Broken Mirror: The intertwining of therapist and client stories of childhood sexual abuse (CSA).

Abstract

In recent years there has been a great deal of attention given to the potential increased risk of Vicarious Traumatisation (VT) for clinicians with a history of Childhood Sexual Abuse (CSA).

I am curious about whether the silencing, which has been ubiquitous within society, is also prevalent within the therapeutic profession. I wonder if therapists with a history of abuse feel they have to bracket their experience, and if this limits the potential for positive transformation.

In this paper I draw upon my narrative study of therapists with a history of abuse. The methodology followed was narrative inquiry with two therapists in addition to an autoethnography. I used 'narrative analysis' to analyse the data. The findings of the study covered themes of transgenerational trauma, 'the wounded healer', caregivers' responsibility in communal cultures, and dissociation.

In this paper, I will consider the part dissociation plays when there is a shared history of trauma, and the ways in which dissociative enactments within the consulting room themselves may be part of the mutual healing. For this paper, only extracts from interviews with one of my participants will be included.

Introduction

One of the core components of my study included an autoethnography. I use the term autoethnography to mean autobiography with an ethnographic dimension using the following definition:

"Autoethnography is an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural." (Ellis & Bochner, 2000, p.739)

Consistent with autoethnography, this paper is written in the first person, in order to encourage the reader to enter and recall the stories emotionally and

cognitively (Ellis & Rawicki, 2013), and to bring the reader closer to my experience.

In this paper, I will be sharing research I conducted using narrative inquiry. I have chosen to focus on themes of silence and dissociation, but rather than share my findings, I believe that the most effective way of making sense through narrative inquiry is to 'think about' the stories (Polkinghorne, 1988) and 'think and feel with' the stories (Frank, 2013). I will draw upon my own autoethnography and narrative conversations with another therapist, Anna (anonymised) who has a personal history of abuse.

In the paper I will be exploring dissociation from a range of perspectives, and I will be considering how the defence against shame is a core component of dissociation. I will also illustrate how working with embodiment can help both client and therapist to make deeper contact and to be less dissociated in their process.

Dissociation is a major failure of integration that interferes with and changes our sense of self and our personality (Boone et. al, 2011). I will be exploring dissociative process in this paper where a full integration of affect is not available. A term originally coined by Janet (1907), dissociation is a key hallmark of trauma, and is now widely recognised as a normal coping mechanism for many survivors of CSA (Van der Kolk, 2015; Herman, 1992; Howell, 2013). I noticed that in the process of preparing this paper, I dissociated a great deal – I went 'into my head' to avoid *feeling* the associated anxiety – my language regarding subjectivity became muddled – sometimes 'I', sometimes 'we'…However in the actual conversations with the therapists who

participated in the research (my participants), I don't believe I did dissociate. Could this point towards the importance of the dialogical nature of our work as therapists and researchers when working with dissociation?

Anna

Anna is a psychotherapist who was molested in a lift by a stranger when she was an eight-year old child. As Anna told me her story, she frequently struggled to find the words, feeling 'frozen', something she felt mirrored her primary feeling when the abuse occurred. There were occasions when she felt thwarted in her usual eloquence as her sentences became a jumble. I am presenting Anna's words in a stanza form to "capture the rhythm and poetic quality of the spoken word that allows the reader to appreciate their narrative structure, meaning and emotional impact". (Etherington, 2008, p.60). Anna told me that what she remembers is:

The feeling of calm

It happened so quickly

Anybody could have come down

That's what happened

Somebody was coming downstairs

You know he must have been

Nervous, or anxious,

But in my memory, it lasts a lot longer than...,

And it's calm,

In my memory it's calm,

And his voice was authoritative but gentle but didn't...,

Not rough, not scary in my memory.

So, and that in itself is disturbing,

That there was a gentleness to it

Which, I couldn't really understand what it was.

So he, um, asked me to do that or made me do that.

And then somebody was coming down the stairs

So he pressed on the button to the next floor

And got out of the lift

And I was left in the lift

And I pressed to the 4th floor.

Anna recognises that she had dissociated and that this dissociation probably began as she was coming down the stairs to enter the lift with her abuser.

When she came out of her dissociative state and ran to her home in floods of tears, her mother appropriated the story to mollify Anna:

> *She explained to me that that there was something wrong with this guy's mind that he was a bit crazy, that there was something wrong with him but that what had happened was that he thought I was pretty and he liked me. And that that's why that happened, and I think what she was trying to do, was downplay the aggression and not make me feel that somebody had wanted to hurt me but I think that it was a very confusing thing to say.*

Anna has struggled ever since to claim this story as her own, and is aware of her potential to dissociate when with her clients.

Anna told me the first time a client brought her story of her childhood abuse, Anna 'froze'. She was stunned at the similarity in their stories: her client was molested by a man, also in a confined space in a public area.

As the client told her the story, Anna had a slight feeling of being aggressed: she told me she was aware of thinking,

> *This is something big, this is something shocking, it's something painful, and I'm in this role, I'm here, stuck in this chair, having to listen to it, and I don't know what to do with it.*

Anna also realised she had a powerful impulse to make placatory remarks which strongly echoed her mother's words in the immediate aftermath of her abuse. As Anna and her client talked about what might have been going on in the abuser's mind, she felt the urge to minimise it as her own mother had.

However, she caught the impulse before a dissociative re-enactment (an unconscious replay of the original experience between Anna and her mother) ensued, and instead engaged with her own feelings of stuckness and helplessness. Davies and Frawley (1994) highlight the potential risk of clinicians, who themselves are survivors, preserving an identification with their own nonabusive parents who were blind to the abuse going on before their eyes. In this moment, Anna was able to notice this identification within her countertransferential response and try an alternative response. As she allowed herself to feel 'done to', albeit in the less sinister setting of the therapy room, she was able to access some compassion for her own 'inner child':

> *The adult in me felt compassionate for the little girl in her, and for the adult in her, and angry on her behalf.*

Anna experienced a form of healing through a shared experience with this client, which hadn't been available through her own therapy. It seemed particularly true with this story, as it was such a secret place, one she hadn't felt able to process with anyone else.

She was able to say to both her client and to herself the words that her mother hadn't said:

> *A terrible thing which should never have happened to a little girl. You were a little girl and he was an adult.*

Anna takes a deep sigh as she tells me of the *relief* she experienced once she had said these words, about an experience which had been brushed under the carpet only days after the event occurred.

Anna's story shows many layers of dissociation: her struggle to find words in telling me her story, her frozen stance with her client, and, perhaps her abuser's dissociative state (calmness) when he assaulted Anna. The abuse, depicted in stanza form here, suggests something other-worldly about the experience.

Though Anna had had many years of personal therapy she had not explored this part of her experience, struggling to own the reality that she had been a victim of abuse. Importantly, whilst Anna was drawn to adopting a position of 'strength' in comforting her client and dissociating, she chose to allow herself to feel impacted, both by her client's story, and by her own sense of helplessness. Anna's initial impulse, with her client, to respond as her own mother had, indicates a type of 'mimicry' (Howell, 2014) which Ferenczi (1949) believed was a dissociative identification with the aggressor. I believe that the relief Anna describes, is that she is able to re-appropriate her story, and say the words that should have been said, and somehow break the bond with the aggressor within her.

Defence against shame as a barrier to therapists' engagement with their own traumatic history

Shame is often considered to be the most insidious and confusing affect when working with abuse and trauma (DeYoung, 2015; Rothschild, 2000; Tangney and Dearing,2011). The pull towards working in the helping professions, may be a flight away from ourselves and our own vulnerability, accompanied by the fantasy of rescuing the *other*. In the psychotherapeutic profession, we credentialise ourselves with our resilience and set 'unrealistic expectations for ourselves and each other about professional detachment and "neutrality"

[which] can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work.'(Saakvitne, 2002, p.446)

Vicarious Traumatisation (VT) describes secondary trauma symptoms which occur through relationship with a survivor of trauma (Pearlman and MacIan 1995). I wonder if many therapists working with survivors of abuse, defend against their own shame, and against the risk of VT, by keeping a *safe* distance from their own history, believing this distancing will be at the service of their clients and themselves.

My autoethnography: shame and silence

For me, in conjunction with the abuse occurring when my cognition was not fully developed, I had the added complication of growing up with two languages. Part of my silence about my abuse was that I was caught between two cultures. Having been brought up with some internalised colonial racism towards my language and culture, I was convinced that the 'me' that participated in these illicit night-time encounters was wrapped up in the shame of being Asian, and therefore definitely not something which could be talked about. Instead, this part of me, for which I took total responsibility, was split off.

As I researched my own experience autoethnographically, what struck me powerfully, was that even though I have done a great deal of processing of the abuse, there is still an extraordinary amount of shame that remains lodged in my body. As I wrote my story, I was burning with shame – somehow unable to

integrate the cognitive understanding that they violated and used me with my embodied felt sense of being responsible for my sexualised behaviour as a child.

As I reflected on the layers of shame, secrecy, badness and silence, it became understandable that I needed to dissociate from these parts of my experience, in order to 'help' the other. Yet, it is this very silence which might facilitate ongoing abuse. Mucci, in highlighting the significance of memory in healing, points to the destructive power of silence in CSA:

> 'Silence in particular, together with the blurring of boundaries we mentioned in our discussion of the knowing and not knowing of trauma, is what is going to cause the transmission of unconscious material from one generation to the other (and this happens both in massive social trauma and in incest).' (Mucci, 2014, p.37).

The power of embodiment

One of the most powerful and transformative aspects of my work with my clients has been to work in an embodied way. The body is the site of our abuse, the site of our shame, and because of this, for many adult survivors, dissociation helps us survive. Given that working directly with the body can be extremely triggering for people who have been abused, my starting point is to work on how we can regulate the autonomic nervous system. In the following vignette, I have combined different embodied encounters with clients to share an insight of how the work affected me:

> *She was silent and her nose was reddening, always a sign that there was a lot of upset which she didn't want to reveal. I gently enquired as to what she was feeling. Looking embarrassed, she admitted that she felt*

hurt by me: she felt that I'd attacked her and misunderstood her motives. I felt a knot tightening in my belly – I was mortified that I'd caused so much pain – we were now both feeling the pain. She wanted to walk out, or go to one of her dissociative coping mechanisms (have a large drink). I asked if we could remain and breathe through it.

She heard my breathing slow down, we both placed our feet firmly on the ground, and as we breathed deeply and allowed the oxygen to nourish us, I felt more forgiving and compassionate towards the punitive parts of myself and wondered if she did as well.

She talked of hating her body and wanting to punish it, by abusing it with drugs, by starving it of nourishment, by stupefying it with alcohol, by picking at it till the skin was raw.

She saw the anguish in my face at the prospect of her wishing to hurt herself this way. It felt important to have the capacity to hold her psychologically, to acknowledge how pain can lead to these self-punishing behaviours, and that it can also deeply impact her therapist who loves her.

Though she didn't cry, her eyes were moist and she rubbed them incessantly. With this indication that she was now in a gentler dialogue with her emotions, I felt a softening inside of me – like a knot was loosening.

Critique

Whilst I have illustrated in this paper how coming closer to our own wounds when working as survivor-therapists can support the therapeutic process, there

remain strong arguments against this. A number of writers caution that boundary issues remain a greater issue for survivor-therapists (Little & Hamby, 1996; Maroda, 2010). I believe that these issues are more likely to occur when clinicians bracket their experience and act unconsciously.

Davies and Frawley (1994) suggest that survivor-therapists may habitually occupy a particular countertransference position, being locked in a masochistic role, disavowing their own abusiveness by "unconsciously agreeing that those patients will enact those feelings for them" (Davies & Frawley, 1994, p.166). In this paper, I have illustrated how the enactments where we own our abusive energy, can be healing for our clients.

The risk of VT continues to cast a long shadow over the field. Pearlman and MacIan's (1995) study which is most often quoted, is contradicted by more recent studies (Van Deusen & Way, 2006; Chouliara et al., 2009; Jenkins et al., 2011) which all concluded that there was no additional risk of VT for clinicians with a history of CSA. My concern remains that the belief that survivor-therapists have not worked through their material fully, contributes to a silencing within the profession.

Methodological and epistemological limitations of this study

It is apparent that the findings of my study are based on a very small scale qualitative research project, and a larger study would clearly be of great merit.

I set out briefly below, why I chose narrative inquiry and analysis for this study.

In my view, narrative inquiry, is not endeavouring to arrive at an objective truth: rather through working with the participants and hearing their stories, my

own *truth* within the autoethnography is enriched. This illuminates a tension I have felt between providing a platform for the participant's voice, following a narrative inquiry approach, and acknowledging that all of the re-storying is from my perspective, and in many ways, thickens my own story. It could be argued that the participants' stories presented here remain concretely within the frame of autoethnography. Kideckel (1997) writes of autoethnography as political resistance when describing oppressed communities. In this sense I am interested in whether this study might indicate yet another oppressed community (the survivor-therapist community), bound together not by geography or ethnicity but by their personal histories. This small study is an attempt to turn the tide against the silence of CSA within the therapist community, giving voice to three people out of "the silent millions of people who have never achieved fame or notoriety" (Evans, 1999, p.137).

I am departing from a heuristic perspective where there is *essence to be arrived at* (Moustakas, 1990). I believe that the narratives depicted are 'reconstructions of the person's experiences, *remembered* and told at a particular point in their lives, to a particular researcher / audience and for a particular purpose' (Etherington, 2008, p.29).

I am also cautious of the interpretive element of research and depart from Smith's notion of the double hermeneutic in Interpretive Phenomenological Analysis (IPA) (Smith et.al, 2009). Rather than prioritising the hermeneutic significance of the researcher's interpretation, I believe that starting with the research conversation itself, there is shared sense-making, as there is within a therapeutic encounter.

Ethical considerations

Underpinned by the key ethical principles of beneficence, non-maleficence, autonomy and fidelity (Bond, 2004; Beauchamp and Childress, 1994), I have tried to strike a balance between the need to protect my clients' anonymity (particularly as they would be considered vulnerable adults), whilst also sharing stories that are true to my participants' experiences - and evocative. I chose to write about my experiences of working with my clients in such a way that whilst the events themselves are true, the characteristics of my clients have been blended so that they cannot be easily identified.

The likelihood of my participants sharing stories of their client work was an ethical consideration. My participants adopted a pseudonym from the outset so that we would have multiple opportunities to protect their and their clients' confidentiality. When I sent my participants the first drafts of their stories, we considered how best to further disguise their identities. As much as I wanted to add some ethnographic colour to the two accounts, we agreed that to protect the therapists' and as a corollary, their clients' confidentiality, I would keep location, culture, ethnicity and class specifics out of the narratives.

The fact that my participants are themselves practitioners indicates they have a strong capacity for self-reflection, and addresses the ethics of working with potentially retraumatising material; my criteria also required that they are in ongoing personal therapy. I obtained Informed Consent from my participants, but I was also guided by Josselson (2007) in adopting an ethical stance towards the research, and being mindful of the risks, pitfalls and limitations and not overly rely on the procedural aspects such as gaining Informed Consent.

As I had decided to give the narratives prominence in this paper, it would have felt incongruent if my participants couldn't be involved in shaping their own stories. Josselson (2007) suggests that where giving a voice is a primary imperative, the researcher sees their own role as a collaborator and conduit and would therefore invite full participation from the participant in writing the narrative.

Suggestions for future research

As well as larger scale studies, what is apparent from my literature review is that the nuance of the therapeutic encounters can be missed when considering themes of dissociation with survivor-therapists working with survivors of CSA, Further qualitative, narrative studies, could help to break the silencing within the profession. I also believe that studies which have a strong emotional component facilitate collaborative witnessing which is of particular transformational value in the field of CSA – a trauma which occurred without witness.

Summary

Unsurprisingly, both Anna and I described feeling a deep level of empathy with our clients' experiences. I wonder if our access to these deep wounds in ourselves, alongside the ability to reflect upon them symbolically, creates a space for our clients so that we can gently nudge them towards talking about their experience. The tension that I experience, in my vignette where the client feels hurt by me, is to ensure that we don't dissociate from the part of ourselves which may be aligned with the abuser within us. Because my identification with the survivor is so strong, it feels painful to think that I might be causing hurt to my clients. Yet these enactments are necessary, as they enable the client to feel

the pain of being a victim, but in a safe setting where they can also find a well of compassion for that child. I distinguish 'enactment' here from an unconscious, unprocessed re-enactment, offering that it is the reflection and sense-making by both therapist and client that is possible, after an enactment, which can offer the healing.

Anna struggled with language at times during the research; I believe that these dissociative moments are part of the 'field' – and that it is these cracks which give us a real sense of her story *and* her work with her clients. In sharing the narratives of two therapist-survivors, I have tried to illustrate the importance of therapists or researchers coming towards the horror of the client's experience, whilst being in full contact with their own history. Rather than leading to vicarious traumatisation, this deep contact with the clinician's own history can allow positive transformation through the facilitation of a deep sense of resonance.

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