The Therapeutic Counterspace as an Ethical Encounter: A Dignified Response to Gendered Sexual Violence and Women's Narratives of Pain

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Abstract

This project emerged from reflection on the shadow stories of women and clinicians' journeys through systems of gendered sexual violence response, and a desire to apprehend and resist the interrelations between western institutional systems where women's pain is produced as suffering, and responses that listen to women's narratives through the restrictions of pathologising practice to configure a hysterical, shameful subject that needs to be 'fixed'. In this project, I take up the position of ethical activist through affirmative ethics in order to move from a listening of pain as symptoms to be extinguished, towards a transformation of therapeutic counterspaces that can hear affective intensities as a process of becoming response-able. In the bringing together of seven professionals that work in the gendered sexual violence sector through a collaborative reflective workshop, we-together opened spaces to share our shadow stories of hearing affective intensities through imperceptible processes and embedded and embodied resistances, to legitimate the untellable practices of creativity and curiosity as a relational assemblage of becoming response-able, developing a collective voice to apprehend ethical activist counterspaces as a 'moving we'. And in doing so, we evoke our expert knowledges of relational affective intensities to move the institutions we work within to become part of the collective relational assemblage, advocating for the creation and protection of spaces where collaborative reflective practices are mobilised as the response-ability for dignified responses to women's pain, and as pathways to freedom, hope and joy for women who have experienced gendered sexual violence, and for the clinicians that walk along side them, together.

Dedication

I dedicate this thesis to my daughters Bella and Scarlett. May you live in a world where you are free to express your innermost affective intensity freely and with enduring potential. I love you to the galaxy, stars, moon and beyond x

Acknowledgments and Gratitude

The completion of this doctoral thesis marks a significant milestone in a profound journey that has been deeply grounded in personal and professional reflection. I have been accompanied by some faithful companions along the way for which I will be forever grateful.

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To the strong and special women who have mentored me throughout my career and those who left this earth before you could see my life work blossom, I promise I will continue to contribute to your honourable work to the best of my ability. Although it is impossible to follow in your footsteps, I promise to make my own.

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Chapter One: My Narrative Beginnings

"Cause even in the madness,
there is peace
drowning out the voices all around me
through all of this chaos
*you are writing a symphony." (*Estevez, *2020)*

Figure 1

Me and My Mother

My journey to becoming a doctoral student started at a young age, as I witnessed my mother experience suffering due to harmful responses to her experience of sexual abuse. As I reflect on our mother-daughter relationship, I have many memories of witnessing the intense emotions my mother carried with her daily, a cloud over us both as we navigated a complex relationship with each other. At times we seemed so close, but at other times, when my mother was left alone with her painful memories, I would feel a deep sense of loss as she distanced herself from our relationship. As I reflect on these moments of recognition, I now understand my mother could not possibly feel safe being in a relationship with me when she lived in a world that could not understand the conditions of her emotional intensities. My mother did not meet the criteria of heteronormativity at the time, the good wife and mother who embraced the joy of motherhood and the familiar rhythms of married life. As she moved through a deep sense of anger, sadness took up space in her everyday world, leaving little room to be fully present in relationships and maternal life. The emotional intensities disrupted the flows of family life as she moved through her everyday expressions of connection and disconnection. Bewildered by this rollercoaster of emotions, my family attempted to understand her pain and move with her experience and at times it became too much. Attempting to engage with mental health responses in her most desperate times, she was assessed through symptoms of psychological distress and diagnosed and treated for, over time Bipolar Disorder (BD), Major Depressive Disorder (MDD), and finally Borderline Personality Disorder (BPD).

As a young person, I tried to make sense of the process of bearing witness to my mother going in and out of the hospital and not understanding why. For me, my mother was not sick in need of treatment, but needed to be understood through care and compassion. I later understood her emotional shifts as a palpable way my mother could express the pain she experienced when she was consumed by memories of sexual abuse. Her embodied pain could not be translated into words, and so, the intensity of her emotions continued to take up space in our family life. I now understand this tsunami of emotions as *affective intensities* that communicated the pain she endured living with the impact of sexual abuse, within the conditions of gendered power relations that understood her psychological distress as a disorder that defined her. In the limitations of listening for symptoms of pathology, professionals could not attend to a deeper understanding of my mother's distress, and her story of abuse remained untold. In my adult

years, I began to understand the harm, enacted and embodied, in a complex power relationship of domination and subordination that could only hear my mother's symptoms through a gendered system of meaning making that held her responsible for her compliance to their authority. The ultimate act of compliance was for her to take medications, that for me, dulled her spirit. And for my mother, the lack of a therapeutic counterspace in which to make sense of her painful memories to alleviate her suffering, locates her as the problem and challenges our ethical responsibilities to very minimally, do no harm.

I remember the affective intensities through which my mother's failure to respond were institutionalised through a cycle of increasing and shifting symptoms and frustrations in the 'battle' for her normalisation. As I bore witness to the institutional care story, I recognised my mother's loss of hope that she could ever feel 'normal', and she voiced a deep sense of loneliness to the point she no longer wanted to exist. I vividly remember my mother waking up from a suicide attempt with anger that she had failed to extinguish her life. Yet, she was not met with institutional care, instead, professionals pathologised her symptoms and expressed their own anger and frustration when they 'heard' her attempts to end her life as non-compliance to their treatment. And I recognise now too, in the moments of hearing, the echoes of listening to women's stories of pain as 'symptoms' of bad (feminine) behaviour and of 'disordered' personality.

Over the years, I have been able to talk to my mother about our collective sadness navigating mental health services, and she shared some of the small actions that I did that were so important to her. The times I sat alongside her at psychiatrist meetings and spoke for her when she appeared paralyzed by fear. The moments we shared our feelings of anger towards a clinic that refused to understand and hear her pain, and the moments of joy and freedom we shared in our relationship as we grew together. Through all the assessment and treatment of my mother's psychological distress, I walked alongside her, listening. As I reflect on these moments, I understand that our intimate mother – daughter relationship could hold many of the shapes, colours, and movements of her distress because I was not constrained by the parameters of the gaze of the clinic. As a daughter, I held enduring love for my mother as we made our lives meaningful through the relationship, not the symptoms. And my mother always responded well when I acknowledged her heart and attended to the pain she continued to experience.

Over time, my mother was able to tell her painful memories, and my understanding of the conditions of her everyday life deepened. And as I began to make sense of my mother's experience, I too began to 'tell' my own story of childhood sexual abuse, recognising that the fear of pathologisation had held my silence. I recognised the gendered social power relations that hold women as responsible for their victimization, I also recognised that silence is entangled in the fear of being heard as 'mad, or 'crazy'. In making sense of the relationship between us, my mother and I moved into a meaningful relationship where the affective flows of meaning making opened the potentials for new conversations where we could recognise our stories of sexual abuse, and re-tell our stories away from pathology. I began to understand the emotional connections moving us through our stories of pain. In making sense of our painful memories together, our emotions were no longer a problem but a pathway to understanding ourselves and each other, toward a re-telling away from our pathologisation, toward an understanding of the meaningfulness of our affective histories.

In 2001, I entered the mental health profession as a junior counsellor employed by Serenity Trust Home, a therapeutic residence for women diagnosed with Post Traumatic Stress Disorder (PTSD) and/or Borderline Personality Disorder (BPD) alongside a history of sexual trauma. I was young, full of hope and ready to provide a therapeutic response that offered ethical care to empower women toward their wellbeing. Instead, I was confronted with a therapeutic community challenged by institutional conditions that continue to determine what can be said. When the focus of 'treatment' is based on criteria that meet symptoms of pathology, we see emerge a figure of the right kind of victim who is worthy of (access to) treatment. I became interested in the ways we can reconfigure the boundaries between the psychological gaze of psychological distress and a therapeutic response.

As I processed 'figuring out' the disrupted stories that my mother and I shared, and as I began working in the sexual violence sector, I remember feeling the tensions between institutional demands and the time it takes to form an ethical therapeutic relationship as a condition of our everyday responsibilities. The process of meeting institutional expectations impacted my practice, the paradox of competing responsibilities. I now found myself in the position of *clinician* and began to understand the experience of professionals working within institutional restrictions. I had the unsettling experience of reconfiguring women into a pathologised subject

to meet the criteria for therapy, and an intense pressure to rush interventions - a structural interruption into the therapeutic relationship, and I felt the unsettling as stress and frustration. The relationship between clinicians and institutions produces a juxtaposing assemblage of an ethical commitment to care while meeting the demands of neoliberalism. As I experienced the tension between care and the forces of institutional constraints, I began to struggle, at times, to hold my resistance - a type of shadow story that has followed me throughout my career as a counsellor.

In and through my experience of bringing my shadow story on my journey as a counsellor, and now as a clinical psychologist, I have struggled to articulate my seemingly untellable experience of hearing women's narratives of pain outside the limitations of pathology, and yet, I recognise my own processes of reconfiguration. As I developed a project focusing on an alternative response to women's painful narratives, I also circled in and through a training programme focusing on clinical processes to understand psychological distress. I began to imagine being a good student within the structures of the institution and at the same time using my location to advocate for shifting how psychology conceptualises women's experiences of sexual violence. And as I moved through the three years of my clinical training, I began to understand that there was potential for discussions about the importance of reflecting on our personal experiences of pain and how this process may enact a deeper understanding of mental distress for clinicians. I found opportunities to lead conversations with other students about case formulation that accounted for depathologised expressions of pain and the importance of building reflective practice as future psychologists. I started to consider that clinical training was yet another opportunity to collaboratively seek change in the mental health profession that has the potential to evoke dignified responses to women's painful narratives, away from stories of shame and blame. In sharing my professional and personal experiences with other students, I recognised a process of mobilisation that allowed for flows of affective processes of meaning making not yet sustained by research and practice within the discipline. Having the privilege to be a part of the clinical psychology training programme, I had the opportunity to embark on this doctoral project and consider how we can we shape a collective effort that has the potential to transform women's experiences (and our own) of mental health services.

Therefore, this project opens a space to reflect on the ongoing issues of working within the limitations of pathologised practice and to reimagine collectively and creatively an ethical counterspace that resists the harms of pathologising women's pain and opens the potential for relational meaning making toward new and hopeful futures.

Chapter Two: Situating Psychology's Gendering Narrative

Figure 2

A Patient Sits Inside Ohio's Cleveland State Mental Hospital in 1946.

Note: Photo by Mary Delaney Cooke/Corbis via Getty Images from Mental Asylums: Haunting Vintage Photos from Decades Past

The Politics of Psychological Suffering

As far back as 1892, publications by/or for women have fought to raise awareness of the social injustices in mental health assessments and treatment of women's emotional pain (Marecek & Gavey, 2013). The resistance to the psychiatric and medical configuration, through the clinical gaze, of sexual difference and feminine desire within a pathologized feminine subject, required feminist scholarship to make sense of the experience of lived subjectivities, and understand the complex gendered social power relations of domination and subordination of living in a

gendered world (Hornstein, 2013; Marecek & Gavey, 2013; Swartz, 2013; Ussher 2013). Psychology for women emerged as a result of feminist political movements in the 1960s and 70s, when "conscious raising groups" (Richmond et al., 2013, p. 444) increased public awareness of the discrimination against women (Marecek, 2003; Richmond, 2013, Weisstein; 77, 93). A scholarly counterspace emerged to illuminate the shared recognition of gender bias and the knowledge produced that pathologise women's experiences of gendered sexual violence - highlighting the façade of objectivity and neoliberal responses to mental distress that continue to hold women responsible for the violence against them (Austin et al., 2006; Davidson & Abramowitz, 1980; Unger, 1998). As an active response to inequitable disciplinary gendered power relations that normalise violence, feminist psychologists began to organise in places where the pathologisation and subjugation of women's emotional pain became contested (Rederstorff et al., 2007; Richmond, 2013). Feminism and psychology emerged as both a *social political movement* and a *critical point of difference* to scientific knowledge of the 'other'- encompassing the history of "feminist critiques of the heterosexist and andocentric" (Rutherford et al., 2012, p. 227) figures produced through the epistemological violence of our discipline (Teo, 2005). In this history, we can trace our struggles to find a place in the affective history of feminism (Wetherell, 2015).

By the 1990s, twenty years into the institutional feminist project, it seemed as if feminist psychology had failed to create the "emancipatory alternatives" (Kitzinger, 1991, p. 49) that would transform disciplinary practices and, in turn, women's experiences of mental health services. Scholars voiced concerns that feminist psychology had become entangled in an "epistemological impasse where researchers' commitments effectively mute its political project, rendering the field acceptable to mainstream psychology yet shorn of its transformative vision" (Rutherford et al., 2010, p. 46). While feminism has never quite managed a mainstream position within the discipline, our critical work heightens tensions with the disciplines' post-positivist knowledge claims. The disciplinary space in which gendered social power relations accommodate feminist research that does not challenge postpositivist commitments, normalises difference through notions of a deficit femininity (Ussher, 2011).

Despite new ways of making gender differences visible in some areas of psychology, the gendered socio-political conditions of everyday lives have meant there remains a dire need for attention to *the politics of knowledge* in which science and feminism are embedded (Rutherford

et al., 2010).

Pathologised Pain and the Figure of the Hysterical Woman

The statistical figure of sexual violence in Aotearoa NZ is shameful. It tells us that more than 50% of women experience physical and/or sexual violence, and more concerningly, Māori women experience the highest prevalence for all forms of violence (Fanslow et al., 2023). While prevalence studies provide us with useful information to draw attention to the problem of sexual violence in the population, given that over 90% of sexual violence is not reported to the police (Ministry of Justice, 2023), the story is necessarily partial, and it is also not a new story. Indeed, there are forty plus years of feminist research that has reported on women's stories of violence in Aotearoa. Research that attends to heteronormativity and the hegemony of patriarchy that structures gendered social power relations (Gavey, 2003; 2005), the enduring effects of the Western colonial patriarchal gaze (Mikaere, 1999; et al., 2021), and the need to account for the intersecting inequities that emerge from, and maintain structural violence that texture the experiences of sexual abuse (Tolmie et al., 2018). However, the normalisation of violence against women has persisted in the conditions of our everyday lives, embedded in social structures and systems that reproduce the conditions for sexual violence.

The clinic is one site at which intersecting sociocultural conditions and gendered power relations intersect to enact further violence against women who have experienced sexual violence. Feminist psychologists have long been concerned that a clinical response to women's experiences of sexual violence minimises women's struggles, invalidates their painful experiences, and withholds treatment (Marecek et al., 1991). And it is here that perhaps, the DSM (Diagnostic Statistical Manual of Mental Disorders, APA, 2013) guidelines that authorize the pathogisation of women's pain, becomes the institutional acoustic for epistemological violence that renders women responsible for the violence of pathology. The DSM provides descriptors, symptoms and other categorizations as criteria for diagnosing specific mental disorders. These criteria define the parameters of the clinical gaze and treating symptoms as the narrative of distress, and response. Lafrance and McKenzie-Mohr (2013) stress that the model of categorising psychological symptoms as a mental disorder provides a process that "demarcates and frames" normal from abnormal (p. 120). It is these symptoms that legitimate dominant

understandings of what counts as a 'normal' response to violence that have become taken-for-granted truth (Lafrance & McKenzie, 2013), and expectations are produced about how women should respond and behave after a sexual violation. Thompson (2020) considers this taken-for-granted dominant knowledge has produced the "privatization of trauma" (p. 105): an individualised and diminished social response to gendered sexual violence, whereby women have become a psychological subject as a result of the "pathologisation of violence against us" (Thompson, 2020, p. 105).

In effect, a type of psychiatrisation occurs when women are subjected to a categorisation process to understand and describe the conditions of their lives as symptoms, disconnected from their embodied effects. This process produces an enactment of suffering through a kind of colonial recruitment (Mills, 2014; Rose, 1998; Thompson, 2020) of psychiatric subjects, whereby mental illness is restricted, diagnosed and controlled by discriminative relations of power (Thompson, 2020). Psychologists then listen to women's painful memories and they are heard through a particular regime of intelligibility of the psy-disciplines. Psychology is told through a narrative of scientific objectivity, produced and authorised through a particular gendered moral order that is sanctioned as legitimate in institutional and social power relations (Coombes & Morgan, 2004). In claiming gender neutrality, psychologists are at risk of over or under-diagnosing (individualising sociocultural structures/systems of violence as individual pathology, or disregarding women's pain and distress due to gendered assumptions of the 'hysterical woman'), and both have the power to produce "mechanisms of social control over women" (Marecek et al., 1991, p. 524). As this knowledge travels through our socio-political landscape, women become produced through their biological difference as mad, bad, and/or sad - their excess of emotion needing to be brought under patriarchal control (Ussher, 2010; 2013). Recognising that affect is tightly bound up with meaning making, how might we re-imagine our understanding of the relationship between pain and suffering, as we attend to the struggles to find our place in the affective history of feminism and psychology?

Medical professionals shaped my mother's symptoms into a 'biomedical paradigm', ignoring the conditions of her everyday life, disciplining her body as a woman who can not be heard (Bartky, 1995, Foucault, 1978, 1980). Eventually, my mother was diagnosed with Borderline Personality Disorder (BPD): a disorder of emotion strongly associated with the

feminine body, where women are accounted for in 75% of all cases (Valero et al., 2025). BPD is a diagnosis often given to women with abuse and trauma backgrounds, for their 'behaviours' that are markedly different from the normalised cultural narrative (Herman, 1992; Herman et al., 1989; Steris, 2013), emergent from a history of classification that characterises personality disorders configured through relationships with hysteria (Coombes & Morgan, 2004; Ussher, 2013). I remember the dis-ease that I felt when I recognized that my mother's suffering was understood through a gendered body where her excess of emotion, the inscription of hysterical woman, was both enacted and embodied as suffering. Remembering my mother's figuration, her emotional excess, and her non-compliance to treatment, I recognise them now as symptoms of the normalisation of patriarchal knowledge and the subjectification of the category woman. And as I made sense of the conditions that made my mother's story (and mine) untellable, I had the recognition that it was too risky and too exhausting, and in the affective flows emerges a figuration of a woman who experiences severe distress as a result of sexual violence 'done' to them. Untellability here, is recognition of our disciplinary power relations that limit what can be said.

Resisting the Singular Story Through Feminist Therapy in Psychology

"Stories matter. Many stories matter. Stories have been used to dispossess and to malign, but stories can also be used to empower and to humanize. Stories can break the dignity of a people, but stories can also repair that broken dignity…When we reject the single story when we realize that there is never a single story about any place, we regain a kind of paradise."
(Adichie, 2009, 17.28)

It matters what stories tell stories and the notion of telling as a requirement for a competent narration is not straight forward. Untellability becomes linked to the chaos not only of the story of sexual abuse, but to the everyday conditions of the patriarchal, individualised, gendered power relations that limit what can be said – the "silencing or degenerative chaos producing effect on personal narrative" (Goldstein, 2012, p.184). As I remember bearing witness to my mother's pain, I recognised her emotional responses to her conditions of everyday life were not about a singular account of her victimisation with effects she needed to recover from. I

struggled to find a location in the psy-literature that could recognise the untellability of her story. This led me on a journey of tracing what has been accomplished as narratives of pain circulate our therapeutic spaces, as each of us leaves an "interpretive fingerprint on the text, as each text slices a small paper cut into our souls" (Fine, 2017, p 2).

I recognise the circular narrative that tells the story of my mother's diagnosis as BPD and the criteria for the legitimacy that could not hear trauma, and whether PTSD might have held a different hearing. After World War II, psychology ignited an interest in a trauma response to returning soldiers based on evidence of long-term distress (Courtois, 2008). A new understanding of trauma was required as the soldiers were men, and therefore did not suffer from hysteria (located in woman's biological difference from men). First included in the third edition of the Diagnostic Statistical Manual of Mental Disorders third edition (DSM-III), Post Traumatic Stress Disorder (PTSD) is understood within a criterion framework, focusing on the threat to life and intense fear resulting from objectively alarming and distressing events, to make sense of symptoms such as nightmares and flashbacks, that had not been well understood before (Tseris, 2013). The emergence of PTSD as a recognised diagnosis was an opportunity for feminist psychologists to configure issues relevant to women's mental health, to bring into view women's experiences of trauma such as sexual violence (Brown, 2004; Wasco, 2003).

By adopting a trauma approach, feminist psychologists were called in to action, connecting sexual violence as a personal trauma to the gendered social power relations that formed the conditions of our everyday lives, including psychological knowledge of distress (Tseris, 2013). In this way, the impact of social and cultural norms that enact blame on women and the offending of the perpetrator becomes visible. The cause-effect linearity of the trauma model invited clinicians to consider "particular action" (Wasco, 2003), such as linking a traumatic event to a series of responses. However, a critical review of the framework showed the model limits the "contextual understandings of actions and reactions related to sexual violence" (Wasco, 2003, p. 311), because it could not recognise the affective flows of meaning making women experience in their everyday lives. Trauma as a singular event and organised through an understanding of symptoms, produces a singular story of trauma that excludes how gender, race, ability and class form the conditions of experiences of trauma and "manifestations of hurt" (Wasco, 2003, p. 313). The circulation of a singular story misses the affective flows through

which we make sense of our experiences as we embody our memories as shame, extending the 'hurt' through isolation and disconnection (Tseris, 2013; Wasco, 2003), constraining the potentials of trauma therapy to resist the repeated configurations of the hysterical woman.

Trauma therapy, however, did open space through which women's stories of pain became visible, through 'trauma talk', a system of meaning making that apprehends a system of discursive representations seek to pattern how experiences of gendered sexual violence can be told. For example, the terms wound, injury, emotional distress, brokenness and damage is a language that attempts to evoke an understanding of the impact of sexual violence, while at the same time providing a type of "diagnostic category" (Marecek, 1999, p.162) for PTSD: a movement through which women's responses to the violence enacted upon them is legitimated within the gaze of the clinic. Furthermore, the language also provides a framework for highlighting the responsibility of sexual abuse is with the perpetrators of violence – labelled as abusers, groomers, predators, and sex offenders – that unequivocally marks them as morally condemnable (Marecek, 1999) and shifts our engagement from the 'pathology' of women's responses to the violence those responses emerged from. The move toward a response-based understanding of sexual violence where women's pain is understood as legitimate responses to the violence enacted upon, them, and the responsibility for that pain is located with the abuser, has the potential to move us from our affective histories of embodied shame (Probyn, 2005) and does not hold women responsible as pathological failures for the violence, or for the interconnecting patriarchal and hegemonic effects of violence (Richmond et al., 2013).

Marecek's (1999) research, based on interviews with forty feminist therapists, wondered how feminist practitioners made sense of trauma talk in the counterspace of hearing women's stories of 'trauma'. For many participants, trauma talk assisted as a "rhetorical resource for voicing their objections, as feminists, to conventional diagnoses and the medical model" (Marecek, 1999, p. 162). Results showed many clinicians viewed diagnostic classifications (excluding PTSD) as an unethical use of a clinicians's power. The power relations that inform mental health care were regarded as "dehumanizing and anti-feminist" (Marecek, 1999, p. 164). However, she also noted a counter-narrative that mobilised an understanding of how the pathologised term 'victim' has the impact of divesting women's sense of agency (Marecek, 1999), by reducing them into distinct, symptoms (flashbacks, body memories). Through the trauma therapy framework, just as

the psychiatric model makes sense of clients' experiences as psychological distress, it becomes a cause-and-effect explanation for the pain, that reduces lived experience for "a uniform narrative: a singular cause reliably (even invariably) produces a fixed set of symptoms" (Marecek, 1991, p.165). And what we hear through the healing narrative in trauma talk, is a passive voice that seeks to remedy clients from the effects of sexual abuse and violence.

In this way, despite its early promises, the figure of the victim emerges again, as a psychologically distressed individual, who must meet the criteria of the singular story to be worthy of a response. Responses organised through an agreed collection of affective symptoms (flashbacks, body memories) reduces the meaning of our experiences to a singular story and does not recognise the structural (patriarchal) and gendered social power relations that condition our everyday lives, and the meaning of the experience is lost. How then, is the mobilisation of pathology able to connect with processes of healing? (Marecek, 1991; 1999). How is it possible to heal the pathology that produces the figure of the (passive) object of sexual abuse (victim) in therapy space? The singular story of victimisation demands an account of our embodied response to abuse in a coherent narrative, and without an active location in their own story, women's stories become untellable, and the 'victim' passively waits to transform into a survivor.
It matters what stories tell stories. Whose stories? How do we tell the untellable? How do we begin to ethically respond to the stories we hear, beyond the acoustics of the institution?

As I mapped the emergence of feminist psychology through the literature, connected with my own stories, I recognised the tensions working within the disciplinary boundaries of psychology and at the same time listened to the gendered conditions of everyday stories of pain. What was missing were the structural and social power relations that normalise gendered violence. So, I began again, seeking a counter-story, the practice of feminism and psychology as an ethical encounter with an(other).

Feminist therapy in psychology also emerged in response to the social movement responding to sexual violence, including child sexual abuse. By the 1980s, the feminist tenets, goals and promises of feminist therapy began to emerge in reviewed publications (Gilbert, 1980; Holroyd, 1976; Marecek & Kravetz, 1977; Rawlings & Carter, 1977; Worell 1980). The aim was to challenge the premise that counselling/psychotherapy is an

individually informed practice. Together, conscious raising groups voiced the importance of challenging two basic psychological premises: (1) women's experience of pain is personal and individualised, and (2) it is a phenomenon that can only be diminished by medical professionals (Evans et al., 2005). A chorus of voices formed to mobilise anti-rape movements and took action in resistance to male violence against women to end gendered social injustices through informed practice (Worell & Johnson, 2001). What emerged was a critique of the structural and social power relations that both produce and reproduce the normalisation of the subjugation of women. This was a "radical departure" from how violence against women had been normalised in the conditions of everyday life, and in mental health responses specifically (Evans et al., 2005).

As social movements proliferated, so too did the movements of western feminism(s) and the critiques of the harms of white feminism(s) that call to account how white feminism(s) exert power over 'other' women's racialised and sexualised bodies, in the same ways colonialism and patriarchy work together. By the 1990s, the challenge for feminist therapies was to reconsider the effects of race, ethnicity and class as texturing the therapeutic relationship (Enns, 1993; Evans et al., 2005), where an understanding of intersectionality opened spaces to engage with how the conditions of everyday experiences is embedded within multiple, intersecting power relations of domination and oppression. Olivia Espin (1994) drew attention to the intersections of culture and sexuality through her work with Latino women and Beverley Greene (1994) examined the intersection of diagnostic criteria and culture with African American women. And while feminist therapy began to open spaces for conversations about inclusivity (more categories of otherness), the subsuming of marginal voices within liberal discourses of diversity can be avoided by identifying the ways through which "social categories such as gender, class, sexuality and race are constituted, and this context itself is analyzed as constituted by these categories" (Salem, 2016, p. 11). The challenge becomes how therapy can be understood as re-telling our stories to recognise the conditions that produce them, toward changing the sociopolitical framework of psychological distress.

Located within poststructural feminist critique, Brown (2020, p. 83) argues that feminist narrative therapy, when responding to the telling of a trauma story, involves a process of

"double listening" – to hear what is difficult to speak. The practice of narrative therapy focuses on the "narrative metaphor" as a counterspace for change, centering on an individual's understanding of reality shaped through their narratives to make meaning out of their everyday lives (Lee, 1997). "Meta narratives" shape our beliefs and perceptions about ourselves "against dominant cultural stories about gender, race, class, sexual orientation, and other differences, as well as ongoing interactions with significant others in our lives" (Lee, 1997, p. 2). Narrative therapy enables a client to re-tell their everyday experiences as clinicians attempt to show how women's stories are never distinctively neutral. Instead, they are "embedded in dominant gendered stories that are central in maintaining the social construction of femininities in contemporary society" (Lee, 1997, p. 2). By providing resources through which to recognise their gendered social location, women's narratives can be re-told through a process of compassion and dignity (Lee, 1997), away from stories of shame and blame.

As a counsellor, engaged in a narrative practice of storying, I have made sense of the process of therapy that empowers women to reconstruct their stories away from pathology. In the safety of a therapeutic relationship, narrative therapy supports women to put together their stories, holding their voice and exploring events and the meanings they have placed on these experiences. In the process of telling and hearing, we could together make sense of the dominant and problematic narrative that limited how they understand their experience, and in that process create new and powerful narratives that have enduring potential. I have also born witness to the troubling revolving door, women already pathologised through their mental health journey, unable to express their distress and where the expression of emotion is understood through the hysterical figure. With Probyn's (2005) work I began to wonder about the enactment and embodiment of shame. As Probyn (2005) writes, "shame demands acknowledgment" (p. xii). I wondered how Probyn's writing might apprehend the multiple bodily expressions of the affective processes that are enacted and embodied through sexual abuse. I began to understand a missing piece of the cartography, the embodied shame produced in the singular pathologised story and wondered how we can build a collective voice of resistance that has the potential to understand the ways in which the enactment of gendered violence and the embodiment of shame are interwoven.

The Enactment of Gendered Sexual Violence and Embodiment of Shame

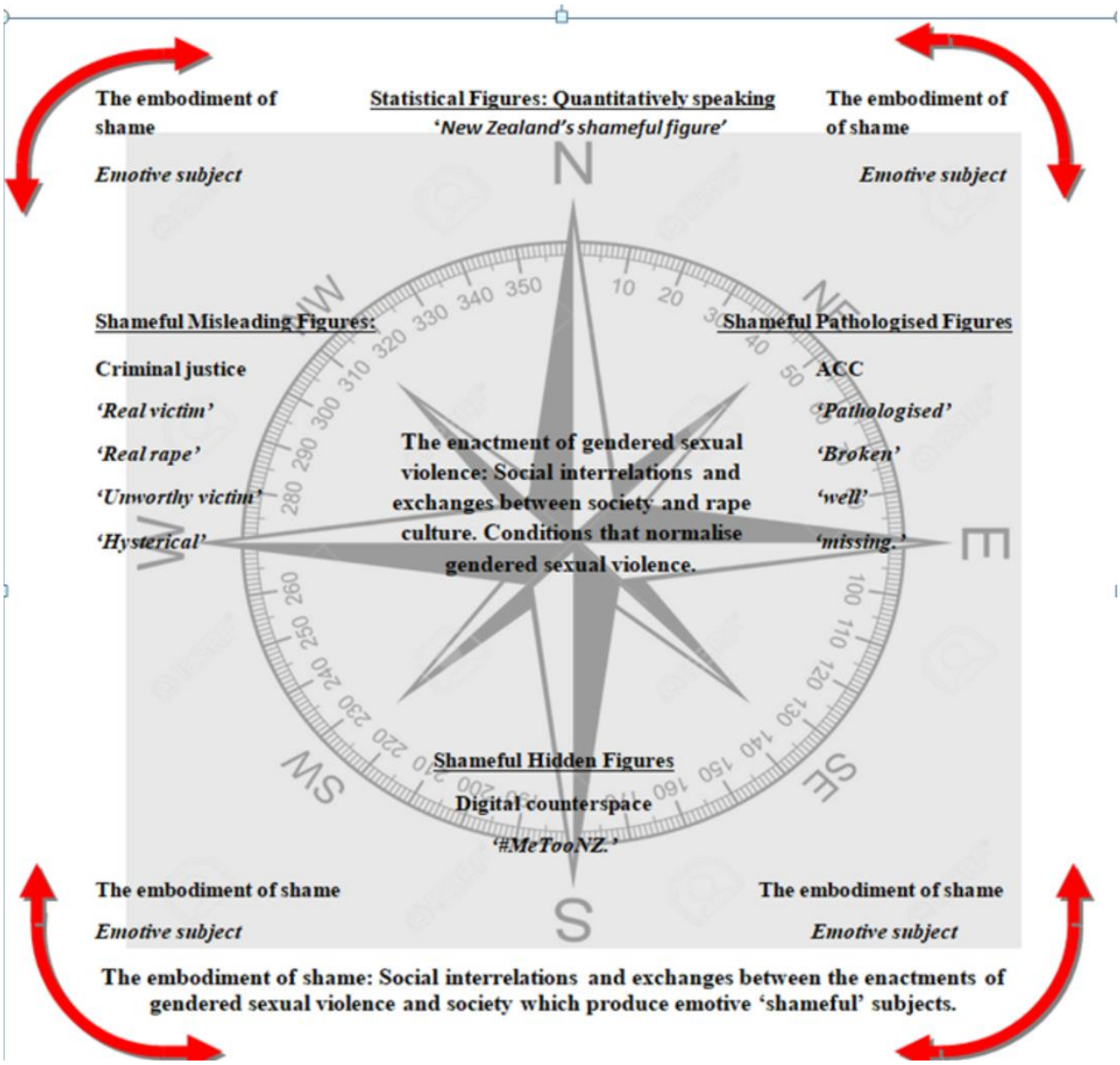
In my earlier research, I examined whether the digital feminist activist counterspace #Me-too[1] as a movement of resistance to the normalisation of gendered sexual violence, had the potential to transform the shameful statistical figures of gendered sexual violence in Aotearoa by recognising the structural and socio-political power relations that limit what can be said (Shelton, 2020). As a movement of resistance located within particular institutions, I acknowledged the emotional commitments to 'call out' the gendered power relations that operate through the normalisation of sexual violence. I was moved to make sense of the circulation of women's narratives of pain, and I recognised the violence of the untellable affective forces of responsibility that produce a shameful figure. I reimagined a process of a reflective practice that brought together two critical areas of feminist theory, the enactment of gendered sexual violence and the embodiment of shame. As intersecting forces, I produced a social compass that recognises the affective flow of responsibility as reconfiguring women's expression of pain into shameful subjects: real victims, unworthy victims, and hysterical women.

The social compass (Figure 3) was developed to provide a cartography for understanding how social and therapeutic counterspaces, without an understanding of the affective forces that form the conditions of women's lives, also reproduce institutional pathologised suffering.

[1] Me Too was firstly a black movement created by Tarana Burke as a response to the high prevalence of sexual violence against women of colour. The social movement was created to address intersectionality and advocate for the multiple subjectivities of Black women living in low socio-economic conditions. However, as the movement travelled, it became whitened globally as a phenomenon that drew attention to sexual harassment and sexual abuse of women being normalised the workplace.

Figure 3

The Social Compass (Shelton, 2020, p. 81).



Understanding the compass as a process of meaning making, I was able to locate the circulating narratives of shame in our institutionalised responses where gendered power relations are normalised and the boundaries between just sex and rape (Gavey, 2005) are contested, culturally. It recognises the shameful pathologised subjects that are configured within services that are set up to provide support to women with lived experiences of sexual violence. The social compass

provided me with an opening for understanding the interrelations between institutional systems that prioritise pathology, and the harmful effects as they become embodied in the experience. And I became interested in how the affective process of meaning making in the enactment and embodiment of shame can move us beyond the singular story of emotional pathology.

So, as I began to embed this research within the collaboration of narratives that have informed my process of moving the singular narrative, and imagined research that might add to the social compass, something of an opening for the possibilities that its application might have for clinical practice. I did not want to reproduce research that would require women's stories of pain to be told, nor did I want to reproduce stories of the institutional framing of the therapeutic process. And I was reminded of the affective flows of meaning making, including shame, that move beyond the generative "proliferation of objects, commodities and data which leave the power structure unchanged and unchallenged" (Braidotti, 2012, p. 344).

I started to make sense of the potentials of exiting the social compass, and charting a new path that moves us, as clinicians, to a reflective non-tolerance for the continued re-production of such harmful conditions. And I began to consider the potential of *thinking differently* in a process of delicate engagement with the criticality of "the collective transnational *movement of narratives*" (Fine, 2017, p. 2) to recognise the partial knowledges that inform our practices. I started to make sense of the power of narrative to apprehend affective intensities through a deeper understanding of what it means to be human and vulnerable, always in a process of *becoming* something. I began to wonder how we could move with the stories that we carry as clinicians (who hold the symbolic power of the discipline) to disrupt the institutions that pathologise women's stories of pain into psychologies of suffering.

The aim of this research was to hear clinician's shadow stories working in the gendered sexual violence sector, listening for the small (untold) ethical actions they mobilise in resistance to institutional practices that pathologise women's narratives of sexual violence. With a chorus of voices mobilising our expert knowledge, how can we make sense of the affective flows moving in and through our therapeutic relationships to both inform our practice and our ethical responsibility to disarticulate pain from suffering?

In the next chapter, I turn to my personal and professional reflections to articulate my shadow stories, and demonstrate how depathologised expressions of pain may provide an opening to consider pain as an affective flow with the power to transform human encounters with each other.

Chapter Three: Mobilising Shadow Stories

" I write for the still fragmented parts in me, trying to bring them together. Whoever can read and use any of this, I write for them as well." (Rich, 1983, p.540)

Depathologised Expressions of Pain: A Personal Reflection

Figure 4

Me at 13 Years Old

And I remember. I remember bearing witness to my mother's painful memories, and I also remember the affective flows of meaning making that followed my childhood emotional intensities (outbursts of anger, sadness, expression of confusions) as I expressed myself. I wasn't a quiet child. Living in a family already under the scrutiny of the psy-disciplines, I was retold as an oversensitive, difficult child and sent to therapy to become more compliant. As I now recognise, the clinician's kindness and desire to understand my pain to find strategies to

reduce my behaviours in the context of a diagnosis of Obsessive Compulsive Disorder that translated my excesses of emotion through the figure of the hysterical subject, left me confused. What I remember is how my body felt, shameful and empty. I so desperately wanted to talk to my mother about the intense feelings of disgust I felt about my body, but there were never any words that could begin to describe the experience. And together we remained separately silenced. There were no words that could be expressed within the conditions of surveillance of our bodily intensities, leaving the embodiment of shame embedded in our everyday materiality

And yet, there was another affective bodily intensity, and that was the experience of movement, and I gravitated toward music and dance. I remember the feeling flow through my body when placing my hand on the stereo to reach for vibrations. Dad always played old records, and I remember the freedom and love of moving my body in the art of dance. At eight years old, I recall my first dance class, the flows of expression in an art form not only moving my body, but the embodied shame I could not express in words. Feelings of anger, sadness, joy and pure electric energy became visible in the expression of dance.

Dance does not question how or why we move; instead, it allows us to flow with the bodily vibrations of sound and feelings - what I now recognise as affective intensities through expressions of movement. And in the process, I reconfigure my experience of embodied shame, and a new bodily intensity emerges, transforming from trapped and tormented to powerful and moving. In a sense, I had an experience of *becoming* human once again, no longer an empty vessel or body without organs (Braidotti, 1994) but a powerful body with the potential for new freedoms, new joy.

Recognising the interconnection between my body and affect, moments on stage became a transformational praxis to perform affective intensity as an art form. The audience witnesses the beauty of affective intensity as a powerful metamorphosis that enables genuine hearing - no longer perceiving pain as a cacophony of symptoms but as a movement with the potential to affect and be affected (Braidotti, 2017). Through my reading of Braidotti, I can re-imagine the performance as an assemblage of which they (the audience) become a part implicitly, in what I make sense of as a *relational affective intensity*. In this moment of recognition, I open a space

to consider the potential in depathologising painful narratives to hear affective intensities, which move from individual experiences of embodied shame to *relational affective intensities* – a hearing of pain for real. I am not required to "tell" my story, and dancing with lyrics to songs opens the space to many readings, but in that moment, it was my story I was connecting to, and through the affective intensity, the audience was able to connect with and legitimate my story through love and experience joy in the moment with me. The potential for storytelling, for thinking differently, for hearing the movements of affective intensities move us into a relationship of transformation.

I remember the particular lyrics to the song "Courage to Change" by artist Sia (2020, track 8) and how they moved me to recognise pain as a *relational affective intensity* that enabled the relationship between my mother and me to become re-told, just as I imagine the potential in creativity to story the relational affective intensities as a process of meaning making.

> [Verse 1]
>
> World, I want to leave you better
>
> I want my life to matter
>
> I am afraid I have no purpose here
>
> I watch the news on TV
>
> Abandon myself daily
>
> I am afraid to let you see the real me
>
> [Pre-Chorus]
>
> Rain, it falls, rain, it falls
>
> Pouring on me
>
> And the rain, it falls, rain, it falls
>
> Sowing the seeds of love and hope, love and hope

We don't have to stay, stuck in the weeds.

It was the feeling of the hearing of the singer's pain that enabled me to also rethink the intensities of pain not as a 'consequence', but as embodied connections. While my mother's painful memories remained untellable except through her affective intensities, I could hear the connections in and through my body, in a complex set of relationships and movements. What was evoked for me was a deep, deep sense of sadness and grief for my mother's cycle of harm in mental health services, and a recognition of feeling 'stuck' led me too to the movement of my journey with love and hope as a survivor, daughter, feminist clinician and researcher (my multiple locations in the chorus of voices that seek to change the apprehension of women's pain). Making sense of painful memories as a relational affective intensity, I transformed back to a daughter - no longer an assemblage of pathologisation - but moving through, and with, a powerful transformational process of becoming free from the constraints of institutional pathologisation. It is movement from listening to pathology to hearing pain for real, embedded and embodied, that provokes creative interruptions and affective intensities as a relational assemblage. And I began to imagine how we as clinicians might also move with imperceptibility, creatively transforming the relationship between hearing and becoming response-able.

I remember the conversations with other professionals where time and time again, we share stories of our amazement for the creative ways women do "tell" their stories. And I also remember, again, the tensions that women face, now, in our current socio-political responses to sexual violence where women are subjected to the demands of assessment, a process through which they are required to answer specific questions that do not dignify affective intensities. As I bring together memories of women's stories that I have heard through practice, I hear a dominant story of the process of assessment and the harmful effects of there being no understanding of the embodied effects – the smells, the fear, the terror, the feelings of inarticulable paralysis - and how they become entangled with feelings of shame and blame.
I became moved into action. I recognised the patterning of the figuration of the psychologically distressed subject as type of empty vessel or a body without organs (Braidotti, 1994) as a process that links pain to psychological suffering, and the enactment of the clinical gaze as a

harmful response. I began to question the profound emotional intensity commensurable to the movement of a body's capacity to act.

Thinking of my potentials as part of the assemblage of institutional pathologised suffering, I too experienced moments of affective intensity as I heard and recognised the suffering that become the conditions of untellability. And I remember, at times, feelings of inadequacy as I responded to the affective intensity, perhaps shedding a tear, within the demands of the institutional response that should distance me. And as I embodied the memories of creative transformations - poetry, writing, art - it became possible to hear the unsaying, as an energy with potential. It is in this space of imagining hearing differently that I recognise how the relationship between clinician and client moves through an ethical encounter of the affective flows of meaning making, and opens possibilities for what Braidotti (2008a) calls a process of disarticulating pain from suffering.

Braidotti Moves Me

"Wanting social justice and aspiring to a better world are deep desires. They are not just words on paper, but materially embedded projections of other ways of becoming human, in their complex, messy materiality." (Braidotti, 2022, p. 217)

Curious about the notion of disarticulating pain from suffering within the context of a long and textured feminist history of bringing sexual violence into view through women's accounts of violence and distress, I did not want to reproduce research that would only contribute to the "hawking of oppression stories" (Fine, 2017, p. 55) within a discipline that participates in and proliferates the categorisation of the effects of violence against women as pathology. Braidotti (2008) argues that it is in these times, these conditions, that we produce and reproduce a "diffuse social climate of mournful resignation, verging on melancholia" (Braidotti, 2008, p. 10). I began to think about the productive nature of emotions (Butler; 1990, 1992, 2006, Gilroy, 2000; Probyn, 2005), such as anger, sorrow, love, and yet, how the affective flows of meaning making, the expression of melancholia as relational loyalty to the pattern of a "collective memory of trauma and pain" (Braidotti, 2008b, p. 4), can work to reproduce negativity in responses to the social injustice that make demands of not only what we tell, but how we tell it,

reconfiguring us as hysterical subjects, suffering psychological distress. As I mobilise these shadow stories, I disrupt the notion that stories are 'political fiction' (Braidotti, 1994, p.4) and imagine an opening for creativity and affective capacity as an exit to the conditions of pathologised practice that produces suffering for women engaging in mental health services. Moving with Braidotti (2008a) into action collectively and collaboratively to re-imagine ethical non-violence, we can open spaces to articulate together our affective histories and open potential lines of new ways of knowing (Braidotti, 2008a, 2019b).

Braidotti (2010, 2022) asks us to think about ethical activism not as oppositional consciousness, but rather as a process of affirmation of engagement and resistance, to enact ethical actions with purpose. If not, a type of oppositional negativity emerges that "implies a belligerent act of negating the present conditions: a double negative that endangers an affirmative "response to painful narratives (Braidotti, 2010, p. 142). Therefore, activism becomes an affirmative assemblage of relationality. So, I return to the potentials of the affirmation of pain, not in its commodification, but in its transformation. Braidotti argues that pain is associated with suffering by force of practice and institution, and asks us to rethink pain through a transformation of meaning – not as an emotion but as a powerful affective process with the potential to effect change (Braidotti, 2006b, 2006c, 2008a, 2008b, 2022b).

As I engaged with Braidotti's notion of pain as transformational, I began to imagine how pain moves our embodied subjectivities. Braidotti (2008a) voices the importance of the subject's affect, and the capacity for interrelations with others: to affect and to be affected by them. Depathologising women's painful narratives informs us that subjectivity is not a singular experience but "consists of affectivity, inter-relationality and the impact of others" (Braidotti, 2008a, p. 18). I began to imagine the power of mobilising "de-psychologizing" (Braidotti, 2008a, p. 18) in the therapeutic counterspace to hear women's pain with purpose, working with a deeper understanding of living to find moments of joy and freedom (Braidotti, 2006c).

Braidotti (2024, p. 1) invites us to consider the importance of producing alternative knowledge outside the constraints of cognitive capitalism[2] and instead looks to the possibilities of "materialist politics as both a possible navigational strategy and an affirmative answer to our

[2]Moulier-Boutang (2011) recognises cognitive capitalism as a form of capitalism based on the accumulation of "immaterial capital"' the dissemination of knowledge and the driving role of the knowledge economy (p. 50).

troubled times". As I moved with Braidotti's politics of action, I began to imagine the transformative epistemic and ethical praxis that may emerge from a collaboration with practitioners and enacted collectively. How might we together become response-able to the affective flows of meaning making that condition our everyday lives?

The Process of Becoming Imperceptible

"Becoming imperceptible is the point of fusion between the self and his/her habitat, the cosmos. It marks the point of the evanescence of the self and its replacement by a living nexus of multiple interconnections that empower not the self, but the collective; not identity, but affirmative subjectivity; not consciousness, but affirmative interconnections." (Braidotti, 2006a, p. 154)

Braidotti (2001, 2015b, 2018, 2022) argues that affirmation calls for us to understand affect not as a singular emotional state located within the individual, but the broader material structural and systemic power relations that are enacted, embedded and embodied. Affirmation of difference can apprehend inter-relationality through attending to our politics of location, as well as the affective intensities that flow through and between bodies, affecting bodies' capacities to act (Braidotti, 2006b, 2022).

In the therapeutic counterspace, a *double shift* (Braidotti, 2013, p. 36) occurs when clinicians move from a frozen/reactive response to pain toward proactive and affirmative engagement with pain's transformational potentials. In understanding pain as a powerful affective intensity, we can imagine the potential in the therapeutic counterspace to reconfigure the conditions of pathology and suffering, to recognise moments of affective intensity as a transformational process – moving away from the melancholy embedded in the social conditions of everyday life that produce hysterical figures. What I was curious about were how we, as clinicians, can become conscious of the double shift Braidotti (2013) speaks of. In these moments of recognition what are the relational, embedded and embodied intensities than enable us to affect and be affected? It is this shift in hearing pain as an affective intensity that enables transformation on the boundaries of our discipline.

In the relational experience of bearing witness to pain, we witness the movement from pathologised bodies to human experiences, that we can relate to. We can open up a space for curiosity in the therapeutic counterspace, which shifts from the understanding of symptoms as the tellable story, to understanding affective flows of meaning making that connect us to our capacity to attain movement through making sense of our limits, together. I recognised that if affirmation is "about freedom from the burden of negativity, freedom through the understanding of our bondage" (Braidotti, 2013, p. 36), then there is potential for us to move beyond the constraints of the institution, and mobilise our knowledges in a movement of becoming imperceptible, a process that realises the deeply connected relationships that form the conditions of everyday lives. I became interested in the process between listening (for suffering) and hearing (affect) as a process of becoming imperceptible. How might the creative potential of hearing the affective flows of meaning making become an ethical encounter for action? And I became curious about other shadow stories that might travel imperceptibly among clinicians who also practice within the troubled relationship between pain and suffering. And I began to have tentative conversations.

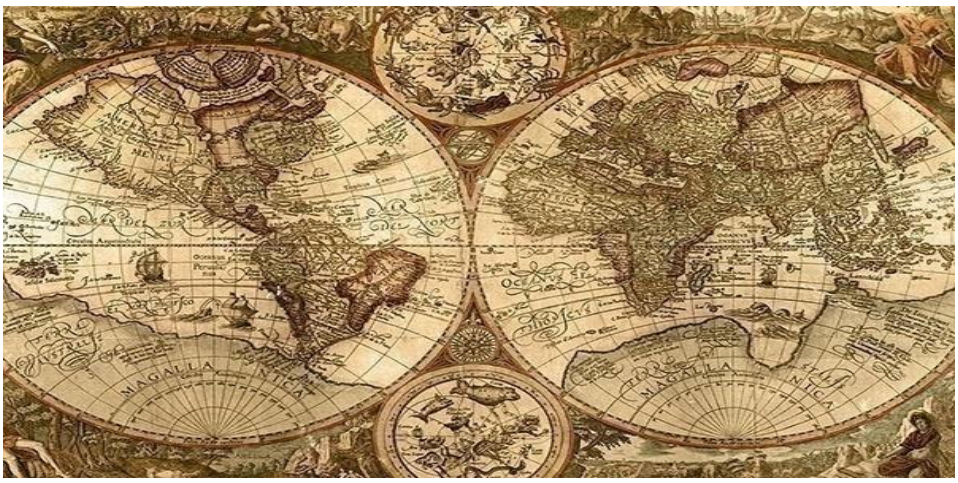
This research is interested in how a process of imperceptibility may evoke a political response to institutional pathologised suffering, transforming how we respond to women's experiences of pain. Moved through thinking (creatively) with affirmative ethics, I understand hearing as a relational process toward ethical response-ability for clinicians to mobilise in their everyday practice. So how do we tell our untellable stories, the shadow stories that open us to the potentials of affective moments of imperceptibility?

Chapter Four: Methodology and Method

"We need cartographies of subjectivity which adequately reflect the processes of flows, fragmentation, mutual interdependence, and mutations that mark our era. In ethics, as in social and political theory, we need to learn to think differently about ourselves and our systems of values, starting with the accounts of our embodied and embedded subjectivity." (Braidotti, 2008a, p. 27)

Figure 5

Imagining Cartographic Connections



Note: Retrieved from https://worldhistory.us/wp-content/uploads/2017/05/ancient-maps-and-cartography.jpg

A Reflective Cartography

Having traced the shadow stories of feminist clinical psychology as a process of cartography, I recognise how they have evolved in response to western knowledge claims that are productive of the conditions of the present as they circulate through cognitive capitalism to produce a figure of hysteria (Braidotti, 1994, 2011a, 2011b, 2018). Engaging with cartographies in this project fulfils a methodological function by providing moments of recognition of the movements of power that are relational – those that hold us in place as entrapment (potestas) and those that move us as empowerment (potentia) (Braidotti, 2018). The two locations of potesta and potentia

interrelate in a co-production of the subject as spatial and temporal, a process of interaction and exchanges (Braidotti, 2008b). Understanding their simultaneous presence, we can begin to aspire towards the importance of making sense of relational affective intensity, not merely as partial location on the map, but as a process of affirmation that has affective capacity. The affected body recognises the affect (usually as a bodily response or feeling) without necessarily being able to 'tell' the experience of intensity (Braidoti, 2006b, 2010b).

The ethics of affirmation and imperceptibility provides a cartography to enable me to track a location within the therapeutic counterspace for clinicians to recognise affective intensity as a relational process for transformational change. Politics of location as ethical activism demands that we, collectively, take up responsibility for our symbolic authority in the assemblages of power that produce the pathologisation of suffering, and respond to the social power relationships that advance social justice, with care and dignity, according to the code of ethics (NZ Psychologists Board, 2002). Respect for the dignity of people in their diversity and through their difference asks us to "embody explicit and mutual expectations of integrity" (p. 21) as an ethical relationship, and an ethical regard for care includes becoming response-able for the production of psychological knowledge (of suffering), including our participation in social and political systems.

Interested in the potentials for shadow stories in our collective memories of trauma and pain, I began to tentatively open spaces to begin thinking (as creativity) about the productive flows of affective meaning making that disrupt the demands of negativity, and circulate in and through the singular story of suffering psychological distress. How do we tell our stories of affective intensity as we pass each other in the corridors of practice? How do we hear the creative moments of the untellable in relationships with one another?

I remember, slowly and tentatively listening to the quiet conversations as we moved together through the assemblage of the corridors, connecting through feelings of isolation and hopelessness. What had troubled me was that there were no new ways to mobilise our collective voices into loud resistance (Fine, 2017). Our collective 'knowing' of affective flows of meaning making became untellable where our institutional responsibilities limit opportunities for reflexive practice, together. I wondered what knowledge could be produced as we engaged relational

reflective practices in our assemblage of becoming response-able (Deleuze & Guattari, 1987; Braidotti, 1994). Curious about the process of disarticulating pain from suffering as a relational affective intensity, how then does an ethics of affirmation enable us to move with the stories of pain reflexively, for action?

Developing a Collaborative Reflective Counterspace

"Wanting social justice and aspiring to a better world are deep desires. They are not just words on paper, but materially embedded projections of other ways of becoming human, in their complex, messy materiality." (Braidotti, 2022, p. 217)

I began to look back in order to move forward and the shadow stories from the corridors began to get louder, I recognised the potentials for collective ethical action. And I began to hear, more loudly, the relationships that were forming, moving in the spaces between institutional requirements and ethical practices that resist the pathologisation of women's pain. As I was beginning to mobilise a design for this research, I recognised how other shadow stories had added another layer of relationships to the design. I could hear a collective voice of response-ability through the voices emerging from the relationships formed in response to the conditions of institutional practice that produces psychological suffering, and I could began to imagine the potential movements that might be possible as we navigate the tensions between the institutional and ethical relationships that we practice. The beginnings of a reflective counterspace emerged through a collaborative process of meaning making with two of the shadow stories of resistance in particular, and I became we.

Through my previous research journey, I remember long conversations with Liza as we together made sense of the figurations of women's pathologisation of pain, and their reconfiguration as suffering from excess, and we also struggled with the embodied effects of our complicity in the assemblage of institutionalised practice. As I developed the social compass, Liza began to understand it as a reflective 'tool' through which we continued to share our experiences of working creatively as we resisted institutional limits to understanding women's experiences of sexual violence.

Below (Figure 6), I share Liza's reflection on how our collaborative understandings of the social

compass changed our practice (together) and started the process of developing this current project, evoking a response to institutional pathologised suffering away from stories of shame and blame as an ethical response-ability: how we can understand *hearing* as a relational process toward ethical response-ability for clinicians, that enables us to tell the potential of affective intensities as a dignified response to violence.

Figure 6

Liza's Reflection Letter

Liza's Reflection Letter 2020

I am a female Clinical Psychologist and work within the ACC Integrated Sensitive Claims Contract (ISSC)[3] both providing assessment and treatment for (primarily) women who have been exposed to sexual violence. My training was primarily in Cognitive Behavioural models but what I have found over ten years of practice was that none of these really spoke to the deeply intense and harmful shame that clients under ISSC presented with. The processing of traumatic memories to unpack the shame, fear and guilt attached to them is the primary therapeutic mode of helping these women. It is a profound privilege to see this embodied shame lifting, to see them re-engage with life, to dress more brightly, relax on the therapy couch, to feel safe, heard and free of blame.

Through reading this Masters thesis and engaging in deep discussions with the author I have found myself questioning my therapy, my training and the ACC process. I noticed I have begun to talk about the wider social and systemic issues of misogyny, rape culture and shame with my clients. They have responded with relief, as this addresses the often-asked questions of "Why me?" and "Why can't I get over this?" and "I must be the only one." This also allows them to position themselves as a collective female voice and experience another emotion: anger, which I have come to realise is a necessary space that clients need to travel to on their path to exit the compass. When a perpetrator is a family this becomes complicated, but allowing them to look at the wider picture beyond the individual, beyond whānau to

[3] The Accident Compensation Corporation (ACC) Integrated Sensitive Claims Contract (ISSC) is an institutional response to sexual victimisation in Aotearoa New Zealand that offers fully funded support, treatment and assessment services for victims/survivors of sexual abuse or assault (Accident Compensation Corporation, 2023).

societal acceptance of rape myths can give clients permission to feel angry without the guilt and helps them to see how and why this happened to them. It has also allowed me as a therapist and woman to understand gendered sexual violence in a more nuanced and feminist-centred way, particularly as someone who is white, middle-class and has not experienced gendered sexual violence personally.

In terms of clinical training in Aotearoa, formulation within a CBT framework is highly valued but there is scant attention paid to wider social and institutional responses to mental health and to sexual violence, instead, training programmes focus on the individual formulation for clients ignoring vital pieces of the formulation puzzle. The psychologist is also encouraged to hold firm "boundaries" and to not insert themselves into the process. What I have learned through my therapy experiences, my own research into therapeutic alliance and this thesis is that the therapy relationship is hugely important in this work and that we need to have this as part of our training. Giving only your name and years in practice to a client while dressed impeccably in a suit and heels can make a therapist seem like the perfect, mentally healthy standard which can surely only intensify the shame of a client who may already hold figures of unworthiness, feeling broken and "crazy." What I have noticed is that when the therapeutic relationship is built on healthy self-disclosure, empathy and warmth then clients feel comfortable to bring up trauma memories in an organic way rather than having therapy be yet another thing "done" to them. This goes against the grain of much of the clinical training and personally was one of the reasons I felt unqualified to pursue this kind of work for many years.

Lastly and most importantly I have realised just how problematic the ACC ISSC system is. When a client needs to undergo three different phases of assessment one of which requires a diagnosis for them to progress to "treatment" it positions them immediately to feel as if they must "prove" their mental health has suffered as a result. The gaps in waiting for each part are non-therapeutic, to say the least, as a client who has never disclosed to anyone and has found the courage to discuss it may wait three weeks until they can visit again. As one of my recent clients put it "How is this supposed to help me?" Women who have already been constrained by silencing from their perpetrator and perhaps family members, and condemnation from a society that blames them are further squeezed into tick boxes, checklists and criteria. I can see this compass becoming a vital tool used in training psychologists and therapists, in improving

> the ACC system and in igniting a new wave of feminist social movement in Aotearoa that refuses to be silent in the face of gendered sexual violence.

The social compass allowed us to visualise how women are positioned in the interrelationship between the enactment of gendered sexual violence and the embodiment of shame, through the power relations that form the conditions of their everyday lives, in multiple movements that configure the simultaneous enactment and embodiment of shame. In developing our ethical relationship with each other, Liza and I engaged in a process of becoming response-able as we recognised our part in the assemblage of pathologisation working under institutional constraints, and we began a process of reflection together.

It became important that the ethical activism that we both sought was the prioritisation of reflective practices within the clinical space, where we could begin conversations about the impact of listening to stories of pain as an affective intensity that had the potential to move us into action within our discipline, and in the sector. What mattered was movement, the movement into a relational practice of storytelling, making sense of painful stories in a process of disarticulating pain from suffering. We began to open a space for our colleagues to come together to talk about stories of pain and how these stories moved us to advocate for a transformation of our practices within the institution. We began conversations about affective flows of meaning making, through our experiences of listening to women's stories of gendered sexual violence. As we worked together to establish a process of an "adequate understanding" of the conditions that are both embodied and embedded locations in our practices, we also began to make sense of affirmative ethics in practice – the consciousness of a relational understanding of affect, and "liberating normativity from its negative underpinning, attaching it instead to affirmation" (Braidotti. 2024, p.25). However, when attempting to organise reflective spaces within the institutional constraints on time, such openings became impossible. However, the 'we' remained active. Moving into peer supervision, we returned to the social compass as a touchstone and we began to imagine how to bring together a reflective workshop that could deepen our understandings of the affective flows of meaning making through our collective responsibilities. The words of Braidotti echoed once again:

> Political activism can be all the more effective if it disengages the process of consciousness-raising from negativity and connects it instead to creative affirmation and the actualization of virtual potentials. Because these are by definition not contained in the present conditions, and cannot emerge from them, they have to be brought about or generated creatively by a qualitative leap of the collective praxis and of our ethical imagination (Braidotti, 2015b, p. 53).

This project was born from my desire to take a "qualitative leap" (Braidotti, 2015a, p. 53), and create the conditions necessary to build an affirmative reflective practice that reimagines the constraints of institutional power relations. Recognising our process of connection through a praxis, as a deeper understanding of the interrelationship between the enactment and embodiment of pain and shame, is a location of *privilege*. Through affirmative ethics as praxis, it is how we move from pain, not as suffering by force of practice and institution, but as transformative of the *conditions of a hearing*.

And We Becomes Three

Remembering with shadow stories, Ani too emerges through the life of the corridors, where we would understand each other through our resistance to the psy-discipline of individual pathology of women's pain and recognised psychology's knowledge claims as partial. Relationally too, we connected with each other as she told stories of how she worked culturally in her clinical work, as resistance to the coloniality of the knowledge that pathologises Māori women's experiences. I experienced her mana[4] as she spoke her resistance in meetings where I could only feel inadequate. And I began to understand the relational process of the affirmation of difference, together but not in sameness (Braidotti, 2011a). As we began a collaborative process of meaning making that endures and exceeds the forceful demands of colonial patriarchy (Mikaere, 1999) through an affirmative process that recognised all knowledges are necessarily partial and incomplete, we created the conditions for more stories to emerge (Fine, 2017, p.284), evoking a

[4] (In te reo Māori) Mana refers to prestige, power, infulence, spiritual power (Moorefield, 2011).

movement, a feeling, a recognition of the ways we make sense of ourselves and each other. And I am reminded of Ani speaking her resistance, and how research that is responsive to relational meaning making necessarily involves decolonising our knowledge claims through a process of disarticulation of our knowledge and ourselves through a willingness to hear (Waitere & Johnston, 2009).

Waitere and Johnston (2009) argue that telling stories, resisting the partiality of our disciplinary knowledge, does not guarantee a hearing within the acoustics of the institution. As Waitere and Johnston argue, speaking and listening are not separable as "productive and receptive modes" (p. 14) because to listen and hear requires active participation through a relational process of meaning making. Māori women are completely aware of the inequities in the conditions of their everyday lives; however, they are often excluded from the spaces that attempt to resolve such dilemmas—they are "physically present, often vocally absent" (p. 6). And as Mikaere (2021) argues, in the end it is the "imposition of patriarchy" that has endured in the ongoing process of colonisation for Māori women (p. 14). To better understand the conditions for gendered sexual violence requires an understanding of how colonisation has shaped the conditions for sexual violence, which for Mikaere, is located at the moment where the normalisation of western imperialism that subjugates women's racialised and sexualised bodies is enacted through violence. Ethical activism, then, is also a process of hearing, beyond the institutional acoustics to challenge the "hegemony of rational, masculine and empirical discourses that continue to marginalise and silence Māori women's knowledges" (Simmonds, 2011, p. 16).

Transforming the conditions for hearing became a collective value for ethical practice as the three of 'we' brought our excitement about the possibilities for working together, weaving a collective relational assemblage to the interrelationships between institutional and therapeutic practices to begin the process of becoming response-able clinicians. And it is through these relationships that the design of the workshop emerged – a reflective counterspace workshop for clinicians working in the gendered sexual violence sector to come together to reimagine affective intensity through affirmative ethics, and produce new and creative ways for hearing women's stories of pain.

Method

The Workshop Design

The workshop, like our collaboration, opened with Liza, Ani and I drawing on the social compass to demonstrate the shameful figures produced within the conditions of pathologised practice (see PowerPoint presentation, Appendix A). The social compass as a visual representation of the complex interweaving of the enactment of gendered sexual violence and the embodiment of shame aimed to open spaces for exploring the transformative potentials of moving from the clinical view of women as 'shameful figures' to 'fix' towards a reimagining of relational affective intensity as a pathway to *hearing* pain affirmatively - an active movement in the therapeutic counterspace. Such movement aimed to provide a site at which we could consider how we may reconfigure the therapeutic counterspace to become an affirmative space to produce response-able knowledge that actively moves women from pathologised subjects to human ethical encounters that "commit political density" (Braidotti, 2011, p. 61); that is, they have a "commitment to account for the material conditions that sustain these different subject positions" (Braidotti, 20110., p. 11).

Research Process

This research is located at the nexus of institutional and practice as an ethical relationship of response-ability. Informed by the code of ethics that guides practice, it makes sense of *how* our ethical responsibilities to respect the dignity of people in a process of affirmation of difference requires us to embody the ethical relationship in a process of affirmation, through a transformation of listening to hearing. Our ethical response-ability to care includes becoming response-able for the production of psychological knowledge (suffering), including our participation in social and political systems.

As this research had as its aim to gain a deeper understanding of difference, not through the pejorative of western knowledge claims, but through a politics of affirmation of the multiplicities, complexities and partialities of our interrelations with the world and each other through our relational encounters, it is an embodied ethical responsibility to hear beyond the acoustics of the institution. Hearing through an ethical process of meaning making opens spaces for the affirmative potentials for knowledges that are partial and relational (Braidotti, 2012; Haraway 1988; Given, 2008; Simmonds, 2011). This requires a recognition that dominant

western knowledge claims serve as a partial, limited knowledge system, and an understanding of the power relations that authorise what narratives, legitimated through our disciplinary practices (Haraway, 1988; Harding, 1992), produce the figure of pathological suffering. Working with hearing as an ethical responsibility of care (Hydén, 2013), it becomes a process where we are moved to hear the affective flows of meaning making to become response-able to the gendered conditions of women's everyday lives.

The institutional location that responds to women's stories of pain, creates the conditions of untellability that have silenced women's affective histories that are outside the dominant story of psychological suffering. How do we make sense of the conditions of women's pain, without hearing the affective history of our colonial and patriarchal institutional practices, the 'knowledge' technologies that discipline our bodies, the violences of difference that render our experiences as untellable?

Understanding relational ethics as a process through which we can transform pain through the politics of affirmation, it then becomes possible to make sense of the movement from listening, to hearing pain as an affective flow of meaning making, a movement of affective flow that brings back the 'felt' body in (e)motion (Braidotti, 2008a, 2008b, 2010b). As we move through affect, we become affected. Moved through thinking (creatively) with affirmative ethics, I understand hearing as a relational process toward becoming ethically response-able for clinicians to mobilise in their everyday practice.

Research generated creatively by a qualitative leap of collective praxis and of our ethical imagination (Braidotti, 2015a) mobilises the qualitative criterion that frames the ethics of affirmation. Cast as a method, a process of "defamiliarizing our habits of thought in a new direction" (Braidotti, 2015b, p. 53) imagines a counterspace as a process of activating professionals to enter into new affective assemblages and relations in the co-creation of alternative ways of understanding knowledge systems and women's affective intensities.

Ethical Conduct

This research was designed as a workshop for practitioners working in the gendered sexual violence sector, in Aotearoa New Zealand, so to participate, they needed to be actively working

in the field of sexual violence, affiliated with a professional body, have a current annual practicing certificate (APC), and be engaged in supervision. These criteria establish the ethical relationships that form the institutional requirements for those working in the sector and who occupy a specific location in the space of response to women's pain through psychological suffering. Therefore, as a workshop among professionals who are, through their practicing certificates, in relationships where they are supported to have these reflective conversations, the project was assessed as low risk through the Massey University Human Ethics Committee peers process However, the normalisation of violence against women has persisted in the conditions of our everyday lives, embedded in social structures and systems that reproduce the conditions for sexual violence (Ethics Notification – 4000024265).

The number of participants for a reflective counterspace was intended to be larger than the three collaborators, but small enough to enable a deeper more nuanced conversation, bringing the untellable into the richness of our collective accounts. The participants were all clinicians who responded to the call for developing reflective practice within institutional systems through affirmative ethics. Therefore, the recruitment of participants was through relational networks with the researcher, including Liza and Ani. We spoke about the potentials of attending a workshop that contributed to the knowledge produced in this research, and as the information sheet (Appendix B) circled through various pathways, potential participants were invited to register to attend. With Liza and Ani, four further participants registered to take part in the workshop. And the collective became seven. As an assemblage that requires recognising creativity and relational affective intensity as a pathway to becoming response-able with affirmative ethics, the organisation of consent is understood as an ongoing process of negotiation. Participant consent forms (Appendix C) were signed on the day of the workshop, as we agreed together on the terms of consent, together. Therefore, before commencing the workshop we revisited what the research was doing, and what they were consenting to.

The professional representation in the group were two social workers, a psychotherapist, two clinical psychologists, a mental health nurse and a counsellor. Five participants identified as New Zealand European, one identified as New Zealand European/Māori, and one identified as Māori. Six participants were women, and one was a man.

Negotiating Ethical Relationships

Although the project was assessed as low risk in the context of the University's procedural ethical processes, this does not imply there were no ethical tensions to consider. A conscious decision was made to weave ethical responses throughout every aspect of this project, mobilising an ethics of affirmation. It is important to emphasise this project does not view ethics as a singular narrative. Instead, the foundations are based on collective responses that are "relational, embedded and embodied social positions" (Braidotti, 2011, p.4).

Thinking with processes of confidentiality, and our ethical obligation to not disclose client information, we discussed how to story our stories, prior to recording the workshop. We also discussed the confidentiality of the group, again mobilising the ethical practice of our professional training. Understanding too, that stories move us, we attended to how we could move in and out of the space safely, should we need a moment, knowing the recording would continue.

Confidentiality and respect for privacy were also discussed as a responsibility to protect the participants' identities within the research, through the use of pseudonyms, removing personal and workplace identifying information from the transcript, and the audio recording was password protected.

As we begin to understand ourselves in a research process, through the politics of affirmation as the beginnings of becoming response-able to each other and to the clients with whom we work, it is impossible to separate our lived experiences from knowledge production in the therapeutic counterspace, and therefore we understand together, that the research process is provoking us into action, through our relational, embedded and embodied social positions.

As a researcher - participant, the responsibilities for hearing to produce new forms of knowledge and practice that are responsive to the gendered conditions of everyday life, including legitimate ways of representing the affective histories of women's stories of pain, are not easy. And I am reminded of the responsibility for the requisite of telling a cohesive narrative through the 'risky business' of telling something of the untellability (the structural power relationships that are colonial, patriarchal, individualised and gendered) that produce

psychological suffering in our institutional practices. It matters what stories tell stories, and yet the notion of telling a coherent story remains troubling in the affective flows of meaning making that bring us into a relationship, emotionally connecting us and the research toward certain actions. Bringing together our stories of our affective histories into a relationship emotionally connects us with the many stories that we hear. Listening to stories of sexual violence do have emotional impacts as we hear intimate accounts of pain, violence, anger and often sadness, which, according to Keene (2022), linger in our work and beyond. I remember too, the gasps of breath, the tears, the relief as we made sense, together, of our affective histories. It is never about one.

Analysis

Storying the analysis is an iterative process of the situated and accountable location of knowledge, as we enter modes of relation through the workshop counterspace. The workshop counterspace is entangled in a relation of knowledge production where meaning making and the production of knowledge are always in a process of becoming response-able (Braidotti, 1991, 2006b; Braidotti & Regan, 2017). The workshop was the space to recognise our process of connection through affirmative ethics as praxis: how we move from pain, not as suffering by force of practice and institution, but as transformative of the conditions of a hearing.

Drawing on affirmative ethics to recognise the relational experience of bearing witness to pain, the analysis moves with how we made sense of shifting our understanding of symptoms as the 'tellable' story, through understanding the affective flows of meaning making that make sense of our limits. We began a process of disarticulating pain from suffering as a relational affective intensity.

As we move away from listening through institutional acoustics, to hearing pain as an affective intensity, I traced, in the analysis, the affective flows of meaning making through the workshop counterspace, recognising the moments for bringing in the affective body – those imperceptible moments that bring back motion into (e)motion (Braidotti, 2010b). I also traced the movements through affirmative ethics: the relational, embedded and embodied intensities to affect and become affected as a potential that hearing affective intensity can offer as an ethical reflective practice. The analysis also connects how we tell our untellable stories, together.

As the analysis moves with the workshop counterspace - the process between listening (for suffering) and hearing (affect) as a process of becoming imperceptible - I also traced our process of hearing the affective flows of meaning making and their potential to become an ethical encounter for action, in the therapeutic counterspace. As such, the analysis traces our movement through the workshop counterspace, reflecting on how we hear, together, loud and quiet resistances that move us to consider other possibilities

Responsible for bringing coherence to the text, I became aware of the problem of the tensions in representing the tellablity of the embodied affective flows of meaning making, those moments of hearing the body, and mobilising our understanding of affective flows of meaning making, in all our bodily senses. The analysis then, follows the enduring twists and turns along the pathways of our locations that moved us in and through differing embodiments and material relations. I have represented each participant through a distinctive font to bring into view the humanness of each participant, while showing the collective flows of relational meaning making as we moved together.

The following chapters trace the affective flows of mobilising our collective voice, as we-together collaboratively and curiously reflect on the movement from listening to pain as pathology, to hearing affective intensities as response-ability. As we move, we evoke our expert knowledges and unite as a chorus of voices – a relational assemblage - that speak with authority to processes of transforming the therapeutic counterspace, and the institutions in which they are embedded, in order to provide dignified responses to women's pain.

Chapter Five : The Workshop as a Counterspace to Discuss, Reflect, and Collaborate

"The physical dimension is only one aspect; mobility also refers to the intellectual space of creativity, that is to say, the freedom to invent new ways of conducting our lives, new schemes of representation of ourselves." (Braidotti, 1994, p. 256)

Opening a Space for Reflection

We, the participants, were all clinicians who responded to the call for a workshop on reflective practice within institutional systems that respond to sexual violence. We were well informed by the echo of conversations in the corridors of our work with each other through networks in the gendered sexual violence sector: the relationships that formed the shadow stories that brought the workshop into life. However, we had not met together before as a group intentionally connected through our participation in a reflective workshop counterspace, meeting together specifically to produce research that seeks to transform the relationship between pain and suffering through affirmative ethics of our double location, both institutional and response-able clinicians.

Ani opened the workshop with a karakia[5] and connected us through a process of whakawhanaungatanga [6]into the sacred space of reflection. The significance of the process of connection was an invitation to engage collaboratively through ethical relationships with each other and to open space for the recognition of affective relations. To connect together in this space of relating with/to one another in the workshop, Ani and Liza and I introduced our connections to each other through our reflective shadow stories as we discussed the mobilising moments that brought us together into this space.

Locating movement in this workshop, as we introduced our shadow stories, we opened with purpose. The recognition of our location(s) in the assemblage of institutional practices that authorise the pathological figure of women's suffering. And the embodied effects of our hearing the painful narratives of these figurations as they are reproduced, and circle, through women's engagement with mental health services.

[5] Karakia is to recite ritual chants, say grace, pray, recite a prayer, chant.
[6] Whakawhanaungatanga is a process of establishing relationships, relating well to others.

So, I began with the story of making sense of my bearing witness to my mother's journey, and how I began to understand the harms of psychological knowledge as it became enacted and embodied in a set of power relations that responded to my mother's pain through a gendered system of meaning making that held her responsible for her compliance to their authority. I connected this story with my process of becoming a clinician, trying to make sense of the affective forces that form the conditions of women's lives and how I began to locate the circulating narrative of shame as an affective flow of responsibility – enacted in the relations of power between institutional systems that prioritise pathology and the harmful effects of the response that produces psychological suffering. The social compass became a cartographical metaphor that allowed us to illuminate aspects of the present. How do we critically accept the present, knowing the harmful practices, but also move with qualitative shifts in the conditions of the production of knowledge. The social compass as it emerged through the shadow stories, held us stuck on the points of the compass and did not provide pathways that enabled an exit but rather opened space for discussion of the tensions that we embody. As I wove these stories through the presentation of the social compass, we began, together (Ani, Liz and I), to create an assemblage that recognised the suffering enacted through the forces of institutional knowledge of pain that reinscribes gendered violence through its response. I also brought with me a feeling of inadequacy, a vulnerability to becoming recognised as too responsive to women's stories of pain, and of fearing I was failing to meet the responsibilities of ethical clinical practice.

Vulnerability to the affective flows of meaning making introduces a connection to bringing in the untellable: the structural power relations of the institution that reproduces gendered violence through their knowledge of women's pathology, and the re-enactment of violence in and through institutional practices. And we began to connect with each other through our recognition of the structural violences women endure through the institutional response to their pain, as we told how our shadow stories recognise the experiences of feeling, hearing and holding stories of pain.

> Ani: When you talked about them [women] being, umm, having them being re-enacted on, again and again, something comes to mind where this young person told me that they had to go through this gruelling process of being questioned and stuff like that to get [institutional] approval and then went through another gruelling couple of hours to be fed back the report and was umm dropped off home by a male they didn't know after that report was fed back and just the fear and the anguish, how they felt about being dropped

> home by someone and they [institution] thought that was ok… by an unknown male… and it baffled me I just couldn't comprehend why that was done.

Ani recognises the movement of gendered social power relations enacted on clients through making sense of an affective intensity, her embodied response of hearing the process of assessment as gruelling. Then, having been delivered a diagnosis in response, she recognises how the gendered conditions of the sexual violence were ignored in their 'care', using an unknown male driver to drop her home alone. Hearing her clients fear and anguish, Ani could not comprehend how this could be understood as ethical practice. This is a narrative that resonated with Liza, as she too witnessed the re-enactment of gendered violence in the institutional response and connected this to how the experience travels through multiple institutional practices that require a singular story of evidence that is then allocated a financial cost response to the assessed fragments of a painful story.

> Liza: Yeah… if you think about if someone has come forward and told parents or partner or if they have come forward to the police, they go through the court system, then [the institution] to get the therapy and then possibly again also for compensation…one of my clients has battled in that aspect [of compensation assessment]… they [Institution] give you a number 15% damaged. 15 % is what they came to in terms of 100% would be someone who wasn't alive. I just remember her saying how do you get 15 % raped. I wasn't 15% raped how does this work.

As we make sense of these questions, hearing the affective meaning making through the stories our clients tell, how is it possible to imagine women's painful experiences within the gendered conditions of their everyday lives as partial (15%)? The affective flows of meaning making hearing our clients' distress enabled us to recognise the gendered structural violence that echoes through the sounds of the institution; broken, fragmented, invisible, scared, and having to battle to find a way through a system where their stories were charted, broken apart into pieces: an affective intensity that recognises a story of violence in the institutional production of suffering.

As Ani and Liza told their shadow stories of understanding the re-enactment of gendered violence through our institutional response, we recognised ourselves in the tension between

institutional and ethical practice. We recognised our embodied responses, anger, disbelief, as we made sense of women's experiences as institutional violence rather than the dignified response-ability that our ethical relationships ask of us. And as we moved with this recognition, we began to hear the affective flows of meaning making that structure the reproduction of sexual violence as a singular injurious event when our clients engage with access to funding for our professional services. What we heard through the affective intensity is the embodiment of the stories that exceed the boundaries of recognition within the conditions of a hearing.

Liza made sense of the conditions of a hearing by locating the limits of the process of an assessment, which, in her story, takes shape through a faceless phone call, with a (white) man with whom she is unable to speak, and who reproduces the invisibility of the 'woman' and her embodied experience. By the time her client gets to their assessment, the conditions for a hearing are already established.

> Liza: The first person who did it [assessment] was white and male and started to do that via a phone call, a non-private phone call. So I helped her to fight to see a woman and have that process be face to face umm but that was a huge battle, and yet she had to do it all again.

Being moved through the recognition of the structural violence of the institution that reproduces suffering, mobilises Liza into action; she resists being complicit with the forceful demands of an institution that has no recognition of the embodied experience and, becoming response-able, engages in the fight to **battle** for her client to access the ethical conditions for a telling of an intimate and deeply embodied story of pain. Moved into action through hearing the affective intensities, at the same time as practicing within the institution, Lisa moves with the tension of acknowledging the gendered structural violence, and her location of resistance, that opened a space for us to think with what we are hearing, as we become ethically response-able. Thinking with what Braidotti (2006a, p.7) envisages as relational ethics, that is a "a radical repositioning or internal transformation" as we become relational in a "productive and affirmative manner", our resistances to institutional violence perhaps move us too, toward a process of becoming imperceptible.

And as a part of our location in the assemblage of institutional systems, Liza too made sense of her troubled location when using her authority to speak as a report writer, drawing on another memory where she embodied the guilt of her participation in the process: her shadow story of being moved by the affective intensity of a clients stories of pain, as she was reducing that telling of that pain into a framework of 'check boxes' for the legitimacy of the institution.

> Liza: When I was doing her report, she handed me this book, and she called it 'it', and it was all taped together, and she said I can't keep this with me anymore, and it was all of her stories of pain, and it was yeah devastating and beautiful and poetic. Halfway through, there was this page, though, and it was like, "How dare you read this. How dare you take my pain and put it in a check box "... I remember feeling so guilty for needing to then literally take that and put it in a check box. She didn't mean it at me, but she had to express it that way...that to me is the enactment right there.

Returning to the social compass, and making sense together of our shadow stories of hearing affective intensities, we began to recognise how we are deeply affected by intimate stories of pain, and we are moved in and through them. And there is a moment of recognition that links this story - through the affective flows of meaning making, heard through the beauty of the poetics of her client's diary writing - to becoming vulnerable. And it is in this moment too, that we can apprehended the creative potential of the process of hearing the affective flows of meaning making by recognising their intensities and mobilising them as ethical encounters for therapeutic action.

In the workshop counterspace we linked the enactment of violence within institutions that configure women as pathological subjects for intervention (excess emotion) to the production of pain as suffering, and through the production of checklists that configure a shameful figure, we recognised affectively our participation in the enactment of the violence against her. And I noticed too, the breath in the room, as we together recognised the repositioning of the clinician, neither axiomatic nor pain-free (Braidotti, 2010). I recognised the moment where the process of "dis-identification from familiar and hence confronting values and identities" (Braidotti, 2010, p.411) was present in the counterspace, as we understood our discomfort as the feeling of loss, embodied in this story as guilt, understanding that hearing carries the burden of response-ability.

I remember hearing the ‘loss’ in Liza’s voice, as she touched on the moment that required her to translate what she had heard into the criteria and symptomology in her report writing, complicit in the production of psychological suffering.

Mindful of the affective intensity that enables us to hear women’s stories of pain, we moved with affective intensity in a process of becoming imperceptible, becoming aware of a transformation in our assemblage between listening for pathology and hearing stories for real, in all their messiness; hearing stories through a missing knowledge of the affective flows of meaning making. Becoming aware of our therapeutic process of imperceptibility we gathered a moment to disarticulate pain from suffering and offer clients an alternative experience, one where although we can not erase the memory of pain, we can respond affirmatively and with compassion. I remembered the moment of recognition in my own journey, as I felt the heaviness of carrying the burden of these transformative moments alone:

> Amelia: There is hope in this story. I want to acknowledge the heaviness of some of that, umm, and for me, it’s been a heaviness I felt like I have carried quite intensely alone. That’s why it is so lovely to have you all here today because the way that I envisage this in the future is that we all work collaboratively in a way we can do this differently. This is one part of what I call the social compass, so the enactment is one point of the compass, but as we moved with the research, I had started to think about where is the emotion in all this…

As we returned to the compass, the discussions opened up the space for a collective call to support one another in the place of hearing pain with purpose. We began to create and imagine spaces to share our shadow stories, remembering the gendered power relations that produce psychological suffering, and recognising too, that we can still move beyond the confinement of suffering through the process of disarticulation. A moment of recognition that embraces hopeful potential to transform the conditions of a hearing. And as we shared our stories together, we evoked a profound understanding of pain away from institutional suffering that impacts our

everyday lives. We hoped that these stories would enable us to begin the process of moving together, as we brought into view the affective flows of meaning making that move us into action.

Making Sense of Relational Affective Intensity Together

The creation of spaces for sharing shadow stories enabled and protected processes of reflection on our practice of ethics of care within institutional responsibilities, and enabled us to acknowledge and also imagine practices that depathologise pain. At the heart of this research is making sense of our movement with emotion that exceeds definition but rather is a practice of movement from listening for, to hearing pain through, the movement of affective flow that brings into view the felt body in (e)motion: affective intensities as transformative in our re-telling. For example, Liza's client became visible through her devastating and beautiful and poetic expression of pain, in a process that produced dignifying reverberations. And here we began to make sense of how we can mobilise our ethical responsibilities to recognise women's painful stories of sexual violence as a relational encounter that hears affective intensities as a mode of affirmative ethical response-ablity toward social justice. Thinking with an ethics of affirmation, the ethical encounter in the therapeutic relationship becomes a place of recognition of how our collaboration enables us to make sense of relational affective intensity as a therapeutic process of disarticulating pain from suffering.

To move with this process, I returned to the compass, where the embodiment of shame emerges as a location circulating in and through our institutional responses where gendered power relations are normalised. Here, the intention was to recognise the shameful pathological subjects produced through the institutional and psychological relationships that pathologise women's stories of violence, both enacted and embodied simultaneously.

> Amelia: and this brought me to what I call the embodiment of shame. So, the embodiment looks at when women are configured in a particular way what is it that they then carry from this experience… for me I had to go through a whole big personal journey about my own experience of shame umm… and so when I had my first child I went into my own ACC

> sensitive claims process umm and worked through that… so what Liza is telling us, is that we can't tell the 'essence' of an experience for women, so this [embodiment] was probably the most difficult part of the compass… and yet I have developed a bit of a problem with shame as a workable concept, because…you can't just label it as shame, or whakamā[7], and think we know… Relationally, shame is much more than a singular emotion.

As we came together for this workshop, I had begun to think, again, about how the affective process of meaning making in the enactment and embodiment of shame can move us beyond the singular story of emotional distress. How does the recognition of shame, as an affective flow of meaning making that is relational, become possible if we recognise it as an affective flow of responsibility that demands our attention? How do we recognise the violence of the untellable affective forces that inscribe our bodies with meaning? As we came together, with our own memories of how the shameful figure is produced through institutional practice, we opened space to make sense of the movement of the potentia of Braidotti's (2017) call for the potential to affect and become affected.

And as I told my story, I recognised the invasiveness of shame as a moment of entrapment in a western individualised story of becoming responsible. Rather than the embodiment of a singular emotion that limits the force of its affective intensity, the embodiment of shame became reconfigured as productive, serving as another moment of reflection on how we can acknowledge, and mobilise, embodied affective flows of meaning making toward collective praxis. And I remember our collective stories of anger, disbelief, guilt and shame, forces that demand our attention, not because they acquire the negativity of self-thought, nor as in oppositional relation with another, but rather, through a recognition that there is pain behind the affect, regardless of whether it arises "from being hurt, lost and dispossessed" or emerges "as a result of a blow, a shock, an act of violence, betrayal, or trauma" (Braidotti, 2011 pp. 288, 322).

[7] Whakamā is a process of relational meaning making, often associated with feelings or expressions of shyness or shame, often at having failed to meet particular social obligations. However, in contemporary times it has come to recognise the feelings of inadequacy or inferiority in uneasy social situations, particularly in a Western context, with an awareness of the conditions that limit a hearing. Understanding whakamā, as Knight (2019) argues, recognises that it is multi-layered and moves with the ongoing effects of colonisation.

Recognising that the embodiment of shame is a process of entrapment where the forces that work to reproduce negativity in responses to social injustice make demands of not only what we tell, but how we tell it, reconfiguring us as hysterical subjects, suffering psychological distress. As we moved with our shadow stories, we began to make sense of the affective flows of meaning making through a process of affirmation of engagement and resistance through our assemblage of relationality, making sense of suffering (the embodiment of shame) as a force of practice and institution.

> Amelia: So I think a part of the conversation today is hearing what other kinds of experiences you have in your clinical work that might describe these embodiments… Trying not to position women as shameful, although the system does… Just like Liza was saying how can you not experience that when you are having to retell your story over and over again and someone says you have to be 15% not ok to have long-term support…

The shifts and flows of emotion in the workshop counterspace were recognisable, and I heard the affective intensity, the breath, as a collective 'knowing' of the shadow stories that inform our double locations. What was so important about recognising the affective response to the forceful demands of the institution as the affective flow that produces embodied shame, was how we could begin to rethink pain through a transformation of meaning, not as an emotion, but as a powerful affective process with potential. It is here, in these shadow stories, that we can begin to hear women's affective intensities as relational, becoming response-able to the meaning making that condition our everyday lives.

As I reflect on the workshop, the social compass became a mechanism for reflective practice that considered the complex interweaving of the enactment of gendered violence and the embodiment of shame, as we began to make sense of the motion of emotion. As we recognise the reconfiguration of pain into suffering through the embodiment of shame it becomes possible to reflect on our affective responses to women's stories of pain and the suffering enacted in and through pathologised practices. We are moved through an affective intensity, an embodied

moment that engages us in a process of response-ability for disarticulating women's pain from suffering. Hearing the recognition in the breath in the room that connected our stories to other stories yet to be told, suggests that there are potentials for a radical change in knowledge and practice.

As Ani, Liza and I shared our locations in the relational assemblage, moving with the shadow stories that recognise the production of psychological suffering, we established connections within the counterspace for becoming vulnerable together:

> Ani: I remember a conversation that we had about the person you were working with who was never asked the question why?
>
> Liza: oh yeah. They were never asked why. It was the labels and what was wrong with them but the why [was missing]. Sometimes women are never really given the opportunity to put into words or to just express themselves.
>
> Jess: It is about why?

Becoming safe in vulnerability together enabled us to recognise how we respond to clients' pain with dignity. No longer alone in these moments of remembering, we become mobilised to ask questions about the conditions for a hearing. Making sense of the institutional constraints moves us from our entrapment in the social compass through the process of imperceptibility - the recognition of the deeply connected relationships between pain and suffering. The imperceptibility of becoming curious moves us away from understanding ourselves as knowing experts of pathological configurations of pain to clinicans that are curious, wanting to move together and hear to enable a dignified and affirmative response. Listening to what brings clients to therapy, the why, rather than a focus on relieving the symptoms of psychological suffering, reconnects us to the therapeutic relationships ethically. And these relationships take time.

At this moment in the workshop, it was important to note the movement outside of the figurations of pathology that were accentuated by the social compass, and we began together to make sense of a therapeutic space in which to hear affective intensities as relational and transformative. Let us consider for a moment if Liza was driven by pathologised practice, it

would not have been possible for her client to articulate herself as the conditions produced would be enacting the embedded institutional response to pain as a symptom to fix. Her client would unlikely have had the opportunity to put words or to just express herself as it would not meet the clinical questions for categorisation of symptoms. It was the embodied tension of the double shift from an institutional response to pain toward a process of affirmative engagement with her client that enabled Liza to become response-able. And the space opened to further vulnerabilities, as our moments of recognition (that were not *thinks)* became a chorus of multisensory felt experiences of affective intensity as further shadow stories were articulated.

> Liza: I had a new sensitive claims client start but when she walked in she was just there privately [private practice]. I just knew, I just knew that this [client] would become a sensitive claim's case, and sure enough, she sat down; she had been to see lots of counsellors over the years, but yeah no one asked why, and when I did, that was enough. And I was thinking, how did I know? My supervisor asked how did you know?... She was literally embodying that in her presentation and her body, it was coming off her in waves. Sometimes it can be hard to understand why people don't ask or don't know.

As Lisa began to apprehend the affective intensity of hearing the body, making sense of a body's capacity to 'tell' a story of pain in the therapeutic counterspace, we opened a space to attend to our bodily locations as affective capacity to act. Recognising the affected body as a response to pain without the requirement of being able to 'tell' the experience opened another conversation about the the multisensory moments of feeling, moving and hearing affective intensity as a therapeutic process. Rather than limited by the conditions of the institution, through opening ourselves to becoming vulnerable, we become response-able together to shift from listening to hearing – to be affected and to affect – to move us beyond the shadows of the institution and toward a collaborative process of knowledge making, hearing the affective flows of meaning making that breathes life into our ethical practices. And becoming vulnerable became the process of making sense of affective intensities, in the workshop counterspace.

Ani: When you talk about that person, we call it ahua[8]. We see it on them. There is something that is overshadowing them in their colour or the way that they appear to you.

Ani apprehends the notion of hearing the affected body through her own embodied location, connecting us to her everyday knowledge of affective intensity that is not constrained through institutional definitions of pathology, and affirms Liza's recognition of the affective intensity inscribed on the body, providing a way of making sense together, bringing the untellable into view. What Ani offers, from her location embedded in Māori knowledge, is a way of hearing the shape, or form, of pain as it appears before us. She too challenges the limits of psychological knowledge, always already recognising its partiality. And it is this opening, that enabled others to reflect on their own location and the potentials for what could be possible, as we de-link pain from suffering.

Ihaka: We have the capacity to see those colours. I love this notion of a social compass and I was wondering where does wairua[9] fit into it.

Amelia: This is where this conversation is important because that's been the missing piece. I have had some conversations with Ani… about wairua, and wondering if it is part of the embodiment but it is something I can't offer as a Pākehā woman.

At this moment in the workshop, I recognised my response to Ihaka's offer of wairua as an opening to see those colours as one of inadequacy. I was listening through the social compass, and became immobilised through my deficit. Reflecting on my response now, of course it was an

[8] (In te reo Māori) Ahua represents shape, character, form, appearance (Moorfield, 2011).
[9] (In te reo Māori) Wairua encompasses the wider context of the spiritual world. Often representing spirit of a person beyond death. Wairua also resides in the heart or mind of someone, and is not easily translated into Eurocentric conditions (Moorfield, 2011).

opening for recognition of the making sense together, through our differences, how we understand affective intensity. Ani and Ihaka are comfortable in their knowledge of wairua to apprehend the movements of the intangible forces beyond the clinic, connecting us to our own affective intensity and response-able practice through collaborative conversations that prompt reflection and curiosity. By shutting down my capacity to hear, I engaged in a moment of protestas, a moment of paralysis as a researcher, when reflecting that the social compass had negated wairua and I had failed. Listening to Ihaka, again, I hear the shared responsibility of meaning making, and understood his question as a process of reciprocity – it is our shared responsibility to feel and experience the reciprocal moment of affect when engaging in therapeutic moments of connections alongside clients. What was beautiful about this moment in the workshop was how everyone began to open the space to discuss wairua as an example of affective intensity.

In the reflective space of collaborative meaning making, the social compass was an opening to share conversations about what we can and can't legitimately know or be as clinicians. And it was in our collaborative conversation sharing how we work creatively inside institutions that we could begin to hear what we are capable of becoming. Together, we were engaging in a process of effectively producing response-able knowledge of what we can be when we are outside the limitations of pathology and free to talk about our experiences of being in the therapeutic relationship. Throughout the workshop, the social compass moved us to tell out shadow stories that opened the potential of reflective collaborative conversations, that helped us to articulate the often untellable stories of relational affective intensity.

> Ani: I was thinking about the young person we both work with [Ihaka and Ani] and how she let us see; she was the compass and leading us in what we needed to do, and we are talking about wairua, it shifts, and it moves, and it shapes wherever it needs to go, and she was the one that showed us that compass and then pulled us together to do certain tasks.

Ani and Ihaka storied their collaborative work to respond to a client's experience of pain and of moving with wairua as they built a pathway to hearing pain with intention and curiosity. In hearing these collective narratives, they were able to apprehend a 'creative moment' that brings

texture to the tenet of ethical thinking. That is, Ihaka and Ani shared their cultural knowledge as a possible exit to pathologisation, as a way of engaging in alternative knowledge and understandings of the therapeutic relationship that are sensate and can not be 'captured', but rather, move us to hearing affective intensity as an energy that brings material relations into view, certainly not new to indigenous knowledges. Ani opens the possibility of hearing pain as a relational wairua experience, a process of hearing where the conditions for politics and ethical agency do not depend on institutional systems to engage ethically response-able therapeutic processes. Here, we can actively engage in the creation of what Braidotti (2008, p.12) calls "alternative social relations and other possible worlds". The potential in being able to hear affective intensity through other ways of knowing is not oppositional, but rather becomes a relational ethics of affirmation to engage action. And Ihaka highlights the relationality of affective flows of meaning making toward legitimating affective flows, drawing on our embodied knowledge of the 'shape' of a dignified and ethical response.

> Ihaka: I'm curious… I don't necessarily see the context of wairua sitting just within a specific ethnicity. I think that it is something that can be brought about through curiosity. This particular wahine[10] was a prime example because she is non-Māori, but from the get-go, what she projected was something that was deeply encased for me into tapu[11] wairua, so that's been the tenet of our exploration…. she has driven that… and allowed us to create something pretty unique I think…. As clinicians, both Māori and non-Māori we need to create a context where we can make sense of the notion of wairua in some way, shape or form and that a journey …just like all our journeys, happens piece by piece.

Ani and Ihaka take up their ethical responsibilities through embracing the potentia of wairua as they move through a process of meaning making with their clients. Mobilising genuine

[10] (In te reo Māori) Wahine means female, women, feminine (Moorfield, 2011).
[11] (In te reo Māori) Tapu means to be sacred (Moorfield, 2011).

relationships with their clients involved remaining curious and creative through a process of hearing affective intensities. And I recognised the challenge, the process of disarticulating ourselves from our western knowledge claims is a process of decolonisation, of ourselves, in the process of becoming response-able.

The reflective workshop, as a process, provided an opening to consider the affective flows of meaning making that exceeds our disciplinary boundaries. Locating relational affective intensity through the mobilisation of wairua became profound in making sense of becoming response-able together. And I remembered, and became moved. Just like my experience of dance, I had a fleeting feeling of the intensity of wairua, as it is embedded and embodied in the affective flows that move us in particular ways together. It is the process of coming together and making sense of pain relationally and with curiosity, leading to moments of joy and freedom that matter.

As we move in relation with one another with relational ethics, the question becomes how we mobilise alternative knowledges to enable the conditions for an ethical hearing, through a process of what Braidotti (2017, p. 302) calls "amour fati" - a way of living up to the intensities of life, to be worthy of all that happens to us – to practice our shared ability to affect and be affected. What does it mean for us to be present in the here and now, together with our clients, in a relationship of reciprocity, making sense of pain through curiosity, acknowledging the limitations of psychological knowledge and moving forward, collaboratively, with potential in a process of becoming vulnerable. How do we create spaces for mobilisation?

Using our New Found Knowledge of Relational Affective Intensity and Building Response-Able Practice Together.

Throughout the workshop counterspace, we started to openly share our shadow stories, that is, the untold stories of how we work creatively and collaboratively inside the therapeutic counterspace, but we also were reminded of the everyday conditions that produce the intensities recognisable as structural violence. Recognising the limits of the institution, we moved through thinking creatively with affirmative ethics to re-imagine our ethical praxis. Amy makes sense of affective flows of responsibility that are intensified through multiagency responses as also configuring women's stories of pain (and shame), recognising that sometimes the only safe space, is our space.

> Amy: "How do we create space for that? Because I can't help reflecting on your conversation and thinking about power and control, which are at the core of sexual violence and then that power and control that then happens within a professional relationship and if there isn't allowed space to connect and have a feeling of being safe and secure and belong, at least even with that therapist... You're trying to then control the process and not follow that compass. I struggle because I know the women that come to our service often have contact with Oranga Tamariki [12] and probations and so many systems and services, and everyone is telling them what to do in a very punishing way without asking why.

The dissection of someone's life through multiagency responses, often means the re-telling of the institutional story, repeatedly, through multiple appointments, including therapy. The question becomes, how do we find spaces for connection, not only for our clients, but with each other. How do we mobilise our creativity? Recognising the limit of institutional power relations and the configuration of women's pain through the social compass, opened the potential to move beyond these structural boundaries, looking for the pathways that moved us into curiosity. And we began to imagine differently, recognising the moments of imperceptibility as ethical practice. We were able to talk about small resistances to institutional restrictions that allowed us to move with affective flows, and as we do, the creative assemblages of our movements through the processes of hearing affective intensities became potentia.

> **Liza: What I have learnt from my clients, they taught me is that a relationship is huge and that can not be rushed and I have begun getting pushback from [institution] going where's this report... but I now have a shifted... I used to worry about doing trauma therapy**

At times, when we are faced with moments of needing to meet our relational obligations to the institution, we experience potestas. However, the institutional responsibilities that restrict us from feeling free to be guided by our therapeutic relationship with clients, does not exclude us from being response-able as we creatively think with potentia. Again, as we engage in the

[12] Oranga Tamariki is the government agency in Aotearoa, New Zealand responsible for protecting and supporting children and young people at risk of harm or in need of care.

process of relational affective intensity, we create the spaces that exceed the parameters of the clinics, and we relinquish the need to be the 'expert' defined through the clinic. Shifting listening to hearing, becomes the process of affirmative ethics that have become mobilised through our shadow stories, and through movements of resistance.

> Liza: I have one gorgeous wahine that we [Liza and Amelia] both ended up working with, and she's taught me that they have got to be the guide. They have got to be the compass themselves, and they will take you where you need to go when they are ready.
>
> Ihaka: Sometimes we're not ready [laughs]
>
> Ani: I know but they make you ready [laughs]

And the laughing is important here, as we recognised the institutional configuration of suffering, our assemblage began taking new pathways, as embedded and embodied within relations of affective intensities. And we become response-able, as we are guided through the affective flow of meaning making the figurations inscribe. In a process of finding new pathways, sometimes our clients really do make us ready. The process here, again, is a process of becoming vulnerable, and the laughter that filled the room at this point was also a collective sigh of relief as we remembered moments of feeling lost in the therapeutic process, uncomfortable with uncertainty. Recognising that we are always already relational, we became open to be able to hear affective intensity, and Ani shared a beautiful moment:

> Ani: for example, with one client, she wanted a whakawātea [13]where the violence occurred. She directed that she planned that out; she pulled us together and made us get our heads together to make it come to light, what she wanted through sound, music, through karakia. There were so many aspects to it; we even used the rākau[14] to do the clearing, and then we went to

[13] (In te reo Māori) Whakawātea means a clearing, freeing, expunging, purging, removal, get rid of (Moorfield, 2011).
[14] (In te reo Māori) Rākau is a stick or piece of wood (Moorfield, 2011).

> the Moana[15]… to let it go out to sea. So these are those processes that we did… in her mind, that is what helped her to heal.

Ani shared her experience of hearing pain guided by her client, not constrained by institutional acoustics. Instead, Ani followed the affective flows and actively entered a space of vulnerability alongside her client as she responded with her embedded and embodied cultural knowledge to move through a process of hearing pain with purpose and intent. Ani engaged a reflective process of speaking about the reciprocal moments of affirmative action that transformed the therapeutic counterspace. The process of depathologising pain and hearing affective intensity was a powerful, reciprocal experience in the therapeutic process. Ani's trust in her cultural knowledge and her willingness to be guided in the therapeutic relationship produced an ethical encounter where her client could move from a 'broken' subject to a woman with the potential to heal.

In an ethical encounter that apprehends doing humanness differently within a politics of location that unfolds with other becomings, including becoming response-able, Ani embraces her relationship of reciprocity through her trust of being guided by affect, creativity and collaboration. As she resists the pathologised suffering women experience in mental health services, she engages the process of becoming imperceptible hearing affective intensity and de-linking pain from suffering as a powerful transformative movement.

> Ani: And with this other young person I worked with she wanted me to show her how to make kawakawa[16] so we went to the forest and did the whole process of karakia, waiata[17] talking about the process of cultivation the reasons why we pick the leaves from here, the meaning and the shape of the kawakawa where it comes from all those things. So when you are saying what're the different things we can use, that compass that they guild us with when you've got all those different kinds of tools you can pull from, different

[15] (In te reo Māori) Moana is the sea/ocean (Moorfield, 2011).
[16] Kawakawa is a native plant, a small densely-branched tree. The plant is often used for medicinal purposes (Moorfield, 2011).
[17] (In te reo Māori) Waiata is a song or chant (Moorfield, 2011).

areas umm. Yeah, it's guided by them, I only showed the process of how it's done… and then I said what do you think you need, and I thought they were going to say behavioural activation or something [laughs] it's not what they said at all, it just blew my mind… I want to do the kawakawa you just showed me.

When Ani was able to bear witness to the power of sharing the spaces of pain most meaningful to her client, she was moved with them into creative spaces of healing. In this story she was blown away that flowing with her client as a human being, first, rather than as a clinician, in the therapeutic encounter, was more highly valued by her client than the therapy itself – and it tells us of the moment where trust is reciprocated through the legitimation of alternative responses to the hearing of pain. And this – the acknowledgement of mobilising relational affective intensities - is the potentia of the creativity of the human clinician in the relational encounter that Ihaka also connected with response-able responses:

Ihaka: We can sit back and actually umm offer something to help… how do we as clinicians step back from our ego and be clinically orientated, culturally oriented, gender orientated in a space that allows our whaiora, our whānau, to become comfortable about sharing that…

Ihaka asks us to consider our ethical encounter together (as clinicians and clients) as a journey, not as a response to suffering, but as an engagement with our humanness, that which connects us through affirmative ethics of becoming response-able active in the work, with otherness and difference.

Amy: And also that their responses have been adaptive for survival, creative strength as well as pain. It's the coming together and how to be whole and holding that

In Amy's narrative, pain is distinctly disarticulated from suffering, that is, Amy tells pain as a creative strength of potential becoming, not a symptom to be fixed, but a powerful force to hold and connect us together in the therapeutic relationship.

Amelia: What we are talking about is what I call depathologised expressions so these are some of the figures we have talked about the real victim, the real rape, the unworthy victim the hysterical the pathologised, broken… but what we are talking about is something quite different, what you are creating is the heart of the compass… all those conversations you are having are not configuring women in a particular way… the compass can guide us, I hope that it becomes a reflective tool to gift to the community so we can have more of these conversations, because we don't have enough of these conversations… it's beautiful hearing all of your conversations about hearing, not just listening to women's stories, but their experiences and the affect, and it's not in a labelled way, it's not you know this criterion, that criteria when you fit in a box.

We came together to make sense of affective intensity, and this raised awareness of the importance of hearing pain through our embodied relationships. We were actively in a space that enabled our curiosities to re-imagine pain, and it felt invigorating, The process of becoming conscious of relational affective intensity as a reflective process helped us to move from a state of conscious negativity to potentia. I remember the shift in the room as we began to openly hear the pain as strength, disarticulated from suffering. But what was even more powerful about this moment was what ethical actions followed:

Amelia: What you are hearing is life-changing for women. So for me, it was dance and music, I know Liza you talked about the book for one of your clients.

Liza: Yeah, she really struggled to verbally say what she wants to say, but her writing that's how she expresses herself… it's poetry… how can I capture her poetry? I've got a client who speaks in metaphor, beautiful metaphors; she just comes up with them, and that is how she expresses herself. She talked about

how it was very intergenerational trauma, so it was that whakapapa[18] of trauma that went way back. She talked about realising that her mother carried a boulder, and she had to carry a rock, and her daughter had a stone, but now her treasured moko, her taonga[19], only has a pebble in his pocket. That's huge for her to realise that. How do I put that in a report? [laughs]

What is important to understand in this process of meaning making is that it moves us into action. And I remembered a fleeting moment of panic as I realised that I had not 'captured' the de-pathologised expressions of pain into words, so that it would be possible to make relational affective intensity into a shape that would be heard by the institution. How can we legitimate and acknowledge these moments in a meaningful way not only in our practice, but also to change the practices of the institution that pathologises women's pain as our ethical responsibility for social justice? But here, I remembered that it is in our ability to advocate, disrupt and resist suffering that we too become free. We can respond affirmatively to women's painful narratives if we reflect on relational affective intensity in the clinical space. By coming together to reflect, we voiced moments of conscious raising of relational affective intensity, and we opened up conversations outside pathologised practice, connecting to other clinicians who work outside the realms of pathology by attending to the potentia of our differences and working with transformative vision disrupting the link of pain to suffering. By making sense of affective intensity together, we engaged in the process of disarticulating ourselves from suffering through affirmative actions. The words of Braidotti emerge again:

This is a practical philosophy that aims at transforming the debris and the ruins into workable possible systems, despair into praxis. Given that the present is not just the record of what we are ceasing to be but also the trace of what we are in the process of becoming, nothing is ever completely lost (Braidotti, 2019, p. 407).

In the process of moving from listening to pathology and being guided by institutional expectations to hearing pain as a relational affective intensity, we are no longer hidden in the corridors. We give new life to clinicians moving out of entrapment and into the potential of what

[18] (In te reo Māori) Whakapapa relates to genealogy, lineage, descent (Moorfield, 2011).
[19] (In te reo Māori) Taonga is sacred property, effects and objects (Moorfield, 2011).

is possible. Although we remain a part of the institutional assemblage, we still have the power to effect change collaboratively. The therapeutic counterspace becomes an ethical encounter as we gain a deeper understanding of our client's experiences and reflect on changes or shifting relationships in our reflective conversations, mobilising relational affective intensity and imperceptibility as a guide to affirmative ethics.

> Liza: But what I struggle with is that ACC, in particular, does have these limitations, it does force you to write things down it relies on that, but what I think I have been doing too much of is being guided by that.... what this discussion is setting off for me is NO let's do what works for the client .

Liza demonstrated an epiphany moment when she recognised that while she was restricted in some ways through the need to continue to support funding applications within the system, she found other pathways for her creative freedoms. No longer linking pain to suffering, she became enabled; hearing the affective intensities to form alternative responses.

> Jess: Ask them for longer than the six hours they give you to write an assessment because it takes longer. Because you want a real korero[20], you don't want to just tick the boxes.

Jess comes alongside Liza to show support, to offer her moments of resistance to institutional restrictions as a collective call for ethical action. It was almost as if we were giving each other permission to trust the therapeutic skills, reflection and therapeutic relationship with each other and our clients to guide ethical practice.

> Liza: It's hard cause it's like yeah working for a system that I know is not completely functioning but really wanting to do the work... I'm probably their least favourite person cause I hand things in late and I take longer and I say No that client will not fill in that psychometric that's completely culturally unsound...

[20] (In te reo Māori) Korero is a conversation (Moorfield, 2011).

Liza narrates the tension between working outside the limitations of pathology and meeting the expectations of institutions, and there is strength in her resistance as she locates herself as standing with authority in her refusal to not fill in that psychometric that's completely culturally unsound, and she imagines herself as their least favourite clinician. As she resists such a figuration, I hear her resistance as joyful – she is remarkably unapologetic despite acknowledging how institutions may configure her. And I recognise the movement of the shadow stories coming to life through the collective mobilisation of affirmative ethics where relational affective intensities enables a legitimation of response-able practice.

When we recognise that the reports become the work, we find creative ways to humanise our therapeutic relationships. Once Liza was able to go back to hearing and engaging with depathologised expressions of pain she could become free of her own entrapment and reemerge as a response-able clinician. Here, I began to make sense of the process of unlearning our privilege.

> Liza: Someone in the room. At the end of the day, when I was freaking out, thinking I can't work with this person, I don't know enough; I would remind myself I am a person sitting opposite a person having a conversation, and to me. I did feel like I had to unlearn some of the psych stuff… I remember they (academia) talked about gaining rapport, and that was all that was said, not how.
>
> Kay: Like that was a 2-minute job…
>
> Liza: Building rapport, tick.
>
> [Laughter]
>
> Liza: I mean the amount of research that shows that [the therapeutic relationship] is what makes the difference
>
> Amy: no matter what you do

Liza: why have we then forgotten that along somewhere the way?... I would love for some of this stuff to seep in keeping with the water analogy ... gently erode some of the stuff around clinical psychology training. To be like where is the relational, not even a lecture on that [laughs]

Amelia: I think the thing about that is being present in the room with a person, being able to show your own emotions. For example, clients will hug me, and I have had clinicians say what are you doing, um, where are your boundaries?

Jess: I was told off. I had an assessment, I won't say where, and I wasn't the assessor in this one, and I had to leave early, and I hugged my client, and it was written in the report, and it was discussed at a staff meeting that I was inappropriate with a client.

Liza: Oh, good lord

Ani: So they call hugging or showing someone gratitude and appreciation as inappropriate? [disbelief]

Liza: I used to pretend I didn't [hug], but I do. And self-disclosure.

Jess: If it is in the service of your client, it can be so powerful.

Amy: As long as you are reflecting.

Our affective histories are missing in institutional responses to sexual violence, and are re-configured through the gaze of objectivity. Interestingly this opening of becoming real through the act of a hug, or the sharing of a story, is re-told in our stories as a creative moment of reciprocal becoming together, woven through the workshop counterspace, and enabled us to

resist the figure of the emotionally incompetent clinician as we liberated ourselves through reflective practices that are lines of flight into new assemblages. Rather than oppositional, this apprehension of how we as clinicians are pathologised too was a transformative process of our becoming imperceptible.

The sharing of these stories from our different locations in the shadows mobilised flows of meaning making that show our commitment to the values and forces that are not yet sustained by the current academic or clinical conditions, evoking embodied connections between us that are needed to shape collective efforts to produce qualitative transformations in our interactions with each other, and opportunities to change women's experiences of mental health services.

And as we moved with the affective intensities of our resistances through the workshop, the re-telling of ourselves through our ethical responsibility to our clients became understood as an affirmative action that holds the potential for transformation.

> **Liza: That's the feedback I get, I like seeing you because you're real, you don't pretend that you know everything.**
>
> Amelia: So the affective intensity is not just the clients' affective intensity; it is an interrelationship… we are not just bystanders, you know, on the sidelines coaching, we're engaging, we're moving, we're experiencing emotions ourselves – not falling apart – but we are allowed to have a tear or to express your own affective intensity in ways that creates that shift and movement in space. Does that make sense?
>
> Jess: Absolutely!
>
> Amelia: ACC or any institution we work under is what we have and so my goal is to not demolish the institution… I struggle with that too as an ACC-sensitive claims

> counsellor, who has also worked in the DHB (District Health Board)… systems galore… I think we don't have to fight against the system, if we look back to the enactment we have done that,… the systems aren't necessarily going to shift but I am incredibly hopeful that perhaps we can infiltrate [laughs]… and continuously create waves.

Together in our affective sense making, we resist the violence that produces suffering enacted through our disciplinary practices, inscribing our bodies with meaning not through oppositional consciousness but through processes of affirmation of engagement and resistance to enact our ethical embodied actions. Instead of entering a possible narrative of confrontation towards systems, we wondered about the ways we can create waves of change by building reflective practice together. Situating this project in the context of advanced capitalism, which is embedded within our insitutional practices (Braidotti, 2022b), we move to consider how we are affected by and affect the conditions of women's pain.

> Amy: I like your metaphor of using waves because when you create a wave, you create movement, and when you create movement, you create space, and that's what women need to be able to experience fully… and I can't help thinking that because I'm a clinical psychologist and therefore supposedly a scientist… We can be very, well science can be, reductionist, and it's almost what happens in a report; everything gets reduced down, and how then do you see the hue and the colour of it? There must be ways in a process that still adhere to letting people know the information they need to know, the system, whilst respecting the hue of that experience the person brings.

Amy takes up the invitation to move with affective intensity as a way to disarticulate the suffering that holds us back in advocating for social change within the institutional system, naming the ethical action as a wave that has the potential to hold both the institutional responsibilities and respecting the hue…the person brings**.** We acknowledge the power relations that make it impossible for women to fight against pathology, and we engage in response-able action as we take up the invitation to create waves ourselves as clinicians. In taking up this

invitation we are **not stuck in the weeds** of suffering, we become response-able as we dare to change pathologised practice, by considering how we create waves in the systems we occupy.

As a collective, acknowledging affective intensities beyond words was felt and powerful. In becoming aware of affective intensities felt in therapeutic counterspace we began to reconfigure our place in the power relations of institutional restrictions, feeling our way out of the 'maze' through sharing our shadow stories and becoming curious as to how we can honour our commitment to provide dignified responses to women's narratives of pain, evoking a sense of freedom for ourselves as response-able clinicians. The ethics of affirmation, with a focus on affect, creativity and collaboration, is grounded in reflection of the "co-presence of pain in and through processes of political change" (Braidotti, 2008b, p. 17). Located within the institutional system, we also still have a political response to pathologised suffering that has the potential to build relationships alongside institutions and begin the process of transforming ourselves in response-able practice.

We do not need to stay entrapped in institutions as intrinsically hopeless, or feel ourselves stuck in institutional pathologised suffering. When we respond to pathologised practice with affirmative ethics, the political becomes "multiple micro-political practices of daily action or intervention in the world we inhabit for ourselves and future generations" (Braidotti, 2008b, p. 18). The practice of ethics of affirmation becomes an ethical accountability to consider our embodied and embedded locations as relational collective actions of "undoing power differentials" (Braidotti, 2012, p. 16), which Braidotti (2012) associates with two critical notions: memory and narratives. In our conversation, we were able to bring these critical notions to life. In reflecting on memories of depathologised practice and sharing narratives of making sense of relational affective intensity, we became immersed in a process of transformation to de-link pain from suffering. We began to see the possible navigation of institutional restrictions, no longer entirely bound by them but as capable of creative action that provide dignified reverberations for our clients and ourselves.

> Ihaka: These systems are all set up, ACC, Ministry of Health all of these systems are set up with a transactional framework in mind… there is a pool of money that sits there

somewhere. I guess what our role is… is to actually navigate that system in a way that releases the resources that sit there and they aren't substantial, are they? Retelling their story just for the purpose of achieving that outcome of funding. **We tell all of the stories just for the purpose of achieving that outcome of funding… I'm sure you guys are all very skilful at it and I guess that's the opportunity that exists within clinical practice to actually acknowledge that we can be minimalists of the system to give it what it needs but maximise the opportunity to provide the resources to our clients…**

Amy: But it's like the system doesn't trust the therapist. Isn't that exactly like when we don't trust women to know what they need.

Jess: And we pass it onto our clients, they feel it.

Ihaka beautifully demonstrates we are capable of sitting inside the assemblage as clinicians funded by systems and advocating for our client's ethical care and right to therapeutic services. Essentially, we become navigators of the system for women as we hold knowledge about how the institution functions and what is needed to access resources. However, the process of navigating this complex relationship with institutions is not a simple transaction. A process that echoes frustration from Amy as she names the tension of not feeling supported when institutions **don't trust the therapist**. Jess identifies the tension we feel when invalidation by institutions impacts how we engage in therapy as **we pass it onto our clients, they feel it**. A shadow story emerges where clinicians hold and negotiate two, often contradictory, positions. That is, we have felt a part of two worlds; firstly, navigating how to tell women's narratives of pain with dignity within institutions that have historically produced a pathologised understanding of pain as a symptom to fix, and secondly; striving to find our voice as social activists for change by maximising the opportunities to access resources for our clients. In holding these two positions we are actively building on the process of becoming response-able as we are not limited within

institutional restrictions but are mobilised to act in our client's best interests by becoming creative in how we navigate systems. Ani shows once again how this is possible:

> Ani: And we change up the therapy to suit by using "the language" of the therapy… so they can stay in the system because they still want the support, so you are using the language in a creative way so you can continue that. But in our case… I called it stabilisation … but really it was wairua therapy because she took us on a whole different journey…

Ani stories how she changes the language of the therapy to ensure her client continues to access ongoing therapy; in this narrative another moment of response-able practice is visible as a mirco-political action in practice. Ani shows that being part of the institutions and ethical actions can co-exist. While Ani held the knowledge that enabled her practice, what of the 'missing' clinicians: those who felt they couldn't speak or don't have the language to enable such material practice? Are there ways the system could transform so that the movement we felt and legitimated as we shared our shadow stories and collaborated together in the workshop is more accessible, more legitimate, more accommodated, and met with less sanction and barriers? This was the power of collaborative reflective practice in the space of the workshop: A collective and mobilised knowledge that could be shared with other clinicians and possibly enable more stories of resistance to institutional suffering to emerge- through reflection of the potentia of affective intensity as a reciprocal experience in the therapeutic counterspace. Ani spoke of such possibilities for including other clinicians in the quest to disarticulate ourselves together by inviting Ihaka to stand with her and work creatively with their client, an invitation that needs a moment of courage as Ihaka speaks to:

> Ihaka: Ani talked about the whakawātea and I remember her [client] saying that I need my home blessed and I remember Ani going, oh we will do that and I looked at Ani and said I hope you aren't including me in the we, that's not my jam eh [laughs].

> Amy: I remember the lady you are talking about she had a relationship with you [Ihaka and

Ani] and a connection for quite a while, and she very much found a space of security and you both together were able to do that work in a very different way because you created that.

Ihaka: She [the client] created that.

Amy: Well you allowed it to happen.

As we engaged in narratives that highlighted our collaborative work alongside clients, we became critical thinkers who showed the intuitive ways we build safe spaces for women to engage in the process of therapy. Ani and Ihaka actively moved with the flow of affective intensity and engaged in creative practice to produce a connection and ethical encounter with each other and their client. Amy calls for Ani and Ihaka to understand the value of their intuitive way of working together- the initial response is that the client **created that** but it is clear the process of building an ethical encounter is more nuanced than a one-way view of clients as the compass that guides therapy. Instead, Amy highlights they allowed it to happen, demonstrating the interrelational process of being in a relationship of reciprocity with each other. The specific focus of this narrative shows response-able clinicians as kind of knowing subjects, always in the process of becoming, and what working collaboratively and reflectively allows in this process (Braidotti, 2018). Ani and Ihaka demonstrate an exchange of knowledge with each other as a relational community, what Braidotti defines as a nomadic, transversal assemblage (Braidotti, 1994; Deleuze & Guattari, 1987). As we see the collaboration of knowledge we also see the materiality: mediated subjects that constitute a materially embodied and embedded community, people, bonded through affirmative ethics. Braidotti (2018) echo's once again, knowledge production is always multiple and collective.

Amelia: Yeah what you were actually doing is an exit to the compass you were acknowledging the enactment you were hearing the embodiment, you were listening to the narratives that weren't around pathology and you did it collaboratively… for me, I felt this huge sense that I had to deliver something amazing to the community. But actually

it's not just me… it's the community that is already doing the work.

Liza: And it's neat knowing other people are working like that, because it can feel isolating and it can feel like "I will get into trouble". Do you know what I mean… if I was found out? [laughs]

We were able to talk about the ways we creatively work with clients that not only made possible the conditions to exit the social compass, but that legitimated our process of becoming together. Liza demonstrates a moment of becoming imperceptible - no longer incompetent, but a part of a collective response-able practice. It was in hearing our collective voice of creativity and curiosity that a re-figuration became a possibility – not only for our clients but for ourselves as clinicians. The problem of pathologised institutional suffering has an important analytic function in our ability to reflect on ourselves, it asks us to confront the juxtaposition of being part of the assemblage, while motivating us to seek new alternative ways of becoming response-able: "The subjects' ethical core isn't to their moral intentionally as much as the effects of power (as repressive-potestas-as well as positive-potentia) their actions are likely to have upon the world" (Braidotti, 2022, p. 148). Braidotti opens the possibility that in becoming aware of our part of the institutional assemblage we can start to see the potentia. The restrictive and empowering modalities of institutional power are not mutually exclusive but rather interweaved relationships of the same process of becoming response-able.

This process of disarticulation provides an opportunity to balance potestas and potentia and gives rise to affirmative or ethical empowering modes of becoming response-able through collective action. Through conversation and deep collaborative reflection, we created a sense of safety to articulate how we resist institutional constraints and build ethical action. When we began to openly share our experiences of engaging in affective intensity as a relational process, not only in the therapeutic counterspace but in our reflections on our practice together, we realised we were not 'stuck' within institutional restrictions/pathology, but instead, we were motivated to consider how to further resist the institutional restrictions and pathology for the betterment of the clients we have the privilege to support. In the 'we together' we felt empowered, no longer isolated and the potentia became palpable – active ethical movements.

Chapter Six: The Collaborative Reflective Workshop Becomes an Ethical Activist Counterspace

"Remembering the wound, the pain, the injustice – bearing witness to the missing people – to those who never managed to gain powers of discursive representation – is central to radical ethics and politics of philosophical nomadism." (Braidotti, 2010b., p. 414)

Feminist politics reflects the hope for transformation by taking as its starting point the embodied and embedded, affective and relational structures of our social relations, an assemblage of the personal and collective, the intimate and the public (Braidotti, 1994, 2011). Collaboratively reflecting on relational affective intensity, we-together apprehended the uncomfortable and provocative, but necessary, consciousness that we are not outside the process of pathologisation of women's pain. But through sharing our shadow stories, we also recognised how we can, and do mobilise dignified responses in our therapeutic counterspaces, movements of imperceptibility where we become a part of the transformational process possible in the clinical space and active participants in the politics of everyday life (Braidotti, 2015b). Sharing our untellable stories of relational affective intensity in the therapeutic process, we apprehend pathologisation within institutions while resisting it, being oppositional, not harmful, in an active and intentional movement to challenge "politicized relational subjects" (Braidotti, 201, p. 240) and evoke dignified responses. And we recognised that processes of collaborative reflective conversations – beyond the whispers in the corridors – could be mobilised to legitimise and protect an alternative collective, affirmative, and ethical counterspace for response-able responses to women's narratives of pain.

Making sense of relational affective intensity collaboratively, we apprehended that finding our way out of the 'maze' could not be 'captured' within a static or fixed model, but instead was a process that evolved as we evolved, a transversal movement of developing a counterspace where we could contribute our own embodied knowledge, hear the knowledge of others, and continue to build response-able practice together. We became to know – together – what was needed was the space to have these conversations regularly so we could create waves of change in the systems we occupy.

Amelia: Even having this conversation right now, I'm just curious about how often you might be able to have a conversation like this…I wonder if we could have the compass like a reflective tool so we can continue to have these conversations.

Liza: That would be so good.

Amy: Here at [our service], there is a lot of talking about where the person is, what we need to allow, create, who needs to be involved where do we step back, where do we step forward. The first time we meet someone it is just to meet them and to connect who we are, and we are allowed to do that because of the leadership and the culture but those things to me… that connection and reflection happens on the hoof… and again you need space to do that…. You need space in your day to be able to do that.

Amy shares her experience of working in a team where the leadership and the culture at her workplace enable the space to connect with clients, build a space of safety, and to recognise relational affective intensity as a therapeutic process: conditions that prioritise the development of therapeutic relationships so we can respond to pain with dignity. In building a 'connection' with our clients they are no longer bodies to diagnose (Braidotti, 1994) and we see an encounter, where the first time we meet someone is to just meet them and connect, not something that is always a reality for clinicians working under institutional restrictions. Our shared shadow stories spoke to the institutional constraints of creating such spaces of connecting, and we began to mobilise a movement of ethical activism where we questioned how we could begin to bring institutions into our relational assemblage to legitimate and protect counterspaces that prioritise the time to develop collaborative reflective relationships with each other and our clients: counterspaces that were systemically embedded so that regardless of the system we work within, we have the spaces for connection we need as clinicians to maintain safe ethical practices. In the collaborative reflective space of the workshop, Ihaka spoke of his understanding of wānanga[21] to explore the possibilities of creating spaces for curious

[21] (In te reo Māori) Wānanga means to meet and discuss, deliberate, consider important topics/subjects together.

collaborative reflection that need not be in the shadows, outside the limitations of institutional restrictions.

> Ihaka: The word that sits with me is the notion of wānanga.. To be able to sit in the space of curiosity and actually be able to hold that and honour the reason why you found yourself in that space, and it takes some effort because we all have egos and we all have timeframes that challenge us, but when you sit in that space of wānanga I think the dynamics change… and even if I think about our MDT(multidisciplinary team meetings) although they are structured they are a wānanga it is collaboration. When I think of that notion of wānanga that fits in my head.. sometimes there are these people of knowing that sit in this collaborative space the kaupapa[22] is set in terms of what we do and why we are here, and we all understand that, and therefore; there is a space for all of us to contribute and things that happen as a result are always better than the single person that is sitting there… whatever their role.

> Jessie: it sounds like that's what you two [Ihaka & Ani] did with your Tangata whaiora[23]

> Ani: when you're talking about how does the wairua moves around, how does it shifts and shapes where she is she is on the compass … it just evolved….

Here, we began to apprehend the potentials that emerge from conversations that engage alternative knowledges often not possible when working in personal and professional silos dominated by western institutional systems of meaning making. Ani moves with affective

[22](In te reo Maori) Kaupapa refers to principles and ideas that act as a base or foundation for action. A kaupapa is a set of values, principles and plans which people have agreed on as a foundation for their actions.
[23] (In te reo Māori) Tangata whairoa means a person seeking health (Moorfield, 2011).

intensity as a wairua experience **which shifts and shapes** how she responds to her client's pain within and through the therapeutic relationship. An intuitive experience, as Ani claims **it just evolved,** but what is in action here is more than just intuitive. This was a process of imperceptibly becoming response-able based on a relationship (therapeutic rapport) and being aware and responsive to the emotions and unspoken affective intensity in the room. Ani's memory of following affective flows in her relationship with her client moved out of the shadows and whispers in the corridor, and became tellable in the process of reflection and collective sharing.

Through sharing our shadow stories of affirmative actions, and following affective flows with our clients outside of western institutional knowledge, practice and restrictions, the figure of the incompetent, pathologised clinician lost power in our collective voice. We began to recognise it was impossible to reprimand a collective. As easy as it is for institutions to blame individual clinicians for not *meeting expectations,* it is near impossible to reduce the voice of the response-able collective.

> Liza: Just lately I have had pushback from the time it has taken…for example, I had actually umm one of my wahine I used whare tapa wha[24] to set out her goals and her big goal was to be a better Nan to her mokopuna[25]… but I got push back on that because why had this taken 4 months. It's taken 4 months because it's a trauma response, it's taken 4 months because it is all of her worries and hyper vigilance come out and it comes out in anger….
>
> Ani: When you think about Ranginui[26] and Papatūānuku[27] and how you come through the Kurawaka[28], the wahine that's her descendants they are going to carry on, and the generations are going to flow through her that is why she

[24] The Whare Tapa Whā model is a Maori health model developed by Doctor Mason Durie mobilsing the concepts on whānau (family), tinana (physical), hinengaro (mental) and wairua (spiritual) health (Durie, 1985).
[25] (In te reo Māori) mokopuna is a noun used for grandchild, descendant, child or grandchild of a son/daughter (Moorfield, 2011).
[26] (In Māori mythology) Ranginui represents the sky father.
[27] (In Māori mythology) Papatūānuku is mother earth, a figure who gives birth to everything, including people. All life is born from the land, which nourishes them ((Moorfield, 2011).
[28] (In Māori mythology) Kurawaka encapsulates the place of creative narratives where the first women was created. It is also known as Kura-waka, the location where the first person was made by the god tāne (male).

is so protective of her mokopuna because she wants them to feel safe….to have the best life they can have.

Liza: Yeah, she recognised that she did not want to be grumpy Nan and that she was too overprotective…but it's like that's not seen as important somehow.

Through the process of collaborative reflection, Ani came alongside Liza to share her cultural knowledge and experience with her, and Liza became response-able as she remembered fighting for her clients' right to take the time to build trust and understand what her hopes are for engaging in therapy to be a better Nan to her mokopuna. By Ani coming along with Liza in her sharing of a moment of isolation when needing to follow a Eurocentric medical model and name therapy goals that fit a particular timeframe, Liza was empowered to trust her knowledge and process in the therapeutic encounter. This collective sharing of expert knowledge and experience of the ways in which we navigate institutional restrictions to guide ethical encounters in the therapeutic counterspace produced an alternative subject of response-ability. And it became evident to us that such reflective conversations were greatly needed for all clinicians working in the sexual violence sector, especially for those for whom opportunities for collaboration and connection are constrained.

Amelia: How do we have this [reflection/collaboration] in other parts of our community like ACC which is more isolated….

Liza: Yes, like private practice…

Amelia: what is possible if we are able to do that… what is the potential? What is it about the space and the ability to be able to collaborate and hear the affective intensity, and not just be under a guideline to meet a criterion? Yes, systems do still want a diagnosis, and I'm not saying all diagnoses are unhelpful sometimes it can help a client make sense of their experiences. But how could we bring these conversations further into the community?

Once we began to move away from the restrictions of pathologised pain that produce suffering, and into the space of potentia, through wānanga we were able to invoke an intentional movement of ethical responsibility, a relational assemblage becoming response-able.

> Amy: I'm just thinking..... what we are talking about is engagement as the most important thing about the wānanga ....we're not talking about the clinical criteria, we are talking about how people are treated, how they are talked to and given information....it's like for gendered sexual violence ACC sensitive claims there is a process of engagement that is primary, and the criteria is an appendix at the end.
>
> Liza: Ohh, yes
>
> Ihaka: It's a relational engagement…and then a diagnosis is added… it's not what brought you into this space.
>
> You know…this [workshop]…whether knowingly or unknowingly, this is a wānanga, we started with a karakia[29], the kaupapa was set, someone saw an opening and is kind of directing, but really the wairua is directing this stuff and whatever closing part to this is important as well… if you were to say how do we bring this to the community I think It's up to us to mirror this stuff and to be almost…champions of wānanga to the best of our ability… I've seen Kay [participant]operating with compassionate, kind, respectful….. they lead from a values perspective and everything else pops in behind.

Ihaka spoke of the workshop as a type of wānanga, that was set up with purpose, intent and

[29] (In te reo Māori) karakia is to recite ritual chants, say grace, pray, recite a prayer, chant (Moorfield, 2011).

care. In so many meetings and training we attend as clinicians, there is a failure to set up our spaces with intent, and alternative knowledge is not allowed to be spoken. Instead, our encounters are guided by institutional restrictions that do not allow for curiosity, generosity and collaboration. The reflective workshop was a space intentionally created for us to no longer whisper in corridors, to feel free to share our narratives of pain and the struggles of working under institutional restrictions, and to be moved with courage to step into the unknown space of alternative knowledge, where we are curious about ourselves as people who hear the stories of pain every day. Ihaka challenged us to all consider our responsibility to become **champions of wānanga** response-ably, to **mirror** our experiences of alternate knowledge and engage in ethical actions in the community: A **relational engagement** where the building therapeutic relationships is mobilised through ethical activism. In this discussion the how becomes important. As we gathered in the safety of genuine reflections, we began to explore how we can develop and utilise these affective flows with our clients.

> Amelia: So I'm curious about how I might be able to take this conversation further up, that is my hope so that we can talk collectively and say this is what we need to be able to provide this service, and I'm honestly trying to fit a lot into a reflective tool and I don't like using that word…. Because it's not static. Movement and curiosity are two words that have stood out for me throughout this whole conversation. I'm trying to put that movement into a particular guide so that perhaps those who aren't doing that work understand why we need this reflective space.

> Ani: I was just thinking Intention, movement and curiosity

> **Ihaka: It's almost like unlearning everything that is installed in you and actually feeling liberated…which allows you to be truly present, because that's what people want us to be.**

Together, as we reconfigured ourselves as response-able clinicians, we began to feel **liberated** through the process of building relationships, relationships not only with each other, but the weaving of our own subjectivities as affective and affected clinicians. Given the time and space for collaborative reflection, we were able to move beyond what we, as clinicians, *have* to do as demanded by institutional frameworks and restrictions, towards what *we can do together*, mobilised by affirmative and relational ethics through a legitimation of affective intensity in response-able practice.

> Kay: I was just reflecting…and I was thinking about how at our service we open up all the doors and because we do our work is hard⋯ I'm reflecting on how important this is to us, how we don't shut those doors on relationships⋯ but I think a lot of our colleagues do because they are overwhelmed, perhaps we shut other doors to keep that relationship open.
>
> Amelia: That is such a good point. I have always wondered what is it then that I am doing differently for clients to say they have never had this experience before, it has been 20 years and I've had so many different counsellors but I have never felt heard before. What is it that I am doing that is helping? You're absolutely right… I am keeping the relationship door open.
>
> Kay: You keep that relationship door open, we may need to shut a few others.
>
> Liza: I think of it as kind of energies, um, like I know in times in my own life when I am feeling a bit, I don't know, maybe I am feeling a bit depressed or anxious myself or something is going on. I will be too open, and I will fully absorb the energies and it's too

much. And I know when I get stressed, my immune system falls over. I guess I don't want to say it but it has a cost, but where does all that energy go, to?

Ihaka: My perspective is that wairua transforms between other beings… How do you ground that so you can keep the relationship doors open?..... we teach our clients distress tolerance, that's a skill eh that we can support people to develop, you know that notion of umm acknowledging that stuff… how do we notice that…

When we come together as a relational assemblage, we can start to support each other as we journey out of the 'maze' of pathologised pain. As Liza speaks to, we (clinicians) must bear witness to traumatic narratives and can almost lose ourselves in melancholy (what Braidotti, 2008b, calls the melancholy of the world). This negative consciousness has a profound impact, not only on our ability to instil hope for our clients but on our own physical and mental well-being. If we sit too long, alone, in the horror and suffering, which is so much a part of engaging within the assemblage of institutional pathologised practice, we lose the fight for our ethical responsibilities toward social justice. However, collaboratively and relationally, we can affirmatively move with the abhorrent, raw emotion and surprisingly beautiful moments of joy and transformation we experience in our therapeutic counterspaces. We no longer have to hold and carry the stories of pain alone, which otherwise could lead to suffering that impacts our work and our personal lives. We are able to come together as clinicians, members of families and of communities, and stay committed to the quest for supporting women who have experienced sexual violence with conviction and heart. To continue to stay in this place of hearing pain we must have "heavy doses of counter-negativity" (Braidotti, 2019., p. 463), forging spaces to make sense of relational affective intensity, and to mobilse as ethical activists. To fight for justice, we have to take on the burden of injustice. To want to improve mental health services, we need to apprehend our part in the process, not in opposition but through affirmative and relational ethics. This takes courage, and we can not achieve this in isolation. It is in *us togethe*r that strength is formed. Engaging in a discussion about affective intensity, we can begin to untangle negative consciousness and hear a different tune. As Ani articulates in the following narrative, the reward for recognising relational affective intensity is hearing and

responding to women's narratives of pain with dignity.

> Ani: And the reward is to go to her [client] and she is doing her art and she's expressing exactly how she felt in that moment when she is getting a trauma response. umm, and her showing me all her paint marks everywhere where she was throwing it, she made this big huge mess but she had done this amazing picture of an expression of herself and it had marks over the mouth of the image which was an expression of her and how she felt in all her pain….. she was so proud of this picture and I was like show me where you did this….I said to stand in that and feel the power……your beautifulness, your uniqueness of you and how you were able to express yourself, safely, you did not hurt yourself.

Ani can articulate the experience of relational affective intensity as she narrates an expression of pain in art, and how in that moment of imperceptibly, her client could feel free to express herself safely and the power of her **beautifulness**. Here, Ani shared with us a a strong sense of knowing herself as a person and clinician, trusting the process of relational affective intensity that is accepted, legitimated and not constrained by institutional restrictions, and in doing so, Ani shared with us the possibilities for a meaningful integration of both our personal and professional worlds that can allow us to be fully and boldly vulnerable alongside our clients safely: how to keep the relationship door open without a personal cost to our own wellbeing. And through ethical activism, we can share this process of becoming response-able through moving with/through affective intensity with the systems and institutions we work within, for, as Kay speaks of below, we-together know what we need to enable our response-ability.

> Kay: I was just thinking about my doors and what I choose to keep open, but also the systems and what they provide me to help keep the door open… the way that I manage to keep the door open is to close the door on the comprehensive assessment and go to plans.. because they are freaking not

up to date [laughs].. the system would come along and say, now Kay you are not doing a very good job…

Ani: It sounds like Kay you are following the compass of the client, and you were getting some report reminder from [institution] that the HoNOS [30]is overdue…. Ohh man

Kay, you're right, something has to give there are never enough hours in the day….What we choose to prioritise is one thing but what the system chooses to prioritise is another…

Amy: it's like when you're a clinical psychologist and you're told to write a formulation report after three sessions, how much time does it take to do that? And do you really know every time you see someone then it shifts? If you put the stakes in the ground how do you respond to the compass if you just fully put these concrete answers….

Amelia: That's where I hope we can give some context to the system and go we need this… you're absolutely right we don't have time. Even just this conversation, imagine we could have these once a month….. maybe where we could have the compass as like an anchor point and let the conversation flow and move and then have some way of taking that to the system and going this is important…

Liza: Oh that would be so good.

As we reflected in the workshop on our location as ethical activists in the movement towards affirmative and response-able response to institutional pathologisation of pain (moments where

[30] The Health of the Nation Outcome Scale (HoNOS) is a clinician-rated tool used to measure health and social functioning of people engaging with mental health services – developed in the United Kingdom College of Psychiatrists Research Unit (Te Pou, 2025). .

we **close the door** to engage relationally with clients and truly hear their narratives of pain with dignity), we also felt the pull back towards negative consciousness, and could feel the weight of institutional restrictions in our practice as clinicians. We felt excitement when sharing our shadow stories of hearing pain with dignity, but the tension of what is expected of us working in the institutional pathologised system would threaten to form a cloud over us. Here, when Kay spoke of the feeling of potestas as she interpreted being told off by institutions for **not doing a very good job** because she had not completed the **comprehensive assessments or go to plans**, we could all feel the assemblage of power and the higher institution as a "globalized advanced capitalism governed by fear" (Braidotti, 2013, p. 36). When we attempt to engage in the process of recognising relational affective intensities in our work and take the time to build relational ethics, we can be met with resistance from institutions and for a brief moment the figure of the incompetent clinician emerges once again. This process becomes a type of surveillance for clinicians as we weave in and out of response-able practice and go back to institutional restrictions, the systems looking down from a position of power as funders of our service and determining whether or not we are competent. However, rather than "extract the energy for collective action from social conditions that offer none" (Braidotti, 2021, p. 146), in the safety of the workshop, we continued to mobilise oppositional consciousness, imagining how we can politically resist institutional pathologised suffering through a collective call to account for institutions to recognise the importance of therapeutic relationships. Affirmative ethics mobilises the "collective power (potentia) to make a positive difference and puts it to the task of enacting alternatives" (Braidotti, 2021, p.146).

The workshop became a reflective space where we-together could stand courageously and firmly in our expertise of response-able knowledge - how we build therapeutic relationships and work collaboratively with creativity - in a way that has immense authority. We could apprehend that stories of institutional restrictions only voiced one part of the assemblage of institutional pathologised suffering, and that our inability to articulate response-able knowledge in larger forums is the injustice of working under institutional constraints. We began to call to account the power relations that refuse to hear or understand the harmful effects of pathologised suffering. In this moment of affective intensity and affirmative ethics, we were very clearly not

constrained by restrictions, and were no longer isolated. We could articulate of our expert knowledge of therapeutic processes, and engaged in a process of becoming response-able as a social movement. When we stand together it is more difficult to reprimand a collective there is power in us-together demanding the building therapeutic relationships as an institutional priority, and we can actively become a part of the assemblage of change as our actions become affirmative ethics when spoken out loud together. And we can develop lines of flight through which we can become response-able for women with lived experiences of sexual violence through the development of reflective spaces to mobilise and sustain our collective voice.

> Kay: The values we have all just talked about are the importance of being in a relationship is what we can take out to the community. I don't think a lot of people get that, certainly, policy people don't get that… the importance of the relationship the time you need to spend doing that.. for me if that was more widely known, if that was more widely understood then everything would start falling into place.

Kay beautifully articulates the movement of relational affective intensity as a therapeutic process with the potential to build ethical relationships, and our response-ability to mobilise this passion as an ethical action. That is, to share the knowledge produced in our collective conversation with **policy people** so they can understand the importance of building **the relationship** and **the time you need doing that** and in doing so, ultimately **everything would start to fall in place.** This is a moment where we remembered we had not, and could never, lose all hope for transformation. Through our reflections on the pathologised assemblage, we were engaging a collective power that has the potential to collaborate with systems and for them to hear how important reflective practice is. In the workshop, we created affirmative, generative values together, and gave voice to relational affective intensities, and through this process we developed a political praxis that engaged oppositional consciousness for transformative change.

Institutional restrictions are real, but they are only part of the cartography. There are so many aspects of working in the gendered sexual violence field when we would need to sit together with ethical non-violence to reflect on our practice; this is precisely what our current political and institutional context does not allow. In coming together in the workshop, affirmation was mobilsed through relational discussions of the injustice of institutional restrictions and giving voice to the untellable. To this location, radical change to mental health services for women needs us (clinicians) to enter a profound transformation of what kind of subjects we are, which can only happen together—collective assemblages of ethical encounters to redefine what we are capable of becoming as response-able clinicians. The heart of the imperceptibility, moving from listening to pathology to moving with pain as a transformational relational affective intensity has only been untellable because of the surveillance and isolation of our clinical identity and practice. It is not the heart that is missing, it is the spaces in/through which we can articulate the heart that has been oppressed. The knowledge produced in the workshop moved affect, creativity and collaboration as affirmative actions. In the collaborative space of reflective practice, we were free to explore what other forms of knowledge are produced in the therapeutic counterspace every day and how they connect to possibilities of political and ethical resistance and alternative, better ways of working together to provide dignified responses to women's painful narratives. In this project, the process of becoming response-able is the culmination of becoming aware of the therapeutic processes that move us from a place of listening to pathology (potestas) to hearing pain as transformational (potentia). We (clinicians) need the freedom and space to embody a multiplicity of other axes or entities that exist outside language, and to apprehend ourselves as subjects in the process of becoming something.

Chapter Seven: A Chorus of Voices

"Political activism can be all the more effective if it disengages the process of consciousness-raising from negativity and connects it instead to creative affirmation and the actualisation of virtual potential."
(Braidotti, 2015b, p. 52)

Building the Production of Response-able Knowledge

The power of this research is the bringing together of people who are open to hearing relational affective intensities and flows of meaning, and of recognising therapeutic processes as a movement from listening to pain as a symptom to hearing pain as transformative, affective and relational. The workshop provided a collaborative reflective counterspace for us to come together, articulate and stand in our expertise that has immense authority. We (clinicians) are not constrained within institutional restrictions or pathology; we are response-able people doing some amazing life-changing work in the gendered sexual violence sector, which needs to be articulated and heard. There was a palpable feeling of joy, hope, freedom and a new energy to share our expert knowledge and ethical actions in our work in the gendered sexual violence sector with other clinicians and institutions. I returned to myself for just one moment, as I felt the intense privilege to be a part of such a powerful and gentle space of reflection, I also felt a desire to close the workshop with intention and care. The workshop ended with manaakitanga[31], and the ending became a new opening.

Here, lies the importance of bringing all the parts of the workshop together. I showed a video of a dance as a visual/sensory summary of the conversations we shared throughout the workshop. Before the clip was played, participants were invited to notice what they felt as they engaged in hearing the pain in the form of art – an invitation I offer to you the reader as you have come alongside me through this project (Figure 4: Choreography @madeelizabeth (youtube.com)).

[31] (In te reo Māori manaakitanga) hospitality, kindness, generosity, support - the process of showing respect, generosity and care for others. (Moorfield, 2011).

Figure 7

The Five Stages of Grief

Note: This image is a snapshot of a YouTube video: The Five Stages of Grief. Choreography by Maddie Drabble @madeelizabeth_. To view the video press Ctrl + and click on link below.

Choreography @madeelizabeth (youtube.com)

Including the dance piece in both the thesis and the workshop is/was a purposeful movement for an experiential exercise to bring to life the relational affective intensity, a way of moving past restrictions of pathologised suffering towards the potential of affective intensity as a powerful initiator of reflective practice that moves outside the realms of language. The video was/is a reflective exercise to consider what depathologised expressions enable in our process of understanding pain. In this experiential exercise, we can view pain as freedom, movement and joy connecting in a deeper understanding of each other. As we sit in the space of no language, we (both us in the workshop and you, the reader) can engage with the dance and share in the movement of affective intensity, engaging in the transitions from *listening* to pain as a pathology to *moving* with pain as transformation – imperceptibility matters. When we can recognise these therapeutic moments, we also recognise the enormity of our privilege to sit alongside women who courageously share their painful narratives. Here in the counterspace without language, it does not matter how we interpret the art piece; what matters is how we feel in the moment and what it moves us to do in our everyday lives.

What follows now is the choral voices of the response-able knowledge that the participants produced through our reflection on a shared moment of listening and feeling the dance/music art piece. Clinicians engaged with relational affective intensity, speaking response-able practice into discursive, embodied waves of movement. These are our voices of resistance, these are the processes of us, the process of our pain as clinicians, our tensions and where we are in conflict with our institutional responsibilities and constrictions and also knowing otherwise. It is this knowing otherwise that we are bringing into the collective conversation in the workshop. That is the process of affirmative ethics, the responsibility to share our expert knowledge of relational affective intensities, how we build therapeutic relationships, and the creative ways we work in the therapeutic counterspace that depathologise women's painful narratives. We, together, when provided a collaborative and reflective counterspace, could disarticulate pain from suffering, feel the restrictions and push back against the institutional pathologised suffering, and ultimately, support each other to move from the individual figure of an incompetent (broken) clinician into a collective voice of response-able clinicians capable of building a social activist counterspace. As we engaged in reflections with intent, movement and curiosity we became response-able and authentic, building a collective voice of hope, compassion with waves of ethical action.

The following collective narratives were transcribed onto their own page. This was purposeful metaphorically and physically speaking to allow the reader to fully engage with each piece of response-able knowledge, and the resulting ethical waves of actions. As you read and engage with the clinicians collective knowledge, I encourage you to notice the ways relational affective intensity moves you, and what ethical waves you may contribute as (together) we continue to pave the way for social justice with oppositional consciousness.

I chose that piece because it was very powerful and showed the movement of affective intensity and how do we capture that in an assessment and that is what we are trying to do every single day in our clinical practice … to be able to create that in the language is incredibly difficult but I do believe there are opportunities to include it somehow… even in the conversations we have as clinicians as we infiltrate the way that we work in the community.. little small steps, it doesn't have to be huge. Even this conversation leaves an imprint. Depathologised expressions of pain are not singular emotions but are a relational affective intensity and women deserve to have that experience, they deserve to have that heard and that is hope in this social compass. I just wanted to add that the young person I was working with who had sexual trauma… was a dancer and I attended that performance and she expressed herself through dance and umm yeah it was very powerful…..[tears] You see when we talked about that piece (music/dance clip) I didn't realise the intensity of how I felt about that young person. I was like ohhhh…. It felt intense, I was really moved by that person. And that's a good thing. I knew the significance of me being there. And would that be seen as a boundary overstep in certain services? Not for me ….. [laughs]"

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Becoming conscious of relational affective intensity is an entrance to hearing affect, creativity and movement in the therapeutic counterspace –the start of an ethical encounter with each other as we engage in transitioning from listening to pathology to moving with pain – imperceptibly matters.

We can't hear women completely if we don't hear their affective intensity. Their voices are lost. **And I really don't like that we do that sometimes….they talked about it a lot when I worked at [institution] the resistant client – how are you going to deal with the angry client…… you know. Wouldn't you be angry too? Exactly.** It's the intolerance to the intensity. **Yeah, it is It's the system's intolerance to the intensity.** I had a whaiora yesterday say to me "This person:" ..who's the ACC case manager.. "doesn't even know me and they are writing about my life" ⋯ so I said to her do you want me to write back to them and let them know.. and so I was doing this email last night and I was thinking do I apologise to them [institution] Heck no, I'm not going too. I wrote an email to say you have no relationship with her, you are addressing her about something she really doesn't want you to know about, and you are assuming so much about her. I didn't put in an apology like I'm sure this wasn't your intention, I just left it, this is how it was for her. **You gave it authenticity…**I know, I normally try and smooth the waters over a bit.**: But what made this experience different for you to be authentic?** Because my whaiora was angry, and I could see she doesn't want any shit from [institution]⋯**You did things differently and usually your defence and comfortableness to smooth things over and make it feel ok was put aside, and…. you opened up that experience for her, she had her special person advocate…..And that shows your shift in being courageous and going to be authentic in this. That's huge**

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Becoming aware of the institutional intolerance to the affective intensity and acknowledging our intuitive movement in the therapy space as legitimate knowledge, we can lean into affect and response-able practice becomes visible with micro-political practices of daily action that have enormous empowering impacts for women.

I'm hearing you talk and I'm going gosh you not only acknowledged that anger in her but the affective response from yourself. We don't talk about our own personal responses in therapy. Ihaka and I, over the years, talked a little bit about Wairua. And I don't talk about it a lot, but there is stuff that happens in the room that I can't explain. I know when energy has shifted because I get a physical sensation, of like a tingling that sometimes goes through my body, and I don't question it. I just got it now, and I know something has shifted, to me, that is working in that space that transpires words. **And they often say that is confirmation of working in wairua.. sitting in the loveliness. That notion of reciprocity, there's an exchange of wairua happening all the time. If we use the metaphor of doors as clinicians as practitioners, or however we choose to describe ourselves, are we opening a door that allows us to connect through wairua? It is a vulnerable space.** I don't talk about this a lot at all. Most clinical psychologists would think I'm nuts if I talked about some of those things that happen in the room. So that's the system that we were trained in. It's the unlearning and the trusting piece.

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Becoming aware of the reciprocal moments of affective intensity (as clinicians) in a space of reflection provides an exit to the entrapment of institutional pathologised suffering. In coming together we are engaged in positive consciousness and can support one another to continue to keep the hope and joy alive- learning new ways of becoming response-able together.

And *what sorts of support do you need to do that?* **I just started with a new supervisor, and it was funny because she had this preamble and she was like, "Now I should let you know that I am not what you might call a proper clinical psychologist. I'm more about process and relationship, don't know if you would like that"?... I was like, that is exactly what I would like [laughs]. I was like, ooh, I found someone, but that is rare..... Being able to say that yes I use appropriate disclosure, yes I hug my clients, yes I have been brought to tears, yes I get angry alongside them and swear at ACC [laughs].**. I visualise the compass with a whole lot of doors around it, and I'm just thinking…. if the clients directing us, and they are going around the compass and they go oops that doors closed, we need to open those doors. **We have to be creative to leave the compass.**

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Becoming free to explore the reciprocal multisensory experiences and affective intensities within our community networks means we are no longer in silos of feeling incompetent or overstepping boundaries when we affirm women's narratives of pain. Instead, we can ask for the space and time to reflect with others - continue to engage in a deeper understanding of pain and sit in the space of vulnerability with ourselves and our clients safely.

We have an ethical responsibility to also be able to share our own affective intensity in our relationship with our client, and that's what I really hope that this compass will bring, these discussions, a safe place to have these discussions. You're right women will rotate around the compass until we open that door. You can have a system that is conditioned on transactions but you can have another system that is embodied in Aroha[32], compassion, kindness and understanding. **Everyone transforms in that space. When you step into a space of wānanga you don't leave the same… if you do maybe you are doing something wrong [laugh]….. you become curious**: Awareness. **And validation. Today's just so validating, it's like cool other people do that too. We have to keep doing this work. I like the analogy that we are eroding it lightly in nice gentle waves.. eventually the rock of the system will just gradually fade away.** I was just thinking about that Gandhi quote being the change you want to see in the world.

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Becoming conscious of our ethical response-ability to share our affective experiences in the therapeutic counterspace with other clinicians, has the potentia to transform not only our clients but ourselves. Just as the social compass showed us what is, the collaborative reflective workshop transitioned us to what we can become - response-able clinicians with expert knowledge of the therapeutic process and relationships. Together, we can build a social activist counterspace motivated by affirmative action.

[32] (In te reo Māori) Aroha encompasses love, concern, compassion and empathy (Moorfield, 2011).

Chapter Eight: Discussion

"E hara taku toa

I te toa takitahii,

He toa takitini

My Strength is not

as an individual, but as a collective."

(Alsop & Kupenga, 2016, p. 117)

Moving Forward with Response-ability

In trying to culminate a complex, interwoven reflection of many years of work, I feel it is important to go back to my narrative beginnings. At its heart, this project was born from a desire to provide dignified responses to women's narratives of pain. A passion that emerged from my experience of bearing witness to my mother's, and the women I worked alongside with in therapeutic counterspaces, suffering: experiences where the institution of the clinic was unable to *hear* their pain and instead listened to their symptoms to pathologise their pain as difference through the configuration of the hysterical subject. I longed for a space where we could move from *listenin*g through the constraints of the clinic, to *hearing pain* as affective intensities, enabling a response-able response through affirmative ethical practice that puts the motion back into (e)motion.

When I started this doctoral journey, I believed I was a lone voice, feeling an overwhelming pressure to make affective intensity visible, palpable and audible, and responded to in ways that affirm women's narratives of pain with dignity; a heavy boulder that almost paralysed me. However, as I progressed through the project, I recognised the many ethical relationships I had built over my career – the assemblage of the corridors - and I began to imagine opening a space for other clinicians to share their shadow stories in reflective collaboration in order to reimagine – together, collectively, creatively – an ethical counterspace that moves with pain, not as suffering, but as the conditions of hearing new and hopeful futures for women who have experienced gendered sexual violence.

Braidotti created footprints in this journey, as I brought with me understandings of affirmative ethics as "pursuing affirmative values and relations" (Braidotti, 2019, p. 136), contextualizing affectivity as an intensely felt experience, and privileging the relational processes that enable a collective, political praxis of hope, compassion, and transformation. Affirmative ethics offers a response-able response to the toxic conditions and injustices of cognitive capitalism and the system of institutional pathologised practice that functions and profits from understanding women's pain as a symptom to fix, enabling us to imagine lines of flight that engages with and transforms the structural violence of imposing pain as suffering. In this project, we – together - mobilise Braidotti's ethics of affirmation as a response to the suffering faced by women who have been pathologised in their pain, and the physical/mental exhaustion of clinicians working within neoliberal systems of response, and we consider how to create reflective counterspaces where conversing about affirmative responses to pain can mobilise the potentials that affective intensities offer our ethical responsibilities and practices for dignified responses to women's narratives of pain.

This dream came to fruition with the development of a reflective workshop: a space where seven practitioners in the gendered sexual violence sector came together to bear witness to our shadow stories, and to legitimise and creatively co-create new ways to become response-able as a 'moving we'. In the workshop, we traced the imperceptive, creative and affective ways clinicians, working under institutions that prioritise pathology as a dominant understanding of pain, are not constrained by institutional restrictions in the therapeutic counterspace. Through affirmative ethics as praxis, we connected through a recognition of affective flows of meaning making which were not *thinks* but powerful relational affective intensities, moving from listening to pain as a symptom to fix, to moving with pain as a motivation for ethical actions and a transformation of the conditions of a hearing. We-together made sense of pain relationally to evoke a political response to institutional practices of pathologisation and structural violence.

In the safety of the workshop, where we could share our shadow stories vulnerably and intentionally, we connected through recognising moments of working creatively under institutions to evoke what we are (capable) of becoming and being. Together we worked to

explore how we can, and do, 'feel our way' through the maze of intuitional response: a relational ethical practice of thinking outside the limitations of pathology. We shared our untellable stories of small resistances and affective intensities that flow through and from our relationships with our clients and each other: affective flows that broke apart the configurations of hysterical women and 'broken' clinicians to weave together a pathway for a more responsible response to women's pain in our ethical encounters.

We recognised how such spaces of movement from negative consciousness to positive passions is not a space accounted for, or privileged, within the institution of the clinic. The limited time and support we have from institutions to reflect on these movements and experiences in the therapeutic counterspace constrain opportunities to support each other (curiously and creatively) as we bear witness to the painful narratives presented to us every day, and to share together our expert knowledge with other clinicians working in the sector. The workshop, as a process of collaborative reflection, brought us together to explore the multisensory moments in the therapeutic counterspace that hold and build therapeutic relationships; an example of affirmative ethics to mobilise response-able responses through relational affective intensity. We became invigorated by/through our ethical responsibility to share our expert knowledge on therapeutic processes, and the powerful potentials building therapeutic relationships for the evoking of a massive transformational social movement for women.

Through collaborative conversations that produce alternative collective knowledges of how we can, and do, embody ethical encounters in the therapeutic counterspace, the personal becomes political, and the imperceptible becomes affirmative. If we remain in the shadows and do not share our knowledge with each other and the institutions we work in and through, we fail to enact our responsibility to evoke social justice outside of the therapeutic counterspace for greater social change. We cannot achieve social activism in isolation, and it is in the *we togethe*r that strength is formed. When we are provided time to come together and reflect, we reimage what is possible in the therapeutic counterspace to depathologise painful narratives and hear the pain as the potential for freedom and joy. This site and space for reflective collaboration and conversation can be mobilised as a process institutions can embrace, imagining systems that prioritise and create collaborative reflexive spaces as essential for maintaining and sustaining ethical care: systems that mobilise relational affective intensity

as a pathway to ethics of affirmation and as an ethical activist counterspace to build political hope.

This project is one step in the process of a reclamation of our power and potential in a system that can feel overpowering and all-encompassing as we work alongside, and within, institutions. And those institutions need to hear, curiously and genuinely, what we need to maintain ethical and safe response-able practices in the gendered sexual violence sector in order to acknowledge and respond to clinicians' well-being in a work sector that is under resourced and over loaded. They need to listen to our collective voice so that we can build response-able practice together, and to contribute new knowledge for ethical activism. When provided the time and space to allow us to explore together the 'other' of ourselves and each other, not constrained by science and pathology, we are moved into action through our processes of hearing for the affective flows of meaning making to produce knowledge as a route to strong objectivity. We become clinicians who engage with clients with compassion and dignity, we have the potential to feel energised and satisfied in our work, enacting a sense of freedom and joy for ourselves as well as the women we have the privilege to support. We will no longer be individual clinicians 'stuck in the weeds', and can become a collective voice and movement of response-able practice together, engaging and processing relational affective intensity as a reflective conscious-raising process with the potentia for ethical/political institutional transformation. We can build an exit to the pathologised suffering and see alternative knowledges emerge, legitimated and protected, that mobilise our expert knowledge of relational affective intensities and therapeutic relationships as a pathway to freedom, not only for women but for the clinicians who work tirelessly in the gendered sexual violence sector.

When institutions become a part of the movement for affirmation, they too have the opportunity to be a part of an ethical response to pathologised suffering. And if they join us in the assemblage of collective reflective practice, it will not matter what institution we work under or how the system changes; it will always be possible to become response-able together. Reflective workshops, as a process legitimated within and endorsed by institutions, can provide conviction for clinicians working under institutional restrictions "like injecting hope into a socially depressed field, or turning exhaustion into an opportunity for radical transformation" (Braidotti, 2022, p. 147). Affirmative ethics is brought about by bringing clinicians together –

"a *we* that is a missing people" (Braidotti, 2022, p. 147) - with a shared passion to enact formative insurgences of the existing conditions, to materialise "virtual possibilities" (Braidotti, 2022, p. 147). Through the movement of disarticulating pain from suffering we can evoke energy and motivation for resisting institutional violence and tell our stories so that institutions can learn how, they too, can become a part of the response-ability to provide ethical and safe services to all women accessing mental health services or any other institution that provides care.

The power of this research is about becoming a part of the collective that advocates for collaborative reflective practice as an essential tenant to maintain dignified responses to gendered sexual violence and clinicians' well-being, asking higher institutional systems to join us through and within clinical psychology training and workplace training. Training programmes and clinicians all speak of the importance of the therapeutic relationship and reflective practice - both tenets are key competencies that are assessed throughout training and by the psychology board. But what this research contributes is exactly how we may build these experiences outside the limitations of institutional pathology and restrictions. Rather than the clinic, and therefore clinicians, assuming a position that is fixed, static and unitary, through mobilising relational entanglements within collaborative reflective processes, we are able to evoke a collective of becoming (becoming a collective): an assemblage of clinicians and reflective practices that move with/beyond the shape of institutions through micropolitical and imperceptible resistance and relational ethics of care: a becoming of response-ability.

The time to build relationships with each other and come together to reflect on how our practice can attend to affective intensities, encourages us to embrace what we intuitively sense, and conceptually know, when we are confronted with pain of multiple others – not all of them human – but senate: a nomadic, transversal assemblage (Braidotti, 1994; Deleuze & Guattari, 1987). Listening to and accounting for pain is a process of dis-identification (yes, it's pain and yes, it is painful) but there is potential to rebuild and move towards a response-able practice that provides clinicians with a sense of freedom while honouring women's narratives of pain with dignity. Bringing together our shadow stories into our clinical identity is a process that collective and collaborative reflective practice can support and encourage. The value of reflective practice is well known in psychology, and holding space for these conversations

would greatly benefit psychologists and needs to be facilitated by institutions. What this thesis demonstrates is that 'we' can only act collectively if we acknowledge that 'we' are in this together, but we are not one and the same (Braidotti, 2024). This research can help define what is meant by that, and contributes to the literature highlighting the need for emotional reflections, and how collaborative reflective counterspaces enhance practice and therapeutic outcomes.

Looking forward, it is going to be vital to understand what is perpetuating such systems pathology and suffering in higher political spheres. Why are clinicians – especially those who prioritise building a therapeutic relationship over administrative expectations – uncomfortable speaking about what they need to maintain ethical practice and continue working in the gendered sexual violence sector? It will be important to initiate a method that apprehends this discomfort and transforms it into authentic guidance for institutions to continue to provide the conditions necessary for clinicians to provide ethical care for women who have experienced gendered sexual violence. Continuing to hear women's narratives of pain with dignity and political action will be of greatest importance, so those who continue to work on the front line (i.e. clinicians) must advise the application of change within institutional systems - always in a process of becoming response-able together.

As I end the project, I am no longer alone, we-together are a collective and we were free all along. With the end of the project, we are nowhere near complete, we have an ethical response-ability to keep the momentum going, to take what has been learnt on our journey to higher institutional systems and advocate for more time to reflect, engage, and collaborate. If not, we risk losing the passionate dedicated professionals who work tirelessly to provide dignified responses to women's narratives of pain, and women are left to rotate the social compass as shameful figures. Now, with this research and knowledge, we have an amazing opportunity to mobilise the potentia not only in the therapeutic counterspace, but also in our work as ethical activists. For that, I am hopeful and remain committed to continuing a journey of advocating for collaborative reflective practice and a career with enduring moments of becoming response-able. Braidotti is a voice that guides us, empowers us to share hope, and consider a deeper understanding of pain but always with ethical action, and so I leave the final words with the echoes of Braidotti. "We need to actively work towards a refusal of horror and violence – the

inhuman aspects of our present – and to turn it into the construction of affirmative alternatives" (Braidotti, 2015b, p. 23).

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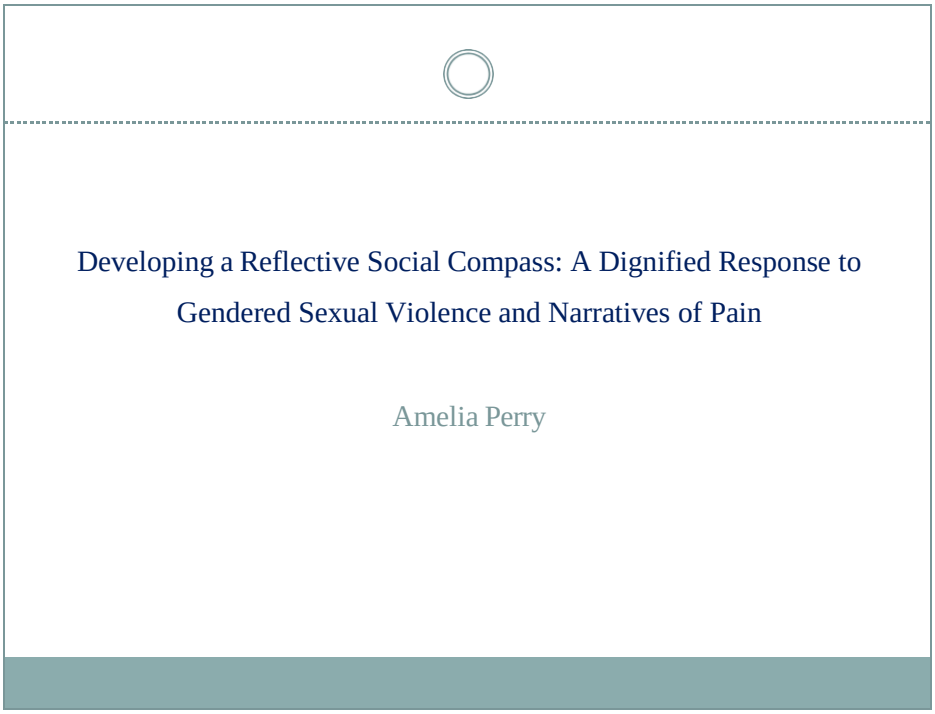
Appendix A: Workshop PowerPoint Presentation



Narrative Beginnings

The Enactment of Gendered Sexual Violence

- Enactment: Social interrelations and exchanges between society and rape culture that normalise gendered sexual violence

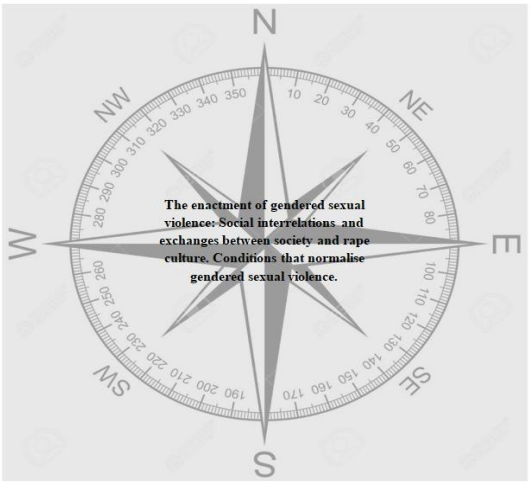


Figure two: The enactment of gendered sexual violence.

The Embodiment of Shame

- Embodiment: Social interrelations between the enactment of gendered sexual violence and society which produce emotive subjects

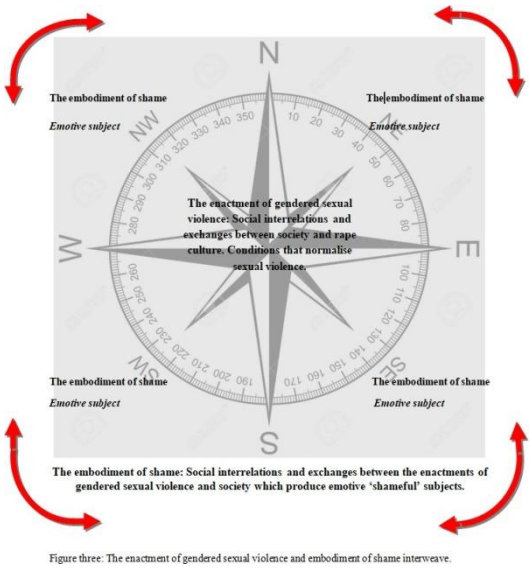


Figure three: The enactment of gendered sexual violence and embodiment of shame interweave.

The Shameful Figures

- Shameful misleading figures

  Real victim Real rape

  Unworthy victim

  Hysterical

- Shameful pathologised figures

  Pathologised

  Broken Well

A Reflective Social Compass

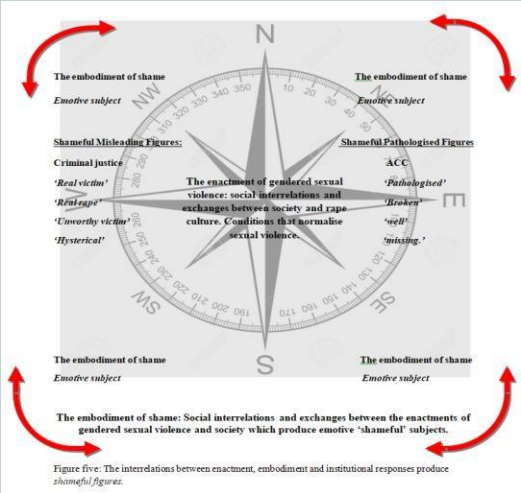


Figure five: The interrelations between enactment, embodiment and institutional responses produce *shameful figures.*

Depathologised Expressions of Pain

l

Music & Dance: An Example of De-Pathologised Pain

The Five Stages of Grief | Choreography @madeelizabeth (youtube.c The Five Stages of Grief | Choreography @madeelizabeth (youtube.com)om)

Reflective Practice: Putting the 'motion' back into emotion

- Depathologised expressions of pain, are not singular 'emotions' but relational and affective intensities.

Group Discussion

- What can we do to build reflective practice that accounts for the Enactment and Embodiment?
- What conditions may be needed to encourage collaborative reflective practice which depathologises pain?
- How do we build the potential in collaboration with institutions?
- How can we open spaces for new forms of knowledge to be included in assessment and treatment in mental health services?

Karakia

Kia hora te marino
May peace be wide-spread
Kia whakapapa pounamu te moana
May the sea be like greenstone
Hei huarahi mā tātou i te rangi nei
A pathway for us all this day
Aroha atu, aroha mai
Give love, receive love
Tātou i a tātou katoa
Let us show respect for each other.

Appendix B: Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Seeking Research Participants

LET'S TALK ABOUT HOW WE DEVELOP REFLECTIVE PRACTICE IN THE GENDERED SEXUAL VIOLENCE FIELD

INFORMATION SHEET

Researcher:

Tēnā Koe, my name is Amelia Perry. I am a clinical psychology doctoral candidate at Massey University. I have also worked as a counsellor in the gendered sexual violence sector for many years. As part of my doctorate, I am researching how registered clinicians develop reflective practice under institutional frameworks in the gendered sexual violence field.

Research Abstract:

In Aotearoa, New Zealand, there is little research on developing reflective practices for clinicians and institutions to respond to women's experiences of pain in ways that avoid pathologising assessment and treatment. Mental health services often require clients to tell and retell the event of sexual violence, which has the potential to perpetuate harm in reliving the trauma. The dominant psychology narrative configures women as mentally ill experiencing psychological symptoms to be fixed, and women become subjects to cure, producing shameful figurations. In listening to women's experiences of pain through the dominant narrative of women's deficit representations, we miss opportunities to hear alternative depathologised expressions of pain and women's voices are lost. In the configuration of the singular pathologised story, an *enactment* of violence is produced, and women go on to *embody* shame as an affective consequence. In developing a reflective practice that considers depathologised expressions as valid knowledge,

we can start to open the space for women to share their experiences in ways that have the potential to reduce shameful experiences in mental health services. This research aims to empower clinicians and institutions to recognise and respond to depathologised expressions of pain, upholding the dignity of women who have experienced gendered sexual violence.

Research project:

As registered clinicians, we often work in private practice or within the confines of institutional expectations, limiting time and space to reflect on our practice. This research workshop aims to provide an open and reflective space where clinicians can discuss collaboratively how they provide responsive and ethical practice within the constraints and challenges of institutions.

The workshop will be approximately two hours, and participants will inform a reflective compass that was developed during my Master's thesis; this will provide opportunities to further develop their reflective practice within institutional constraints.

This research project is taking a collaborative research design; participants will be a part of a group conversation to share ideas on how we can depathologise women's experiences of mental health services and ultimately reduce shame for women with lived experiences of sexual violence.

Participants:

This project focuses on clinicians' experiences working in the gendered sexual violence field, so participants must be affiliated with a professional body and engaged in supervision. Clinicians from varying professions, including social workers, counsellors, psychotherapists and psychologists, are welcome to contribute. I will be recruiting participants by asking trusted intermediary colleagues to provide this information sheet to clinicians they think may be interested in participating. You have been given this sheet because a mutual person thinks you may be interested in participating.

Project procedures:

A short PowerPoint presentation will be delivered on a proposed social compass to depathologise women's experiences of sexual violence. Guest speakers will also share their experiences building reflective practice under institutional expectations. This presentation will be followed by a group discussion, which will explore topics such as: How do we, as clinicians, look after ourselves when doing this work? How do we bring conscious awareness to our work? How do we feel about the assessment and therapeutic processes under institutions? How would we like the process of assessment and therapy to look and feel? How can we collaborate to develop a reflective practice that depathologises women's experiences?

Participants' Rights:

Although you have been given this information sheet, you are under no obligation to accept the invitation. However, if you would like to participate, you have the right to:

- Not discuss any topic or answer any question that you would rather not talk about.
- Ask questions regarding the study at any point in the process.
- Understand the process thoroughly.
- Take space away from the workshop at any time.
- Understand that your name will not be used, nor will any identifiable information about you or your workplace.
- Have a copy of a summary of the research findings when the research finishes.

Thank you for taking the time to read this information sheet. Participating in this research is voluntary and confidential. The person who gave you the sheet will not know if you contact me, and I will not tell them who participates in this study. If you decide you would like to participate or discuss the research with me in person, don't hesitate to contact me via email, phone or text, and we can arrange an initial meeting to discuss the research process.

Ngā mihi nui

Amelia Perry

Workshop Details:

Date: Thursday 13th October 2022

Time: 4-6 pm. Participants are welcome to stay for refreshments afterwards.

Venue: [redacted]

To attend the workshop as a participant, please get in touch with Amelia Perry on [redacted], or email [redacted] to confirm attendance.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz

Appendix C: Consent form

I understand the information sheet and the nature and purpose of the study. All my questions have been answered adequately.

I understand that participation in this study is a collaborative process and involves a group discussion with both the presenters and other participants.

I understand that no discomfort is anticipated from being in this study. However, the nature of the conversation is sensitive and we will be sharing our clinical narratives. The researcher will emphasise to all participants the importance of confidentiality, and not disclosing any client details in our conversations.

I understand that my responses will remain confidential, and no identifying information about me or my workplace will be included in any reports.

I agree to the workshop being digitally recorded.

The workshop questions are directed to the group, not to individuals, and I understand that I do not have to answer or participate in the conversation if I do not feel comfortable.

I understand that I can step away from the workshop at any point, but the recording will continue until the study is complete.

I understand I will have access to a summary of the research at its completion.

I agree to participate in the research under the conditions described in the Information Sheet provided.

Declaration by Participant:

I _____agree to participate in this research as explained in

Signature: _____Date:

Appendix D: Internship Case Study

Te Mata a Māui ‘s Collective Trauma: How My Doctoral Research Informed My Work as a Clinical Psychology Intern Amidst a Natural Disaster

This case study was completed during the period of an internship at The Child, Adolescent and Family Service at Te Whatu Ora Te Mata a Māui Hawkes Bay in 2023 as part of a Doctor of Clinical Psychology and represents the work of Amelia Perry under the supervision of CJ L’Hoste.

The Privacy of clients is maintained by de-identifying their personal information and utilising pseudonyms, following the Code of Ethics for Psychologists Working in Aotearoa/New Zealand.

Name: Amelia Perry, Intern Psychologist, the Child, Adolescent and Family Service, Hawkes Bay

Student ID: [redacted]
Supervisor: Dr Kirsty Ross
Word Count: 3380

Candidate: Amelia Perry Supervisor: Dr Kirsty Ross

Date: 19.11.23

Abstract

Cyclone Gabriel hit Te Mata a Māui in February 2023, one week after starting my Child, Adolescent and Family Service (CAFS) internship. This case study is primarily based on my perspective as an intern psychologist involved in a brief intervention immediately following Cyclone Gabriel. I summarise my doctoral research and the process of engaging in reflexivity and de-pathologisation of painful narratives when responding to vulnerable communities after a natural disaster. Reflections then follow about how my research experience contributed to my development as a clinician working with whānau impacted by the collective trauma experienced due to Cyclone Gabriel. This case study brings together how research informs practice within a scientist-practitioner model and highlights the importance of reflexivity for clinicians. Clinically, the need to depathologise painful narratives resulting from collective trauma (including natural disasters) reflects trauma-informed care that supports community and individual healing and resilience.

My Narrative Beginnings

As I neared the end of the internship, I found myself returning to my "roots", where I come from and what the future may hold as I enter a profession as a Clinical Psychologist. To achieve this mammoth task, I need to start from my narrative beginnings, acknowledging my whakapapa, where I come from and how I got here -an initial point of my social compass. My journey to being a clinical psychology student began as a child, witnessing my mother's pain and subjugated journey through mental health services. Without my mother's courage to share with me her experience of childhood sexual abuse and her willingness to have me walk alongside her in mental health services, I do not believe I would be here today. In witnessing my mother's pain (and the dismissal of her story), I developed a passion for providing respectful and dignified responses to women with lived experiences of gendered sexual violence.

I have had the privilege of supporting many amazing women as a counsellor and, more recently, as an ACC-registered sensitive claims therapist. I have worked in private and public

settings, which has been rewarding and challenging. I've had moments of feeling I have impacted women's lives positively, but I also struggled with a missing piece. As a counsellor, I was limited in how I could advocate for clients during the assessment process. I had witnessed many assessments as re-traumatising and pathologising for clients, which placed further blame and shame on women seeking mental health services. I began to consider what would need to change to inform the assessment of mental health and, alternatively, include depathologised expressions of pain as a valuable tenet. At the onset of the clinical psychology training programme, I began to consider how I could influence the process to be interrelational, attending to affective intensity and 'leaning into' distress with humility and courage, as opposed to avoiding or taming affectivity. Still, I continued to be troubled by the medical professionals' attempts to extinguish affective experiences with medication or therapy, as though they needed to be tamed, and I began to wonder how I could create waves of change in ways that do not push against institutions but work alongside them.

So here, I turn to the work of Rosi Braidotti, a feminist philosopher who prompted reflection and curiosity about how feminist activism and psychology can move beyond the pathologised and apprehend the interrelations. I argue that pathologised medical representations of women's pain have become an embedded social response to gendered sexual violence, limiting creativity and focusing on women's narratives as an instrument of social change. To apprehend the interrelationships between clinicians and institutions, we can open up space to focus our understanding of the mechanics of figuration as "Materialistic mappings of embedded and embodied social positions" (Braidotti, 2011, p.4). Braidotti (2010) argues that essential ethical activism is built on oppositional consciousness. Resistance as oppositional negativity "implies a belligerent act of negating the present conditions: a double negative that endangers an affirmative" (Braidotti, 2010., p. 142). In the absence of dignified responses, we see women are at risk of being reconstructed as *shameful figures,* as they are expected to re-tell their stories of shame and pain over and over again – a type of embodied pain that has dire consequences on women's everyday materiality (Shelton, 2020). Braidotti (2010) argues oppositional consciousness is not the same as resistance (negativity) and instead claims activism needs to build strategies to assemble affirmation (Braidotti, 2010). How could I even begin to make waves as one person among institutional restrictions?

In my doctoral research, I hope to understand how professionals can embrace affective intensity as a valuable tenet to hear/feel – an interrelational process that seeks to attend to distress as a powerful force for healing. The challenge of balancing my position in my research and completing an internship with a "clinical focus" was one that I was unsure I would manage and expected would be a gradual and emerging process; little did I know I would be thrown into a natural disaster which almost fast forwarded this crisis of personal and professional identity. However, before reflecting on this subjectivity, I will situate my experience by returning to the research that guided this complexity.

Doctoral Research Overview

My doctoral research focused on developing reflective practices for clinicians and institutions in response to women's experiences of pain without pathologising assessment and treatment. Mental health services often require clients to tell and re-tell the event of sexual violence, which has the potential to re-traumatise women by reliving distressing experiences. The dominant psychology narrative configures women as mentally ill, experiencing psychological symptoms to be fixed, and women become subjects to cure; this process can have the consequence of producing shameful figurations. In listening to women's experiences of pain through the dominant narrative of women's deficit representations, we miss opportunities to hear depathologised expressions of pain and women's voices are lost. In the configuration of the singular pathologised story, violence is *enacted*, and women go on to *embody* shame as an affective consequence. In developing a reflective practice that considers depathologised narratives of pain as valid knowledge, we can start to open the space for women to share their experiences in ways that have the potential to reduce shameful experiences in mental health services. This research aims to empower clinicians and institutions to recognise and respond to depathologised expressions of pain, upholding the dignity of women who have experienced gendered sexual violence and expands on my Master's research.

In my Master's study, I developed a social compass that brought together the enactment of gendered sexual violence and the embodiment of shame. The model of the social compass

that comes together in the figure below is not intended to account for all subjectivities. Instead, it aims to demonstrate the social exchanges and interrelations between the *enactment* of gendered sexual violence and the *embodiment* of shame and how women's bodies are figured and reconfigured within institutional/societal responses to produce shameful emotive subjects. In understanding the enactment and embodiment as a social compass, we can see the interchange between gendered sexual violence and shame through multiple interconnecting relationships.

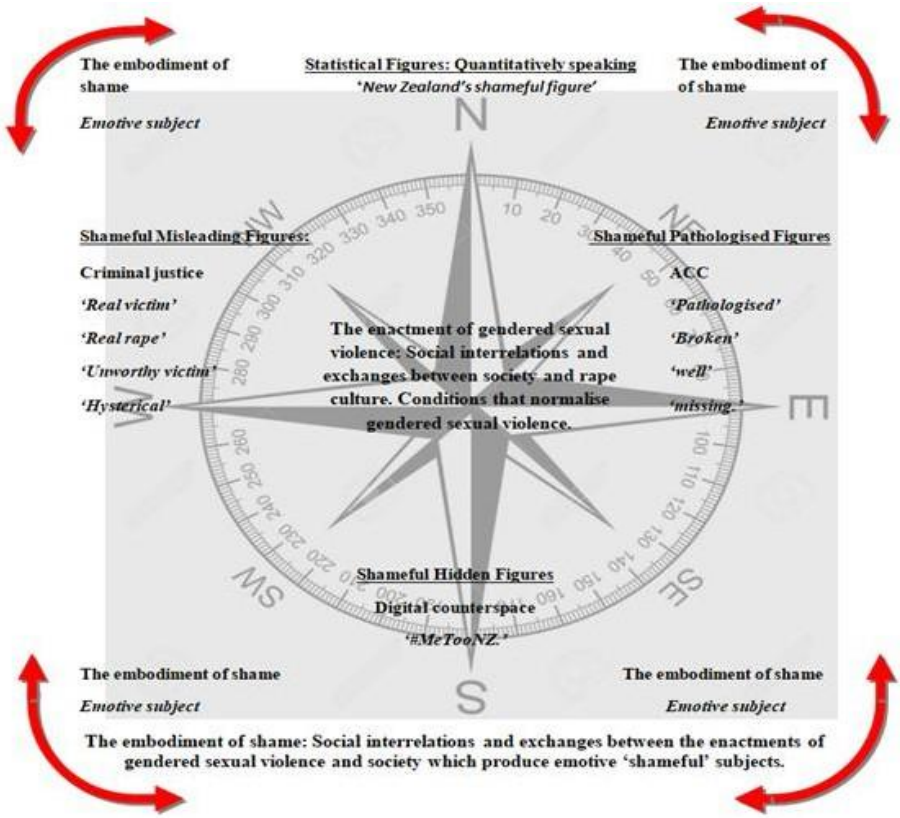


Figure one: A social compass to demonstrate the reciprocity between gendered sexual violence and shame (Shelton, 2020).

The social compass allows us to visualise how women are positioned in the interrelations between enactment and embodiment, with limited agency, and in the spaces between are multiple movements enacting and embodying shameful figurations. It is a privilege to hear the stories of women's pain, and I recognise safe spaces for women to be acknowledged and

validated are necessary. Yet, as therapists in institutional responses, we try to 'fix' embodied emotions as if they are unruly and require disciplinary practices of institutional knowledge that categorise their distress as a mental disorder or feminine fragility. Women are placed in the position of re-telling their stories as they circle in and through a re-enactment of gendered sexual violence and embodied shame.

My doctoral research seeks to further develop the social compass as a reflective tool for clinicians in mental health services. In engaging with clinicians' experiences working in the gendered sexual violence community, a qualitative approach is proposed to utilise feminist ethics of care epistemology and a narrative inquiry methodology. These methodological processes were chosen specifically to ensure women were not placed in a position of sharing stories of pain that may limit what can be heard and reduce the meaning of the pathologic experience. Instead, clinicians were invited to engage in a reflective workshop that aimed to gather rich contextual information on how therapists make sense of reflective practices that account for the *enactment of gendered sexual violence* and *embodiment of shame* to recognise depathologised expressions of pain that sit outside the singular pathologised story. The project aims to reduce the pathologisation of women's painful narratives by providing a reflexive social compass for clinicians and institutions in practice – a dignified response to gendered sexual violence and women's narratives of pain. However, as an intern, I needed to push against this social compass to fit into my role as an intern position. Although I was aware the conflict would be present, I was unaware that this conflict would be even further tested as a category four cyclone hit my beautiful hometown. This experience would shape my internship both metaphorically and figuratively.

Although my research focuses on clinicians' experiences working with women who have lived experience of gendered sexual violence, my internship allowed me to consider how reflective practice that considers the enactment of trauma and embodiment of affective consequences can guide clinicians and institutions when responding to other traumatic events. An unexpected turn of events would lead me to deeply consider how the social compass may be adapted to guide clinicians to respond in a dignified manner to 'happening in the moment' painful narratives.

Cyclone Gabriel: An Internship Turned Upside Down

Cyclone Gabriel hit Te Mata a Māui in February 2023, one week after starting my internship with the Child, Adolescent and Family Service (CAFS). Although my family and I were not severely impacted, ignoring the destruction surrounding my beautiful hometown was impossible. Visions of once stunning landscapes were utterly devastated, and Napier and Hastings were 'literally' pulled apart. What was once a 20-minute drive between cities became a dangerous 2-hour drive through flooded and damaged roads. One of the vivid recollections of this experience was looking out towards Te Mata-o-Rongokako and adjacent hills, once a green and vibrant mountain, now covered in slips that gave the appearance of visible scars on the land.

Understandably, my internship was impacted by the crisis response that needed to take precedence over orientation, and I found myself amidst a civil emergency. Te Whatu Ora became focused on providing psychological first aid as a first point of call, developing worksheets and videos in response to the widespread tragedy, and rushing into communities in helicopters with "psychological experts" to respond to the collective trauma of cyclone Gabriel. I immediately began to feel a tension of being true to my research while meeting the needs of a community in crisis and fitting into the "box" that Te Whatu Ora moulded to respond to disaster. Psychological first aid (PFA) is an "intervention" often delivered immediately after a disaster and seeks to establish safety, provide accurate information and combat misinformation while conveying hope and focusing on community strengths. The basic tenet is to attend to communities' needs by establishing social connections and providing practical support (Schulenberg et al., 2008). First responders use PFA to relieve distress in addition to helping people come to terms with significant grief and loss. However, I couldn't help but wonder if this response was appropriate and sufficient in meeting the needs of whānau, minimising the displacement and collective trauma that decimated an entire community, and pathologising a painful experience in ways that perhaps lacked the compassion of listening. I found myself putting together handouts that focused on normalising responses to natural disasters with catchlines such as; "a normal reaction to an abnormal event" and reading resources emailed to staff as a way to respond to distress, almost scripted

as prompts:

"It is likely that you will encounter challenging conversations with anxious, distressed or frustrated people. Should this happen, here are some strategies to use. Should you sense that the person needs to let off some steam – listen - no matter how negative their speech. If they are being negative or in distress, this is essentially positive, as they are communicating their needs, and asking for help".

Here, we see an institutional response to "challenging" conversations in an attempt to categorise and pathologise using terms such as anxious, distressed and frustrated as a type of problem to be extinguished, followed by "instructions" to listen to their responses through a lens of pathologised speech. Yet, Te Whatu Ora asked staff to stop seeing clients and attend "acute presentations" only. I felt like I was not helping my community as I could not start building a caseload immediately, and I recognised the clients already engaged in our service were left to process the enormity of their new reality. When I was finally "given permission" to contact families, it was clear they felt unheard, forgotten and angry with the response from clinicians as we were seen to jump to interventions for a collective trauma while they waited in silence.

I couldn't fathom how we could engage in a process that failed to care for our existing clients, as we were told to stop all work and focus on "psychological first aid". I was angry, hurt and deflated before starting my clinical work, as I went to local schools to meet with staff (who were just as shellshocked as their students) and hand out the very information that went against my research hopes, that pathologising speaking out about the traumatic stories – a type of re-traumatising and expecting families to express the sadness in words, totally lacking alternative depathologised expressions of pain – an injustice unfolding before I could begin my internship. Still, the institution continued to send staff messages that seemed all too limited, as follows:

"If your efforts to de-escalate the situation aren't working … STOP! You will know within 2 or 3 minutes if you are making a difference. If the person isn't calming down, ask your team for help or tell them you are ending the conversation. Reasoning with someone who is highly distressed and angry is not possible. Your only objective should be to reduce the level of arousal so that discussion becomes possible. We are all driven to fight, fight or freeze when

scared. However, to calm someone angry or upset, you must appear calm yourself ... even if you aren't."

The "advice" to staff is to "reduce arousal so that discussion becomes possible", and an assumption is made that to relate to a person in distress is intolerable by the clinician (Shelton, 2020). Blame is somehow placed on the person as an individualised process. This response completely negates the clinician's responsibility in the relationship. It is vital to note that as clinicians, we, too, experienced the natural disaster ourselves. We heard and saw the destruction and decimation of land and had personal stories of hearing, seeing and feeling the effects of the cyclone all around us. My research examines the interrelational process as an essential response to painful narratives. Clinicians and institutions are not innocent bystanders in response to the stories told. Instead of prioritising pathologised representations in responding, listening, and writing about pain, we must understand the interrelations. I argue relational ethics is a fundamental response to painful narratives that positions "ethical action explicitly in the relationship" (Given, 2008., p. 2).

Ethics of affirmation requires more than 'fixing' ethical dilemmas through moral reasoning or a framework for making ethical decisions, which Te Whatu Ora attempted in handouts to staff. Ethics is about the interconnection between people; paying attention to the depathologised expressions of pain or the unspoken affective intensities is an essential tenet of responding in ways that do not enact further violence and respond with care (Braidotti, 2001; 2010). Braidotti (2001) foregrounds the importance that ethical responsibility remains "eminently political" (p. 381) and is the convenience of accountability in relational and collective modes of interrelations. A relational process seeks to reveal power relations and reduce power disparity (Braidotti, 2001). Here, Braidotti brings attention to relational ethics as a type of "politics of location" (Braidotti, 2001, p. 381). It is vital to draw on a "critical reflexive politics of location" (Madhok, 2020, p. 396) because it opens up possibilities to engage with the pain in alternative ways and respond to affective intensities instead of the singular pathologised story. I began conversing with other staff members about their thoughts and feelings on Te Whatu Ora's response to Cyclone Gabriel. I heard how uncomfortable they felt in "rushing" into communities in ways that placed us as an expert. One conversation, in particular, stood out in speaking with a Māori colleague about the loss of a local marae. The colleagues expressed

anger and sadness at the fact mental health clinicians presented to the tangata whenua with handouts and "psychological first aid" as a type of consultation for their loss. A colonised approach to displacement and a Eurocentric medical model failed to seek advice and guidance from the local kaumatua and kui or kaumātua services, who knew the community well and had existing relationships. My colleague said we failed to see the existing strengths of Māori, and instead, we responded with the standardised medical protocol. This example is only one of the many conversations I had with staff, but it highlights the embedded neoliberal colonised approach to trauma. That is, immediately responding to an individual's pain as an "emotion" to be extinguished and ignored. This process implies distress needs to be managed within comfortable parameters that individuals must stay within, or they will be avoided or disciplined. I began to reflect on the social compass as a guide in the chaos, which helped me bravely have these conversations—and encouraged me to think about my role in the institutional response.

Conclusion

As I navigated the end of the internship, I continued to be troubled by the singular pathologised story; however, I also found hope in the ongoing conversations with colleagues across services. It is indeed possible to influence how clinicians respond to painful narratives by using the social compass as a guide, not only in the field of sexual violence but in other traumatic responses, such as a natural disaster. I now find myself an emerging psychologist and know I can continue to balance the expectations of institutions while honouring my values of de-pathologising pain for women. I am in a constant state of 'becoming'; there is no fixed destination, but what I do now as I enter a career as a clinical psychologist, Braidotti reminds me that all change needs to be collective, relational and affirmative. We cannot leave the stories of pain circulating without purpose or care. To focus on the pathologised singular narrative, we inadvertently miss the client's painful expressions of intensity, which go on to be embodied if not felt and heard by clinicians. This research aims to bring attention to reflective practice that accounts for the enactment of trauma and embodiment of affective consequences (including shame) while striving to work collaboratively with institutions to depathologise pain. The challenge (that I wholeheartedly accept) is to develop a reflexive social compass for

clinicians and institutions to use in practice – a dignified response to trauma and narratives of Pain.

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