenge.

Hostile parenting

This is the experience of a parent's behaviour and way of relating which is actively shaming and destructive for the adolescent's emerging self-experience. In fact, it can be positively dangerous for the adolescent's sense of self to emerge at all within the parenting space. The parent–adolescent relationship is organised around the parent's abusive/addictive behaviours and the adolescent adjusts accordingly. He learns to be hyperattentive to parental needs and the parent's feeling world, and to relinquish his own – this is in direct contrast to receptive parenting. In these cases, perhaps the parent is verbally, physically and/or sexually abusive; the parent is addicted to some substance or behaviour; or the parent is living with significant mental health issues which impact the parenting space. In these instances, it is the parent who is creating and maintaining the distress and danger in the adolescent's experience.

Whilst non-receptivity within the parenting space can create feelings of hopelessness at times, hostile parenting creates despair. The burning existential question for these adolescents is not, 'Who am I?', but rather, 'What's wrong with me?' Despair is a mixture of powerlessness, hopelessness, and rage. This despair is internalised and is translated into a deep and core belief, namely, 'There *must* be something wrong with me'. Psychological chaos ensues.

The adolescent self and trauma

I am interested in the phenomenological experience of trauma for adolescents, and the consequent impact of this trauma on development. Ongoing dialogue with many adolescents over the years has led me to identify two qualitatively different experiences of trauma which I have named *trauma-within* and *trauma-without*. Trauma-without is an experience of trauma which is created from outside the family field, e.g. a family member's death through illness, a road traffic accident, rape by an outsider. These testing and often overwhelming experiences thwart the adolescent's otherwise normative developmental path; there is rupture and distress in the adolescent's experience of contact

boundary. Trauma-without is often experienced as life-changing, with adolescents frequently expressing a sense that 'life will never be the same again'.

Trauma-within is the experience of trauma which emerges from the ground of family experience (e.g. parental addiction, abuse in all its forms of children or adolescents by caregivers). Hostile parenting is traumatising for the developing adolescent. It creates a degree of dispiritedness, shame, and isolation which I do not meet in adolescents who have been through even the most brutal distress having occurred outside the family. Creative adjustment makes it possible to live, though it usually comes at a terrible cost to the self.

Below are two clinical examples of working with adolescents who have experienced trauma. Gearóid's experience of trauma-without and the therapeutic intervention are qualitatively different to Mick's experience, in that Gearóid's distress was not created within the parenting space. It has been a longer and more complex road for Mick. Despair is much harder to heal.

Trauma-without

Gearóid is 13-years-old and the middle child in a family of three boys. Two years ago his family were returning home from a day by the seaside when a drunk driver hit their vehicle. Within a short time the emergency vehicles arrived at the scene and the family were brought to three different hospitals. His mother was taken in one ambulance, Gearóid in the next, his father and two brothers in the third. Gearóid's father and siblings escaped with minor injury. His mother received life-threatening injuries and was hospitalised for three months. Everyone, including Gearóid, thought for a while that she was going to die. Gearóid himself sustained considerable injury and was hospitalised for three weeks. He faces several more years of surgical procedure and an intensive physical rehabilitation process. His parents brought him to see me about a year ago as they felt they had 'lost their son'. Their description of Gearóid fitted perfectly with someone who was experiencing post-traumatic stress. This is what happened when we met.

Gearóid isn't too sure about meeting me and like many adolescent males, is fairly monosyllabic in his dialogue. To step right in and get him talking about the accident would be to re-traumatise him – his terror is palpable behind the nonchalant veneer. So we just hang out. I teach him how to play chess (badly); he likes messing about with the clay and painting masks. We are establishing contact. He and I know that we can't touch this 'other stuff' with a bargepole. Not yet. It takes five sessions for adequate safety to be created in order for Gearóid to tell me that he isn't sleeping too well and is having nightmares. We start gently and tentatively to court the unspeakable. I am supporting the other members of Gearóid's family also at this time as they struggle to come to terms with what has happened to the family. I meet with his father who, as he speaks of the accident, describes intense feelings of failure and worthlessness at not having been able to save his family. He is a firefighter and has attended similar scenes many times, but that night he could do nothing to protect his family from the oncoming headlights on his side of the road. He sees the lights every time he closes his eyes. By now he is in tears and shaking. Gearóid's dad brings him to my office each week, makes himself a coffee and reads the paper in my waiting room. Gearóid has become withdrawn from his family for some time, but is liking this weekly ritual of a drive with his dad to my office and back. Sometimes I invite his dad to stay for a part of the session and sometimes it is just Gearóid and me. As the weeks progress, we talk about what life was like 'before' and what it has been like for him since the accident. He tells me that he knows he needs to talk about the actual event but he doesn't know how or when. We talk about what it would be like to talk about it. His symptoms begin to decrease and he is feeling a little better.

One day, as he is describing the anxiety he always feels on car journeys, I can see that something powerful is happening for him. 'You're back there now, aren't you?', I say gently. He tells me that he can see the car crash and he can hear all the sounds. He puts his head in his hands and is doing his utmost not to cry. I have a choice now – how do I best support this teenager in this moment? The answer is obvious to me – I don't support him at all. I step out of the way and let his father do the supporting. My hunch is that it will be healing for them both. So I tell him I'd like to invite his dad in. He nods that it's OK. I call his dad and tell him to sit by Gearóid, that his son needs his support. Silently he pulls a chair over to Gearóid, puts both arms around him and pulls his son's head in to his chest. As soon as he does this, Gearóid starts to sob loudly. Before long, dad's tears are falling on Gearóid's hair. When the tears subside they begin to talk about the night of the crash. The following week I meet with Gearóid and both his parents. There are more tears and hugging, and important acknowledgement from everyone present of how difficult this whole nightmare has been for Gearóid: his injuries and ongoing treatment, travelling alone in an ambulance to a strange hospital many miles from his home not knowing what was happening, lengthy separation from his mother whom he was sure he would never see again, his rage at the drunk driver who caused so much devastation to his family, the anxiety and isolation he has experienced since the accident. These few sessions proved transformative and life-giving to Gearóid.

I am not so sure that this adolescent would have experienced this depth of healing had his parents not

been involved in the work. Indeed, the trauma had impacted the parenting space and it was just as important for Gearóid's development to address this as it was to process his traumatic memories. The traumatic experience had rendered the parenting space non-receptive and frozen; and so in order fully to support this adolescent's development, Gearóid needed his parents' support and they needed to be able to support their son. This clinical example is fairly typical of how I support an adolescent who has experienced trauma-without – i.e. when the traumatic experience is something which has happened *to* the family as opposed to something which has happened *in* the family. The work was to support Gearóid to come to terms with something '*bad*' that had happened. It is a very different experience to support someone who believes '*he is bad*' because of what has happened in his life.

Trauma-within

Mick, aged fourteen years, is doing poorly in school and has an 'anger management' problem. The school has tried everything; expulsion is on the cards if he does not improve his attitude. Therapy is suggested to his father as something which might help Mick to deal with his anger and to develop a more responsible attitude towards his education and to those in authority. His father thinks this would be a good idea too – he is difficult to handle at home and he thinks Mick might have ADHD 'or something'. He wonders if I do CBT – he doesn't know what it is, but he's heard it is the best. I bite my tongue. Mick is disrespectful to everyone and is constantly fighting with his older brother. With this adolescent, the referral route is predictable – an 'acting-out' symptom is identified. The tight feeling in my body as I speak with Mick's father on the phone informs me that this father will be wanting therapy on his terms. The implicit message is, 'This can't continue. Nobody knows what to do with him. *You* are the expert; *you* fix him.' I feel that familiar pressure to 'deliver the goods'. This is what happens when we meet.

I arrange an initial meeting with Mick and his parents. Only Mick and his father arrive. Mick avoids eye contact as he and his father come in and sit down. Why would he want to make eye contact? His father and I are going to sit and talk about how bad he is for the next hour. With raised eyebrows I will listen to the litany of offences. I will tell him that it is not acceptable for him to act in this aggressive way – it is doing him no favours and he is throwing his life away. He should know better. I will teach him strategies like counting backwards from ten to zero or to walk away in order to dissolve his anger in situations. I am another 'do-gooder' adult who is trying to change him. I will not take him seriously. He is armed and ready to defend himself from the shame which is coming his way. Mick wants to get the hell out of here as quickly as possible and who could blame him?

He and his father arrive at my office with an implicit assumption that there is something wrong with him. To be of any meaningful support to Mick I am going to have to blast this unspoken assumption quickly. That is not difficult as I do not share it. If he is angry, he has reason to be angry. He may not be containing and directing his anger appropriately, but there is nothing wrong with him. This is my baseline, and as soon as Mick picks this up there will be a possibility of real connection between the two of us. I am not interested in his anger, or in any 'acting-out' symptom which brings an adolescent through my door. I am interested in getting to know Mick and seeing what happens when he and his father sit down to talk. I am interested that his mother has not come. I hold a posture of curiosity and warmth. My only agenda is not to shame either of these people sitting here with me. I begin by announcing that therapy will be firmly on Mick's terms: I never work with kids who do not want to be here and I won't ever make someone come if they don't want to. We are going to have a conversation and Mick will be 'sussing me out' (he smiles and we have eye contact), so at the end of the conversation I want Mick to decide if he'd like to come back next time or not. Does that sound OK to him? 'Aye.' (His voice is in the room now too.) He doesn't even have to speak – I'd like to hear from his dad, and if Mick wants to respond or say anything that's fine. Is that OK? (He nods his head in agreement whilst making eye contact with me.) I continue by adding that I've had a brief phone conversation with his dad and it sounds like things are pretty tough for Mick. I have never met an unreasonable adolescent. Kids who are angry have good reason to be angry, but it sounds like his anger is getting him into trouble.

I'd like to hear from his dad what he thinks life is like for Mick. I have indicated that I do not intend to shame Mick. He's not sure what to make of me, though he's more open to what might take place now. As his father speaks, I must nip the shaming tirade in the bud every time it starts. It doesn't take long to get beyond the 'bad behaviour' track. Soon this irate and frustrated father is describing what life has been like in the family and the conversation shifts into a deeper mode. His son is no longer the focus of his dialogue – this creates necessary breathing space for Mick. His wife left when Mick was 8-years-old. She is alcoholic and towards the end became violent and verbally abusive with Mick and his older brother when she was drunk. Mick doesn't flinch. His father worked a lot and wasn't there much of the time. Before we go any further, it is obvious to me why Mick might be angry. I am guessing that this adolescent is also feeling incredibly hurt. Translating

hurt into anger works as an excellent self-preservation mechanism for adolescents.

The mother–son parenting space is characterised by hostility. I want to find out the level of involvement she has in Mick's life, if any. At this stage I am not clear whether she will be involved in the work or not. Either way, the hostility has left a legacy which will need to be attended to. With all the focus on Mick's 'acting-out' behaviours, the paternal parenting space has become non-receptive. I imagine Mick has experienced non-receptivity within the father–son parenting space for a while, perhaps it has been characteristic throughout their relationship. Blame is unhelpful and unproductive in these situations. It can have no place in the work. I remain curious and warm.

The art now is in creating ground for deeper receptivity to emerge within the father–son parenting space. This will be a core, ongoing aspect of the work and a key support in Mick's healthy self-development. If I can find a way of offering support to the parent so that he can find greater balance, then I create greater capacity for him to support his son. Firstly, I support Mick's father by expressing my sadness at what has happened and asking what the experience has been like for him. He talks about being left with two sons aged thirteen and eight years, whilst having a business to run; of how difficult and stressful it has been; of how angry and betrayed he feels that his wife left to go live with another man without even telling him; he hates her, they all hate her. He becomes upset and apologises for his tears. I stay with his father for another while and then I turn to Mick and remark that this has really been very difficult for his father who has had to carry a lot. I ask him what he thinks it has been like for his dad. Mick isn't being asked to account for his unacceptable, aggressive behaviour or say anything about himself. There is no obvious shaming agenda here; it is safe for him to respond. He thinks it has been hard for his father. I ask him how he thinks his dad has coped. Mick responds by saying that he feels his dad is a good dad and has made a good job of being a single parent. There is room for humour in this piece and for the first time there is an experience of three-way contact. I am guessing it has been a while since they smiled at one another.

His father's experience has been acknowledged a little by all of us. Now I shift the focus of the dialogue: I want us to look through Mick's lens. I could ask Mick directly, though I suspect that the response might be a shrug of the shoulders and a comment from him such as 'Shit happens'. A valuable opportunity will have been lost. Adolescents often do not have language for their experience. When trauma-within is present, the adolescent's experience is commonly dismissed because it is too painful a reality – both for him and for other family members. I so frequently encounter adolescents who are not merely unwilling to talk about difficult experiences; it is as if they have some deep-seated, trauma-induced dumbness or aphasia with regards to their distress. The quality of their silence is less to do with resistance or ineloquence, and more a statement about being unconscious about being unable to speak.

Having a parent attempt to acknowledge the adolescent's experience is a helpful start in supporting an adolescent to give voice to and come to terms with his experience. It also gives him an experience of being seen and received by his environment. I am guessing this part is very necessary for Mick and so I turn to his dad. I ask his father what he thinks this whole experience has been like for Mick – the years of living with an alcoholic mother, of having her walk out one day when he was 8-years-old, his journey since then. There is a sadness and softness in his voice as he speaks. His son cried himself to sleep for a long time after his mother left. He used to stand outside Mick's bedroom door and listen. He didn't know what to do or say, so he thought it was best to leave him. It used to break his heart. He cries a little and then apologises for his tears again. *(Mick is visibly moved and we later discover that he never knew until this moment of his father's presence outside his bedroom door all those years ago.)* She hasn't even sent him a birthday card since she left. She makes no effort to see him even though she lives in the next town. He, himself, has been very busy and has not always been there. Mick spends a lot of time on his own and has probably been very lonely. It has been really hard on Mick. His father has tried his best, but wee boys need their mothers. Mick and his father are struggling to hold back the tears.

I indicate to Mick I have a hunch that his father has guessed well. He nods in agreement. His father turns directly to him and says, 'I'm sorry son'. There are some tears on both sides now. For the first time in his life, Mick's experience has been acknowledged. And this acknowledgement has come with an expression of care and love. *Somebody gives a shit.* I imagine that will have come as a surprise to him. Later in the session I ask his father to describe his son: Mick is a great lad, very smart and capable. He could do whatever he wants if he put his mind to it. He's determined and stubborn, a bit like his father. He is kind and direct – you know where you stand with him. 'You sound like you are very proud of your son', I say. 'Och God, I am surely' is the response. I turn to Mick, 'He sounds to me like a dad who really loves his son'. Mick nods and I see a faint smile. 'Of course I love him. He's my wee man', adds his father. I ask him curiously if he knew that his dad felt all these things about him. He didn't. It's good to hear them. Later, as we bring the session to a close, I invite them both back the next week – maybe we'll do a half-hour with them both, and a half-hour with just Mick and me.

What does he think? He nods. His father is also happy to come. We are off to a good start: focus on the 'acting-out' symptom has been re-directed to the context of Mick's experience. The potential for shame is immense otherwise. I continue to involve his father, and later his older brother, in the work.

Healing internalised hostility: re-framing the space

Over the next few weeks we work to establish firm relational connections. Mick is feeling more comfortable with me and during an individual session recounts a recurring dream: his mother is walking in the middle of a road carrying him in her arms. He is a small baby. She wants to smoke and so removes one hand, putting it in her pocket to get her pack of cigarettes. Her lighter is in her other pocket, so she takes her remaining hand away to fetch it. Mick drops suddenly to the ground. He wakes up trembling and crying just before he hits the ground. His heart is pounding. This dream has captured his experience vividly. It offers us a powerful metaphor to work with as he begins to articulate his phenomenological experience. He remembers in meticulous detail the day his mother left – she made him help pack and carry her belongings to the car. He tearfully begged her not to go. It didn't matter about all the bad stuff, he just wanted her to stay. He cried that much after she drove off that he vomited. He was there by himself until his father came home. It seemed like forever. The fact that he is voicing his dream and his memories to someone is healing in itself, but it is not enough. Depth healing is required. Physiologically we store trauma: the day his mother left has been buried alive in Mick's muscles, bones, and cells. We pay attention to what is happening in his body: he feels like he wants to be sick, his legs feel like jelly, his heart is pounding, his chest is sore, he has a pain in his solar plexus like someone is sticking a knife into it. I know because he tells me and because I can feel his sensations in my body also. We breathe and ground. The tears come and they keep coming. With trauma, embodiment work is necessary. Throughout the work we pay attention to his physical experience; bodies need to heal too.

Over the coming weeks he articulates more and more of his experience. Weaved through the dialogue another important aspect of the healing is occurring. We work now at a cognitive level – reframing his experience without the shame. He has internalised the hostility and so we have to put an end to the myth he has created of *the defective self*. We piece together what he knows. His mother's father was a violent alcoholic. He was killed in the Troubles when she was 13-years-old (interestingly she left when her eldest child was also aged thirteen). She was the eldest girl in a family of seven children and had to leave school after his death to help take care of her siblings, most of them boys. She evidently and understandably experienced a strong sense of injustice for not having had the opportunity to get a decent education or good job. She held her husband and sons accountable for her unhappiness, for her drinking and for holding her back in life. Without blame or demonising, we look objectively at his family situation and see that maybe his mother's drinking and destructive behaviour was not because Mick was a bad child (which at 8-years-old he was convinced of), but was an expression of the pain she was experiencing. This does not exonerate his mother or make it OK that she caused so much distress to Mick. Rather, it provides the adolescent with a wider perspective from which to contextualise and make meaning of his experience of them both within the parenting space. He had tried his best to be a good boy and make her happy but it never worked – if only he could have been better! He sees now that it was not about him. He begins to separate out her behaviour from his self-experience.

Adolescent despair cycle

Adolescents can experience bewilderment in response to hostility within the parenting space. Bewilderment leads to a sense of internalised accountability, which in turn creates self-directed hostility. This can generate a wave of despair. The end result is devastation, though the adolescent's seemingly defeatist behaviour almost always translates as vivid moments of eloquence, which constitute part of his resource pack for living with this unacknowledged overwhelm. This cyclical shame-script most often begins in childhood, becoming embedded and implicit in self-experience and goes something like this:

Bewilderment: *silent, frantic questioning about why this experience is happening.*
Internalised accountability: *the 'why' is answered and sense is made from the chaos through self-directed blame – this is all the child's fault.*
Internalised hostility: *the natural evolution of this cycle is that the child now believes he is, of course, a bad and shameful individual. Self-contempt ensues.*
Internalised despair: *this hostility crystallises into a concrete experience of The Defective Self, i.e. 'there must be something wrong with me'.*
Devastation: *Invisibly or obviously destructive behaviour directed at self and/or environment.*

Mick begins to understand why he is so angry all the time. Destructive behaviour is an excellent idea. It is a creative attempt to heal, although it does have its obvious limitations. So we re-frame: 'My mother is

screwed up because she had a hard time and didn't have much support. She wasn't happy and she drank to anaesthetise her pain. I get why she did it but what she did wasn't OK. It wasn't her fault *but it wasn't OK*. Her drinking and beating me and leaving wasn't OK. And it was about her, not about me.' The cloak of shame is discarded and the self is no longer experienced as defective. The internal perception of self moves from '*There must be something wrong with me*' to '*Maybe I'm OK after all*'. For the adolescent, this is a very liberating place at which to arrive. We can get to this place with or without the hostile parent being involved in the work. It is not about parents changing their behaviour (if this happens it is wonderful), it is about acknowledgement of the adolescent's experience and a stepping back to see his or her experience from a more balanced, contextualised perspective. The internalised shame is dispelled and as this happens, the self-destructive urge dissolves.

Adolescent *Weltzschmerz*

Weltzschmerz is a German word meaning world pain or world weariness. For me, it comes closest to describing the yearning and residual shame which many adolescents experience as they come to terms with the trauma of being parented in a hostile relational space. A deep sense of loss emerges which has to do with the absence of a meaningful parental presence in the adolescent's life. I am reminded of a 17-year-old client's description of standing by the graveside on the day of her father's funeral. She felt sad; though not about the man who had passed away – she was relieved he was gone from the world, which would now be a safer place for her. My young client felt sad because she became poignantly aware that she was burying her one chance to have a dad. She described feelings of intense disappointment and emptiness as she stood by the grave.

And so, as Mick begins to take himself seriously in the world, reparative work includes attending to this *Weltzschmerz*. The adolescent now makes deeper meaning of his experience in the world and grieves for what might have been. It is important to acknowledge precisely what has been lost: having had a parent who was not capable of meeting her child's needs; how terrible life has been because of the hostility; the difference a receptive parenting space would have made in his life; the cost of having internalised the hostility throughout his childhood, etc. This process engenders self-compassion and creates new ground for the adolescent to envision a meaningful future and to begin to find a place of belonging in the world. The adolescent no longer defines himself by the quality of parenting space he experienced. He has given birth to an existential self. He has a voice and a life.

Faith and hope

The adolescent's environment is predominantly, though not exclusively, a world influenced and shaped by parental connections. Healthy evolution of the parent–adolescent relational space during adolescence necessitates a transformation of the contact boundaries. Parents do not matter any less than they did during childhood; they merely assume a more influence-based, less outwardly active role in the adolescent's world. Supportive reassurance from parents is immensely validating for the adolescent, whose ongoing experience of being received by her environment becomes integrated into overall self-experience: *They have faith in me; I can have faith in myself and my expanding world.*

Creating deeper receptivity where there is a quality of non-receptive parenting is always very possible and an important focus of work with adolescents. Working with a hostile parenting space is different. It is not simply a matter of creating greater receptivity. Re-framing the space by developing a more real and grounded perspective of the parent–adolescent relational connection is necessary in order to heal the adolescent's deep self-shame which permeates the space. Some women and men cause unspeakable hurt to their children and often the damage to the parenting space is irreparable. *The damage to the adolescent's self-experience is not.* Mostly, the adolescent's despair will not or cannot be healed within this space. There are other spaces. Inadequate parenting does not necessarily result in failure to thrive – other life-giving aspects of her environment can make all the difference in the world: an encouraging teacher or sports coach, a grandparent, a best friend, a guitar, a therapist. Very often, adolescents whose experience of being parented was less than supportive arrive at adulthood as happy, confident, self-assured men and women – and they make wonderful parents themselves. They have found support elsewhere and their healthy self-process is not due to the parenting they received, but in spite of it. Thankfully, humans are wonderfully resilient and resourceful. And so, as therapists, we must always hold a tremendous posture of hope when we meet our adolescent clients.

References

Beisser, A. (1970). The Paradoxical Theory of Change. In Fagan, J. and Shepherd, I. L. (eds.), *Gestalt Therapy Now: Theory, Techniques, Applications*, pp. 77–80. Palo Alto, CA: Science & Behavior Books.

Kepner, J. (1995). *Healing Tasks: Psychotherapy with Adult Survivors of Childhood Abuse.* San Francisco: Jossey-Bass.

Lee, R. G. and Harris, N. (eds.) (2011). *Relational Child, Relational Brain.* New York: Routledge, Taylor & Francis Group/Gestalt-Press.

McConville, M. (1995). *Adolescence: Psychotherapy and the Emergent Self*. San Francisco: Jossey-Bass.

McConville, M. (2001). Lewinian Field Theory, Adolescent Development, and Psychotherapy. In McConville, M. and Wheeler, G. (eds.) (2001), *The Heart of Development: Gestalt Approaches to Working with Children, Adolescents and Their Worlds. Vol. 2: Adolescence*. Hillsdale, NJ: Analytic Press.

Oaklander, V. (1978/1988). *Windows to Our Children*: *A Gestalt Therapy Approach to Children and Adolescents*. Moab, Utah: Real People Press.

Perls, F., Hefferline, R. and Goodman, P. (1951). *Gestalt Therapy: Excitement and Growth in the Human Personality*. New York: Dell.

Taylor, M. (2014). *Trauma Therapy and Clinical Practice: Neuroscience, Gestalt and the Body*. Maidenhead, Berkshire, UK: Open University Press.

Bronagh Starrs is Director of Blackfort Adolescent Gestalt Institute and is Course Director of a 2-year Advanced Post-Qualifying Diploma in Gestalt Adolescent Psychotherapy. She maintains a private practice in Omagh, Northern Ireland, as a psychotherapist, supervisor, and school consultant, specialising in working with children, adolescents, and their families. She has considerable experience as a trainer in adolescent development and therapy throughout Ireland and also teaches and presents internationally on the developmental implication of trauma on the adolescent journey.

Address for correspondence: Blackfort Adolescent Gestalt Institute, 174 Blackfort Road, Omagh, Co. Tyrone, N. Ireland, BT78 2HZ, UK.
Email: bronaghstarrs@gmail.com

Alternatively, Gestalt literature on working with secondary manifestations of trauma8 may also have been included.Â This results in the loss of a sense of agency leading to hopelessness and despair and internalisation of the negative affect from caregivers as an expression of oneâ€™s intrinsic defectiveness and unlovability (Sapriel, 2012). As stated earlier, without awareness of sensation no clear figures can be formed (Melnick & Nevis, 1997), which means, â€œwithout an authentic self, there can be no nourishing contact with another.Â A Gestalt Approach to Treating Alcoholism and Eating Disorders. Gestalt! 8(2). Retrieved from http://www.g-gej.org/8-2/alcoholism.html Kepner, J. (2003). A Gestalt Therapy Approach to Trauma Treatment, by Ivana Vidakovic â€“ Comment, by Willi Butollo; Assessing Suicidal Risk, by Dave Mann â€“ Comment, by Jelena Zeleskov Djoric. Part IV â€“ Specific Clinical Sufferings â€œWhat Does it Look Like?â€. A Gestalt Approach to Dementia, by Frans Meulmeester â€“ Comment, by Katerina Siampani; Dependent Behaviors, by Philip Brownell and Peter Schulthess â€“ Comment, by Nathalie Casabo; Beyond the Pillars of Hercules. The Gestalt approach embraces a personâ€™s physical, psychological, intellectual, emotional, interpersonal and spiritual experience. Each of these interconnected aspects of living is considered inseparable from a personâ€™s environment, history and culture. See more ideas about gestalt therapy, therapy, spiritual experience.Â Gestalt Therapy is a growth-oriented approach to working with people that emphasizes context and relationship. The Gestalt approach embraces a personâ€™s physical, psychological, intellectual, emotional, interpersonal and spiritual experience. Each of these interconnected aspects of living is considered inseparable from a personâ€™s environment, history and culture. These Gestalt tasks can easily be integrated with other, more mainstream models of working with trauma and working couples. An example of this integrated approach is offered to explore the ramifications of the theoretical assertion.Â Coupleâ€™s therapy, in particular, has not commonly been seen as a natural â€œfitâ€ for Gestalt practice. The authorâ€™s view is that the recent rise of integrated therapy and the need for Evidence-Based Treatment separate from issues of allegiance to a particular school of therapy has created a new opportunity to reconsider Gestalt therapy theory and practice in coupleâ€™s work. It is particularly relevant for work with couples in which one or both have been traumatized.