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The Construction of Self in an Adult Survivor of Childhood Sexual Abuse

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

by

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May 2011

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Dedication

This is dedicated to all survivors who have yet to find their voice,

and to the people in my life who have helped me to find mine.

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Abstract

Counselors working in a wide array of settings are likely to encounter clients who have significant histories of childhood trauma, including childhood sexual abuse (CSA). The effects of CSA on the adult survivor are complex, and often difficult to resolve. Many trauma theorists have hypothesized that these problems may be mediated by disturbances in the survivor's construction of self. This exploratory, phenomenological study examined the subjective self as it moved through the processes of therapy and recovery from CSA. The data consisted of written material generated over several years of my own therapeutic work, including journals, letters, and poems. The analysis of data revealed significant shifts in elements of the self including the development of a truer and more coherent autobiographical narrative, a greater sense of connection with and ownership of the body, and a stronger sense of both autonomy and the ability to enter and sustain healthy relationships. The purpose of this study was to offer a conceptual bridge between the subjective world of a survivor and the theoretical and clinical perspectives of the practicing counselor and counselor educator. The results revealed one person's strategies for creating a stronger and more integrated self as well as suggestions for future research.

Chapter One

Introduction

Counselors working in a wide range of settings are likely to encounter clients who have experienced childhood or adolescent trauma, including childhood sexual abuse (CSA). Although abuse may or may not be identified by the client as a presenting problem, CSA or other forms of childhood trauma have been found to be underlying elements of much of the distress with which clients present in mental health clinics, school and college counseling centers, substance abuse programs, eating disorders programs, and private counseling and psychotherapy practices (Gold, 2004; Lambie, 2005). CSA has been identified as a possible causative or contributing factor in several formal psychiatric diagnoses including mood disorders, anxiety disorders including posttraumatic stress disorder (PTSD), dissociative disorders, addictive and compulsive behaviors, eating disorders, and personality disorders (Banyard, Williams, & Siegel, 2001; Lang et al., 2008). Adult survivors of CSA have also been shown to be at increased risk for social, occupational, and relationship dysfunction (Kristensen & Lau, 2007) and suicide (Abdulrehman & DeLuca, 2001; Segal, 2009). Certain physical syndromes, including chronic pain disorders such as fibromyalgia, are strongly associated with a history of CSA (DeCivita, Bernatsky, & Dobkin, 2004). Trauma-based disorders are not only pervasive and multidimensional, but tend to be treatment resistant (van der Kolk, Roth, Pelcovitz, Sunday, & Spinozza, 2005). An understanding of the dynamics of trauma, and CSA specifically, is therefore relevant to the practice of counseling in virtually all settings and areas of specialization.

Problem Statement

In light of the wide variety of clinical disorders associated with a history of CSA, and the complexity and tenacity of many of the problematic feelings and behaviors of these clients, an

understanding of the mechanisms by which CSA leads to mental health problems, as well as the mechanisms by which recovery from CSA takes place, would enhance counseling practice and education (Courtois, 2004). A central theme in much of the literature regarding the effects of CSA is that of the self (Cahill, 2001; Ingersoll & Cook-Greuter, 2007; van der Kolk et al., 2005). The "self" is a conceptual entity so ubiquitous throughout psychological theories, and a notion so common to our everyday experience, that it may easily be taken for granted. Therefore, the definition of the self, and thus the conceptualizations of the ways in which the self might be affected by factors such as CSA, should be approached with theoretical clarity and consistency in order for meaningful research to be performed. For the purposes of this study I was particularly interested in exploring the nature of the self in the dimensions of autonomy vs. relationship and embodiment vs. transcendence as constructed and expressed in personal narratives.

Theoretical and Conceptual Frameworks

The theoretical frameworks guiding this study were constructivist psychology and feminist social theory. Constructivist psychology maintains that the self, and individuals' experiences of and meanings attached to the self, are not fixed entities independent of their environment, but are instead fluid, contextual constructions produced within the individual's ongoing interactions with the environment (D'Andrea, 2000). This environment consists of external people and events, as well as an internal environment in the form of messages and values that have been internalized from others (McAdams, 2006). It is important to recognize that, within a constructivist paradigm, the self is not merely influenced by, or even formed by, interaction with these environmental phenomena; in a purely constructivist frame the self indeed *is* these interactions (Bohan, 2002). In this sense, the self cannot exist independently of the environment.

The socially constructed self has been explored and described in terms of personal narratives and internal dialogues. The narrative self both creates, and is created by, coherent stories that describe and explain the self situated in time and space. The self-narrative is an expression of meaning-making, and these constructed meanings can be a focus of narrative therapy (McAdams, 2006) as well as research (e.g., O'Kearney & Perrott, 2006; Thiele, Laireiter, & Baumann, 2002). Internal dialogues, as the term implies, are ongoing conversations that happen within the person, again in an effort at meaning-making. While occurring in the present, internal dialogues place the self in different temporal positions as the self shifts its perspective from subject to object, and this temporal movement may be a key mechanism by which traumatic material is processed and worked through (Cooper, 2003; Friedman, 2008; Hermans, 2003). These notions of the self as temporally situated and dialogic were central to the methodology and assumptions of this study, as I will explain below.

This model of a self created and re-created by internal and external environments might seem to preclude the possibility of an autonomous self, and render the physical or embodied self somewhat irrelevant. On the contrary, a socially constructed self can be thought of as deriving its autonomy and its experience of embodiment from the same processes by which other aspects of the self develop. Rather than implying a lack of connection to others, autonomy is, in constructivist psychology, made possible by social arrangements that both allow and restrict any given individual's exercise of separateness (Brison, 2002; Friedman, 1997).

Within a dialogic model of the self, autonomy and individuation, like any experience of self, is derived from ongoing discursive exchanges. This model, however, assumes a speaking self, that is, an "I" who is permitted a place in the discourse. Absence of an "I" is indicative of

marginalization; the marginalized "me" is a creation of the discourse of more powerful others. As Harden (2000) observed, "Thus, the speaking form is privileged" (p. 507).

The body, while it may seem to be simply a physical entity not amenable to social influence, can indeed be considered a social construction. The experience of embodiment as an element of the self depends upon multiple factors including socially constructed physical boundaries, meanings attached to physical characteristics and experiences, and notions of ownership of the body (Brison, 2002). The construction of the embodied self, then, is also contributive to and affected by the experience of sexual violation. As discussed in the previous paragraph, the ability to enter and engage in discourse regarding the body belongs to those privileged to do so.

Finally, the self exists within, and interacts with, social relationships on a wide range of scales. Members of socially marginalized or disempowered social groups, including in many cases women and in virtually all cases children, may be rendered more vulnerable to harm in relationships characterized by an imbalance of power (Bohan, 2002). Again, it is important from a constructivist perspective to recognize that the self in such a relationship is not simply influenced by, but is in a real sense consisting of, that differential of power.

Power within social structures, and the way that this power is used, are focal concerns of feminist theory. Feminist scholars do not agree on a single, unified model of self and society, but agree that power and meaning are central to any person's construction of his or her self and place in society (Brown, 2004). Feminist epistemologies of the self are congruent with the basic assumptions of constructivist theory, with an emphasis on the construction of gender roles and expectations, and social and political systems that serve to define the feminine self in certain ways (Gremillon, 2004). Dialogic models of the self (e.g., Hermans, 2003) are also consistent

with feminist and constructivist paradigms. Theorists from any of these broad perspectives of how reality is constructed and validated would agree with the notion that social systems that deny, ignore, or otherwise discredit a person's experience, particularly one as sensitive and emotionally charged as CSA, serve to move that experience "outside the realm of socially validated reality" (Herman, 1992, p. 8).

Purpose of the Study

The purpose of this study was to explore the construction of self as expressed in the written artifacts that I produced during several years of my own recovery from the effects of CSA. The decisions to use my own experiences rather than those of another, and to use written artifacts rather than recollection, were made in the interest of staying true to the values and social priorities expressed in feminism, and to the conceptual underpinnings of constructivist psychology. Specifically, feminist social theory and research consider women's subjective experience as central to the development of knowledge, thus a first-person account is assumed to be a valid and important source of information and understanding (White, Russo, & Travis, 2001). The exploration of culturally constructed meanings in text, by way of content analysis, is also consistent with feminist research principles and practices (Hesse-Biber & Leavy, 2007). It is within this epistemological view that I justified my decision to use my first-person voice, in the form of written material, as well as my third-person voice, in the role of researcher, as sources of information and understanding.

My decision to use my journals and other writings from a specific period in my life as raw data for this study, rather than depending on current recollections, was also based in postmodernist epistemology and feminist philosophy, as it allowed me to capture the experiences of selves that existed in a different time and context. Constructivist psychology would consider

the remembered self as being qualitatively different from the self that is being remembered (Hermans, 2003). Because of the many practical and ethical impediments to gathering this kind of information from women who are in the recovery process, including a risk of taking advantage of differences in social and personal power, I chose to use my own writings as artifacts of "real-time" experience. I think that the justification for this unconventional design will become self-evident to the reader as the study unfolds.

General Research Questions

There are three general questions that I explored in this study:

1. How is the self expressed in therapeutic writing, such as journals, internal dialogue exercises, and poetry?

2. How does CSA inform the adult survivor's sense of self?

3. How does the survivor's sense of self shift or change in the process of recovery?

Conceptual Definitions

The two major phenomena under study were childhood sexual abuse (CSA) and the self. The American Psychological Association (APA) defines CSA in terms of the power imbalance between the perpetrator and the victim, which is used by the perpetrator to coerce the victim into sexual activity for the gratification of the perpetrator. The definition does not focus on specific acts or groups of acts, and can include both contact and noncontact forms of sexual activity, such as certain kinds of child pornography. Although specific definitions of sexual abuse vary, most sources agree that sexual contact between a child and an adult, or between children at the behest of an adult, constitutes abuse, whether or not the child appears to be distressed at the time of the event (APA, n.d.).

It is also important to clearly present a definition of "child." Victims of CSA range in age from infancy through adolescence, and differences in physical size and strength are less important than are differences in levels of emotional or social power (APA, n.d.). Adolescents, who may be physically full-grown and strong, still may not have the emotional wherewithal to counter the advances of an authority figure (Livingston, Hequembourg, Testa, & VanZile-Tamsen, 2007). Therefore, I have included in my definition of CSA sexual contact between an adolescent and a parent or other family member, teacher or coach, clergy, counselor or therapist, or other person in a position of power.

Arriving at a definition of the self was a more daunting task, but equally important to this study. In keeping with the feminist and constructivist theoretical foundations as described above, I have defined "self" for the purposes of this study as my experience of being, as distinct from that which is nonself (other), expressed in the written material that served as raw data for this study. I have derived phenomenological descriptions and theoretical interpretations of self from the analysis of this data, and further discussed them as they compared to the professional literature on the subject.

There were three distinct aspects of my self that I thought of as different "selves" for the purpose of this study. First, there was my subject-self as manifested in the journal entries and other writings that served as my raw data; second, my researcher-self, reading and interpreting that data from the perspective of an "other"; and third, my remembering-self, my subjective experience of remembering and applying meaning to my process of healing. While all of these actors were me, each was a somewhat different me, in terms of context, time, and perspective. This triadic conception of my self was important to the formulation of my methodology, and for developing mechanisms for each step of the research process.

Methodology

The notion of my self as three distinct actors in this process was important in that it allowed me to draw distinctions among my intended methodology and those of autobiography, self-study, and autoethnography. All of these methods use the researcher's own experience as the subject under study, but with different purposes, foci, and sources of information. While my methods contained elements of all of these, there were significant differences.

Autobiography is the story of the narrator's life as remembered and told from the present point of view, and is often focused more on the events of the story than on the processes underlying those events (Creswell, 2007). Like autobiography, my study explored and communicated processes of growth and change, of crisis and adaptation, and of learning. Unlike autobiography, however, was my focus on documents as artifacts, rather than simply on my own memories of my experiences.

Self-study has some similarities to my methodology as well, particularly in the use of existing documents or other artifacts as sources of data. However, the examples of self-study that I have found in the literature have appeared to be primarily descriptive or evaluative in nature (e.g., McIntyre & Cole, 2001; St. Maurice, 2002), while I wished to approach my artifacts in more of an interpretive, phenomenological manner.

Ethnography, which is derived from research traditions in anthropology and sociology, is the description and interpretation of a cultural group for an audience of people who are outside of that culture. Autoethnography is a form of ethnography that examines cultural phenomena from multiple perspectives, with the researcher as a member (not merely a temporary participant-observer) of the group being studied (Duncan, 2004; Ellis, 1999). I am asserting that, in many ways, survivors of CSA constitute a culture. Consumers and providers of mental health care

services also represent cultures that have their own sets of roles, rules, and power structures, and these factors are crucial to a feminist conceptualization of the healing process.

The genre of portraiture was the qualitative method that resonated most for me, mainly in that it intentionally blurs the boundaries between art and science, and rejects the notion that either form of knowing is more real or more important than the other. Portraiture concerns itself with an in-depth exploration of a subject, actively pursuing the particular as a portal to the universal (Lawrence-Lightfoot & Davis, 1997) and as such fits well with the aims of this research. The product of portraiture is more than its constitutive elements, and this emphasis on the "aesthetic whole" (Hackmann, 2002, p. 51) appealed to me and was consistent with my holistic framework.

Portraiture also places a heavy emphasis on voice as a research tool; the voices of my self situated in specific places, times, and circumstances served as my subject, my process, and my product. It was in the interaction of the three "selves" I described earlier – the subject-self, the researcher-self, and the remembering self – that I think the real value of this work lies. Therefore, I have chosen to label my methodology as self-portraiture.

Limitations, Delimitations, and Significance

Any qualitative research, by its nature, is subject to inherent limitations when compared to more traditional empirical approaches. Concepts such as validity and generalizability give way to more appropriate standards of trustworthiness and applicability. While standards and processes for enhancing trustworthiness in qualitative research are evolving, it is not generally the intention of researchers of this sort (including myself) to adhere to the same notions of "good science" as might be practiced by quantitative, experimental researchers.

One method of ensuring the trustworthiness of a qualitative study such as this is triangulation, or the analysis of data from multiple perspectives (Mathison, 1988). Based on my constructivist assertion that the self is temporally as well as contextually situated, I am, for the purposes of this research, considering my "past self" as distinct from my remembering self and my researcher self. I used content analysis to identify themes, trends, and crises related to the construct of self within the written data; triangulation was done by first reviewing the data and its meaning from the perspective of participant-researcher, second as I remember it from my current personal perspective, and finally by comparing my findings to the existing theoretical and clinical literature regarding the subject of the self and CSA.

The design of this study, using myself in the role of researcher as well as my past self as subject, presents unique challenges. Subjectivity, which would be considered a threat to the validity of experimental research, is accepted as inevitable in much of qualitative inquiry, and is actively embraced in feminist scholarship (Worell & Etaugh, 1994). The role of subjectivity, however, and attempts to make it explicit, vary depending on the study's purpose and design. In this study, subjectivity is obvious; what might not be so obvious are the shifts in subjectivity, as well as objectivity, among the different aspects of the design and the different layers of meaning embedded in the study. I have tried to make my shifting perspectives as subject, rememberer, and researcher as explicit as possible.

This study is, of course, delimited to a single case. While I expected to encounter universal themes in the analysis of the data, my goal was depth rather than breadth. The unique elements of my own experience (or that of any other person) cannot be reproduced or replicated, and should not be subjected to the kind of reduction that would be needed to produce a replicable study. I expect that, like much of qualitative research, the knowledge gleaned from my unique

experiences of abuse and recovery will inform, to different degrees, the universal realm of human harm and healing, as well as generate questions for future research.

The potential usefulness of this study is supported by the hardiness and universality of the central concept of the self. The self as a construct is a focus of interest in multiple areas of study regarding mental health. Another value of this research is that it advances the field of wellness-oriented, strengths-based counseling theory and practice. By examining the internal dynamics of healing, rather than focusing on pathology, the insight gained from this project will, I hope, contribute to the theoretical basis of professional counseling and support the development of counseling interventions that promote wellness and personal strength; The findings of this study may evolve into grounded-theory studies and, eventually, to the development of trestable hypothessis.

Chapter Two

Review of the Literature

It is not unusual to hear someone who has survived a traumatic event say, "I'm not the same person I was before this happened." This notion of self-loss is a consistent theme in the literature regarding the effects of CSA and other forms of severe trauma upon the adult survivor. The purpose of this exploratory study was to identify, describe, and interpret themes related to the self of a survivor of CSA as expressed in my own journals and other written materials produced during a decade of intensive therapy. In this review I will first describe the theoretical and philosophical foundations upon which the practical literature is based. Next, I will report on studies that address the impact of CSA on the development and experience of the self of the adult survivor, with an emphasis on studies that used narrative approaches.

Loss or disruption of the self can be conceptualized in constructivist, humanist, and feminist orientations, and while each may have some distinctions from the others, their similarities are more numerous and more central. This review includes studies and analyses grounded in all of these theories. Because the reality of CSA has been acknowledged by societies at some times in history, and has been either denied or minimized at other times, the social elements of CSA – its reality, prevalence, and significance – have played different roles in the validation of the experiences of survivors (Herman, 1992). The vagaries of social and professional recognition and denial of CSA over time, while very relevant from the social-historical and psychological perspectives, are beyond the scope of this paper; however, the importance of social convention in the definition of individual experience must be acknowledged. Therefore, I must note that the scope of this review is limited to Western, European-American literature and social structures, as I recognize the tremendous variation in women's experiences across worldwide cultures.

Feminism, Constructivism, and Sexual Violence

In various times and places throughout history, rape, specifically the rape of women by men, has been considered as a sexual crime, a property crime, a tactic of warfare, a tool for social oppression, and even a natural expression of uninhibited male sexuality (Cahill, 2001). The recognition of the reality and pervasiveness of the sexual abuse of children has also been subject to periodic shifts in the social consciousness, as has the validation of survivors' experiences by the mental health establishment (Herman, 1992). The meanings that individuals and societies attach to the crime of rape, whether against adult women or children, are informed by the way people see and understand men, women, and children, as well as sexuality and power, within their cultures. All of these topics are built on the foundation of the constructions of selves: the selves of the perpetrators and of the victims, and issues of value, power, and ownership of these selves (Cahill, 2001).

My theoretical perspectives in this discussion are feminist and constructivist, although I must first note that there is no single feminist ontology; in fact, there are widely disputed notions of the self among feminist scholars and activists, and differences of opinion regarding how those notions either advance or hinder the status of women (Bohan, 2002). Three aspects of the construction of the self are of particular relevance to this study. The question of the self as embodied or transcendent informs the nature of sexual violence, and whether it should be considered as different from other types of interpersonal violence. The understanding of the self as relational or autonomous in nature, and whether this nature differs between sexes, has deep implications regarding the notions of ownership, control, and individual and social meanings attached to sexual violence (Brison, 2002). Finally, the narrative self, that is, the self as both

created by, and expressed in, life stories, is the central element in the processes of finding, telling, and rewriting one's story of victimization, survival and recovery (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003; Sutherland & Bryant, 2005).

Embodiment and the rational self.

The embodied self, an individual identity that is inextricably embedded in the physical body, has been a somewhat contentious subject in feminist literature, and a bit of history might help to explain this. For centuries, much of Western philosophy concerned itself with the metaphysical realm and advanced the ideal of a rational, transcendent self. This notion of the rational self that transcends the physical realm generally has been associated with mainstream philosophy beginning with the writings of Descartes, and also has been implicitly (if not explicitly) male (Bohan, 2002). Meanwhile, the female body has been the object of a conceptual and attitudinal schism. It has been glorified and sanctified on the one hand for its ability to produce and nurture offspring as well as its aesthetic and sexual appeal to men, while it has been vilified for essentially the same characteristics. From ancient times as expressed in mythology, to religious beliefs and practices that attach shame or danger to the female body, to modern psychological debates regarding essentialist claims to male and female traits, the female body has been subject to powerful and confusing reactions and interpretations (e. g., Cahill, 2001; Offman & Kleinplatz, 2004).

The female body as an object (or even an instigator) of male lust and aggression is particularly important to this discussion. The notion that the way a girl or woman dresses or carries herself could invite rape is still believed, if not always openly admitted (Brison, 2002). Even when the victim is a child, the overt or covert assertion of seduction on the part of the child victim, while seemingly ludicrous, can become a deeply-embedded belief in the survivor and a

barrier to healing (Courtois, 1996). The experiences of shame, blame, and humiliation that may be suffered by a rape or CSA survivor, possibly reinforced by messages from family members, friends, and the criminal justice system, are considered by many to be a major reason that these crimes are grossly underreported (Brison, 2002; Cahill, 2001).

In the 1970s, liberal feminist scholars and activists openly rejected the notion of rape as a function of sexuality, with the intent of nullifying the victim-blaming or tacit acceptance of rape. Rape was framed instead as purely an act of violence, qualitatively no different from other types of physical assault (Cahill, 2001). This conceptualization of rape gained a good deal of support and helped to dismantle many of the oppressive beliefs and practices, such as court testimony regarding a victim's past sexual history, that had prevented victims from receiving justice, or, in many cases, from even seeking it. The willingness of women and other activists to bring rape into open discourse, and the internalization of the message that rape was an act of violence rather than an act of sex, did much in the way of exposing, criminalizing, and punishing rape (White et al., 2001).

For some feminists, however, the dissociation of the body from the mind and sexuality from rape seemed to be a mistake. They noted that the effects of rape were qualitatively different from the effects of other types of assault, and the basis for that difference appeared to be in the way rape altered the victim's sense of herself and her relationship to the world. Even women who have never been raped, it was argued, limit their freedom of movement and association because the possibility of rape is always there (White et al., 2001). This omnipresent danger, this awareness of being "rapable," had become a part of women's everyday experience (Brison, 2002; Cahill, 2001). These realizations led feminist thinkers to revisit the question of the sexual, or at least gendered, quality of rape.

The idea that rape could or should be classified as no different from any other type of assault rested on two distinct but interrelated assumptions. The first is the classical Western philosophy of Cartesian dualism, the notion that the mind, as the true essence of the self, is separate from the body. If we accept this dualistic assumption, it would seem that recovering from rape should be like recovering from any other assault. This kind of reasoning can lead to the presumption that, once the flesh has healed, the problem is over because the transcendent self has been untouched. Even the presence of typical post-traumatic stress could be explained in such a framework, as anyone who has been victimized is susceptible to the development of such responses. It would follow, then, that the transcendent self should be quite able to recover from rape just as it would any physical assault (Cahill, 2001). The second assumption is that equality means sameness. In this line of thinking, if women claimed equality, they would have to accept the notion of sameness, a notion that precludes a gendered interpretation of any event, including the experience of rape.

Like many either/or proclamations, this notion of rape as an act of violence, not sex, opened the door to a host of unforeseen consequences. If rape was simply another form of physical assault, why should rape victims be treated any differently from other crime victims? Why should their names and pictures be kept private? Why should the range of questions asked in court proceedings be limited? *Why couldn't women just get over it?*

Finding the answers to these questions required a re-evaluation of the feminine self. Feminist inquiry is rooted in respect for the voice of the woman as one of authority (Brabeck, 2000; Brown, 2004), and the experiences of women who had been raped belied the idea that the phenomenon of rape was no different from that of being physically assaulted. The notion of the

self as embodied had to be brought into open discourse again, but without the kind of biological determinism that would bring us back to accepting the female body as inherently, and thus inevitably, rapable (Cahill, 2001).

Postmodernism offers an alternative to the dichotomous thinking that constrains other epistemologies. Rather than considering body and mind, or intellect and emotion, as dualities, they can be thought of as complimentary aspects of a complex and multidimensional self, what Battersby (1998) colorfully termed "fleshy metaphysics." Likewise, a postmodernist acceptance of reality as fluid and dynamic allows a model of embodiment as being experienced in different ways by different individuals and in different contexts (Bohan, 2002). This critical paradigm shift, away from the constriction of seeking some single universal truth with regards to the phenomenon of rape, allowed a return to the proper and appropriate locus of inquiry: the subjective experience of the individual woman (Brabeck, 2000).

Autonomy and the relational self.

The question of the self, particularly the feminine self, as autonomous or relational can get stuck in the same kind of quagmire when dualistic, modernistic, thinking is employed. The question of the nature of autonomy and relationship in the construction of women's selves has been a significant source of debate throughout the 20th century (Friedman, 1997) and continues into the current one. A central aspect of the idealized rational (and again, implicitly male) self is its potential to achieve autonomy. This autonomous self is the agent of its own actions, the creator of its own worldview, and the referent for its experiences. The body is the vehicle for this idealized self, and as such it is under the full control of the self occupying it (Bohan, 2002). This experience of autonomous agency does not reflect the lived experience of most people,

particularly those who have been marginalized and disenfranchised in society, and it certainly bears no resemblance to the experiences of people who are responsible for birthing, nursing, and nurturing offspring.

Feminist scholars and theorists in the 1980s and 1990s, building upon the seminal works of Gilligan (1993), Belenky, Clinchy, Goldberger, and Tarule (1986) and others, developed and expanded self-in-relation models that emphasized the centrality of relationship in the development of women's identities, morality, and cognitive processes. These characterizations of the feminine self as relational were advanced not as a weakness or deficiency of women, but as an asset that was woefully underdeveloped in men. This conceptualization of difference was based not in biological determinism, but in social construction of gender roles (Bohan, 2002).

Again, however, feminist scholars were not in agreement regarding this notion of a relational self, and some balked at the idea of a self that was not fully autonomous. A woman, or a child, in this kind of thinking, would be unable to fully consent to any sexual act. Wouldn't such an assumption reinforce the notion that rape is, to some degree, an extension of the natural order of things? Could not rape, then, be considered as simply a variant of "normal" sex (Cahill, 2001)?

The answer to this question lies in the way we define the concept of autonomy. It is common for people to think of autonomy as individuation and separation, even isolation. But recent feminist writers (e.g. Bohan, 2002; Brison, 2002; Cahill, 2001; Hoffman, 2006) have instead presented a notion of relational autonomy, that is, autonomy that is rooted in, and contributes to, social systems. Again, the dichotomous way of thinking had to be abandoned in favor of more complexity. The self is neither fully individual, nor fully interrelated. It is both, and this is true for males and females (Friedman, 1997). The difference, again, lies not in the

biological sex of the person but in the social systems that construct experience. In a strict social constructivist framework, it could even be argued that the self *is* the social discourse (Bohan, 2002), and thus is constantly changing.

The narrative self in feminist and constructivist psychology.

A notion of the self as narrative, grounded in the stories people hear and tell about themselves that create, as well as communicate, who they are, is central to constructivist theory and to feminist values regarding the importance of voice. One's conceptions of one's self, and others' conceptions of them as expressed in life stories, create a coherent identity as an individual situated in time and space. This self evolves as the stories accumulate, moving through life as a relatively unbroken autobiography unfolds. Individual and cultural stories both create and communicate not only memories of what has happened in one's life, but interpretations of how and why, shaping self-stories and the meanings assigned to them (McAdams, 2001).

The narrative approach to conceptualizing and communicating human experience goes back at least as far as William James, who in the 1890s emphasized a stream of consciousness as the essence of the self (Meares, 1999). As research shifted to methodologies that were more similar to those used in the physical sciences, individual narratives were rejected as lacking in scientific rigor. However, with the postmodernist movement in the late 20th century, narrative research and pedagogy has gained acceptance in mainstream psychology as applied to individuals, couples and families, organizations, and societies (McAdams, 2001).

The narrative of the self, and the narrative *as* the self, exists on multiple planes or levels of experience. At the biological level are brain and sensory structures that perceive, process, store and retrieve data. These structures and processes can be profoundly affected by early

trauma (van der Kolk, 1996). At the interpersonal level, dyadic self-storying occurs between, for example, a client and therapist, and creates the major focus of narrative therapy (McAdams, 2001). At the cultural level, shared linguistic structures inform meaning, and narrative is woven through the fabric of human consciousness (Neimeyer, Herrero, & Botella, 2006).

Sexual violence and the self.

Sexual violence can have profound effects on the ways that victims experience their selves, in the realms of embodiment, autonomy, and narrative. The physical self is invaded, injured, and held captive in sexual assault, including CSA. Its ability to define and defend its own boundaries is overwhelmed. This aspect of the effect of rape and CSA on the physical self seems fairly obvious. What is less obvious, and perhaps less understood, are the many ways by which the victim loses ownership of her body in the aftermath of sexual violence. Recent research in the emerging field of traumatology has been focused on the enduring physiologic, cognitive, and emotional effects of extreme trauma including CSA. Of particular interest is the way that trauma seems to imprint and influence mechanisms of memory, emotion, and physiologic arousal. Flashbacks and tactile memories can appear at any time, provoked by even the slightest environmental trigger and often with no warning. The body's "fight or flight" mechanism may remain in emergency mode for years, accounting for the hyperarousal and exaggerated startle response seen in post-traumatic stress (van der Kolk, 2002). Eating, sleeping, and elimination can be negatively affected. The survivor's ability to communicate physically, through both sexual and nonsexual touch, may be restricted. Even the range of the body's movement can be restricted in the aftermath, as the survivor limits her movements in response to ongoing fear (Brison, 2002; Cahill, 2001).

The autonomous self, if considered within the relational model described above, is also destroyed both during and after sexual assault or CSA. Autonomy is possible only in a world where individuals act according to social norms, creating a reasonably predictable world. The profound breach of trust in sexual assault can render all relationships as suspect (Linehan, 1993). This is especially likely to be so when the victim is a child and the perpetrator is someone upon whom the child's survival depends (Courtois, 1996; Herman, 1992).

Autonomy also involves the free exercise of one's will. In rape or CSA, the will of the victim is rendered useless, even irrelevant. The ability to function as a self-agent is gone. The victim becomes instead the object of the rapist's will. Even after the rape, and perhaps for many years, the loss of will or agency persists as physical and emotional repercussions continue to dominate the victim's experience, effectively re-creating the rape over and over again (Brison, 2002; van der Kolk, 1996).

The narrative self is also severely altered in sexual trauma. The unwritten rules of social discourse discourage open discussion about the horrors of rape, child sexual abuse, war, and political terrorism. Shared traumas, such as natural disasters or terrorist attacks, may be brought into open discourse more readily than individual traumas such as interpersonal violence and CSA. At best, these topics are likely to be discussed as abstractions or viewed as happening to fictional TV and movie characters. Survivors of sexual trauma often find themselves unable to speak openly about their experiences (Herman, 1992). Well-meaning friends and others will often discourage the victim from talking about it, encouraging her or him instead to put it behind her or him. The result is a fractured narrative and, therefore, a fractured self and a profound feeling of alienation. Brison (2002) wrote in her memoir of surviving rape that she sometimes felt "as though I had, in fact, died, and no one had bothered to come to the funeral" (p.13).

Finally, the narrative self assumes the presence of a continuous memory, a life story that is likely to contain twists and surprises, but that remains reasonably coherent over time. One's life story moves from past, through present, and into an imagined and intended future. Memory can be profoundly altered in severe trauma, to the point of full amnesia. The past self – the pre-trauma self – may feel to the victim as if it has died (Scheman, 1997). Intrusive memories and flashbacks have the effect of keeping the traumatic experiences alive in a kind of eternal present that can only be described as torture. Memories may be experienced in the emotional and sensory areas of the brain, but inaccessible to the parts of the brain that produce speech, making the act of telling one's story physically impossible (van der Kolk, 1996). And the future, rather than being a refuge for the imagination or a guiding force for present action, feels at best unattainable and at worst, a continuation of the victim's current agony. The loss or absence of coherence, whether structural, phenomenological, or emotional, in the life narratives of CSA and other trauma survivors can be profound, and can be the source of much distress and psychopathology (DiMaggio, 2006; Neimeyer et al., 2006; O'Kearney & Perrott, 2006).

Review of the Research Literature

The amount of research literature on the effects of sexual trauma, and the variety of approaches and theories by which this research is done, has increased dramatically in the last two decades. The vast majority of studies have been focused on the relationship between specific aspects of the self and the prevalence and severity of clinical PTSD symptoms or other psychopathology. I will present this review of the literature as it addresses the question of the self in three ways. First, I will describe studies that focus on self-definition or self-concept in survivors, including both cognitive and emotional experiences of self, and how these experiences may influence the development of psychopathology. Second, I will review studies that focus on

acts of violence toward the self, including self-mutilation and suicide. Within this broad concept I will include a discussion of the phenomenon of the failure or inability to protect one's self from repeated assault. Finally, I will explore the literature that addresses the narrative self, and how this narrative may be profoundly altered in the aftermath of trauma, including CSA.

Self-definition and sexual trauma.

Trauma survivors' views of self, in terms of the connection of personal identity to the trauma as well as self-judgments, have been shown to correlate with PTSD symptoms. Sutherland and Bryant (2005), in a study comparing trauma-exposed people with and without PTSD to non-exposed controls, found that those exhibiting PTSD symptoms were more likely to have trauma-based self-defining memories, and to identify personal goals that had to do with trauma, such as avoiding future victimization or recovering from the effects of the trauma. Those in the trauma-exposed, non-PTSD group, as well as the control group, were able to retrieve more varied self-defining memories. The authors proposed that self-definition as a victim or survivor was related to more pervasive and severe post-traumatic psychopathology.

Thompson and Waltz (2008) found PTSD symptom severity to be inversely related to self-compassion in a community sample of trauma survivors. A low level of self-compassion was particularly associated with avoidance symptoms such as numbing and dissociation, suggesting that an inability to extend compassion to oneself is related to an inability to confront trauma-based memories and feelings.

Self-destructive or non-protective behaviors and trauma.

The occurrence of various self-destructive behaviors among CSA survivors, ranging from sexual risk-taking to addictions, eating disorders, self-mutilation and suicide, has also been extensively chronicled, although not thoroughly understood. In a study of incarcerated women,

Milligan and Andrews (2005) found that anger, shame, and a history of CSA were positively correlated with self-harming behavior; interestingly, bodily shame showed the strongest relationship to both CSA and self-harm, which is suggestive of the importance of the embodied self in the aftermath of sexual trauma. Likewise, Murray and Waller (2002) found that shame played a mediating role in bulimic behavior in a nonclinical sample of college women with a reported history of CSA, particularly intra-familial abuse. Weierich and Nock (2008) found that in a sample of CSA survivors, non-suicidal self injury was more likely to occur, especially in survivors with numbing/avoidance and re-experiencing as prominent PTSD symptoms.

Several researchers (Blaauw, Arensman, Kraaij, Winkel, & Bout, 2002; Roy & Janal, 2005; Verona, Hicks, & Patrick, 2005) have linked CSA history to an increased incidence of attempted and completed suicide. The risk of suicide has been found to extend from adolescence (Shaunesey, Cohen, Plummer, & Berman, 1993) through older adulthood (Draper et al., 2008). Using a retrospective analysis of 200 case files, Read, Agar, Barker-Collo, Davies, and Moskowitz (2001) concluded that abuse history should be routinely considered in assessing for suicide risk. Segal (2009) investigated suicide risk from a different perspective. In a sample of women students, those who had experienced sexual assault (at any age) demonstrated less resilience against suicide as measured by cognitive deterrents, such as self-perceived coping abilities and moral objections. This may mean that the survivor might be more likely than others to act on suicidal impulses, although the rate of completed suicides was not reported in this study.

While the mechanisms are not clear, numerous studies have linked CSA with an increased risk of sexual victimization and relationship violence later in life. Kessler and Bieschke (1999) found a link between high degrees of shame and the risk of re-victimization in

adult survivors. Testa, VanZile-Tamsen, and Livingston (2005) found a significant correlation between CSA and sexual risk-taking, thus an increased risk of re-victimization, in adult women. Feiring, Simon, and Cleland (2009) had similar findings in a sample of adolescents, using stigmatization rather than shame as the organizing concept. Whatever the mechanism, repeated sexual victimization only adds to the disruption of self already present in the survivor.

The narrative self.

Research on the specific issues, challenges and transformation of the narrative self is often done in a case-study design or in the form of a structured or directed narrative, that is, written or oral responses to questions or prompts provided by the researcher. It is important to note that, while narrative formats are very conducive to the process of holistic, constructivist research, not all narrative research is true to these values, principles and assumptions. Narrative research can be as reductionistic as other approaches, rendering experience as a set of disconnected parts. It can also be used to force narratives of human experience into narrow definitions of coherence, linguistic categories, or other value-driven criteria presumed to indicate different degrees of mental health. Because the "self" can be defined in many ways, much of the research focuses on one aspect or dimension of the self, a single symptom or symptom cluster, and the presence and severity of psychopathology. Sutherland and Bryant (2005) explored self-defining autobiographical memories in a sample of trauma-exposed people with and without PTSD and non-exposed controls, and found that trauma-based self-defining memories predicted the presence of PTSD. Similarly, Bernsten and Rubin (2007) found a high degree of concordance between the centrality of the traumatic event as a part of self-definition, and the severity of PTSD symptoms. Neither study was limited to a particular type of trauma such as CSA.

Daigneault, Tourigny, and Hebert (2006), in a study of sexually abused adolescent girls, explored the concept of self-blame as a mediating factor in post-traumatic pathology; specifically, they found a significant relationship between generalized self-blame and trauma-related self-blame, and that trauma-related self-blame had a small but significant predictive power regarding specific post-traumatic symptoms.

Other researchers have focused on the disruption of autobiographical memory, or "broken" self-narratives, as a locus of distress among survivors (Sewell & Williams, 2002; Neimeyer et al., 2006). The effects of trauma on autobiographical memory can be profound, ranging from fragmentation and generalization of memories to full amnesia. Even when the narrative maintains a cohesive story or plot, the disconnection of the story from the dominant individual, relational, and cultural constructs that form the narrator's worldview can lead to a disrupted narrative of the self. In other words, the material elements of the story may not fit with the underlying meanings, values, and assumptions of the larger self-story, leaving the narrator disconnected from the narration.

While reductionist approaches to narrative may be too confining and contrived, I should note that too little consensus in our formulation, communication, and interpretation of narratives can leave them devoid of meaning and useless as ways of knowing (Harter, 2007). The ideal narrative is open to uniqueness as well as commonality in language as a tool for generating and sharing knowledge.

First-Person Narrative Research on CSA

The use of first-person narrative as a source of valid insight is gaining acceptance within constructivist and humanistic approaches to understanding human behavior, and is the keystone of feminist theory. However, there is a paucity of professional literature that emphasizes the

voice of the victim/survivor of CSA. I found only one article written by a professional who was also a survivor, and this author used a pseudonym (Hollander, 2004). It has been my experience that within mainstream professional and academic circles, the direct voice of the victim of rape or CSA is not always welcome (Herman, 1992; Hoult, 1998). Some of this lack of acceptance likely stems from the victim's voice as a woman or a (once-wounded) child, but much of it probably has to do with the victim's status as a patient or client in need of mental health care and the stigma attached to such a status (Johnstone, 2001; Muncey & Robinson, 2007). Speaking about victims, or speaking for victims, however well-intentioned, repeats the act of silencing us. At the very least, it excludes us from contributing directly to the professional knowledge base that informs sexual violence and its aftermath. One challenge, as well as a benefit, of writing this kind of study is that it is an explicit act of defiance against these tacit prohibitions.

Chapter Three

Research Design and Methodology

This exploratory, phenomenological study was conducted using narratives, both in the nature of the data and in my analysis of them. Within the broader category of narrative research, the differences among specific methodologies can be subtle, and different sources may not completely agree when defining and describing these methods (Foster, McAllister, & O'Brien, 2006). This is as it should be; narrative research is a fluid process in which the methods shift in response to the data, and should not be forced into a rigid methodological mold. This does not mean that methodology is not important; on the contrary, the methods must be designed and adapted in such ways as to best serve the purposes of the particular research question (Creswell, 2007).

Description of and Rationales for the Methodology of Self-Portraiture

My research design incorporated elements of autobiography, ethnography, and portraiture, resulting in a design that I chose to call "self-portraiture." Autobiography is the narrator's life story as remembered and told from the present point of view, and is generally focused more on the events of the story than on the processes underlying those events (Creswell, 2007). Like autobiography, my study explored and communicated events related to growth and change, crisis and adaptation, and loss and learning. Another area of similarity between my study and autobiography was that I had to provide some amount of autobiographical narrative in order to supply the relevant contextual events that shaped the meaning of the data. Unlike autobiography, however, has been my focus on documents as artifacts rather than simply on my own memories of my experiences. This was, of course, intentional, in that I hoped to capture the

phenomena as I experienced them at the time they were occurring, rather than as I perceived them at the time of data analysis and reporting.

Ethnography, which is derived from research traditions in anthropology and sociology, is the description and interpretation of a cultural group for the benefit of those who are outside of that culture (Creswell, 2007; Quimby, 2006). Autoethnography examines cultural phenomena from multiple perspectives, with the researcher as a member (not merely a temporary participant-observer) of the group being studied (Duncan, 2004; Ellis, 1999). At first glance, I might have rejected the idea that people recovering from childhood sexual abuse constitute a culture, but when I really examined that question, I had to reconsider. Clearly, the broader culture to which we all belong assigns meaning and value to the experiences of sexual abuse and recovery (Meares, 1999). As a feminist researcher, I recognized that the culture-bound meanings and implications of my journey were of central importance, as they shaped the intrapersonal and interpersonal processes of meaning-making.

The cultures of the mental health care system, both its providers and its consumers, also present sets of roles, rules, and power structures that I thought were crucial to a feminist conceptualization of the healing process and the experience of being a consumer of mental health care (Foster, McAllister, & O'Brien, 2006). One of the driving forces for me in doing this work was the hope that it might offer the audience of my research – counselors and counselor educators – a glimpse into a world that is, in many ways, different from the one they normally occupy. The experience of enduring a course of serious emotional dysfunction and its treatment can profoundly alter one's worldview (Barowski, 2007), something that I hope this work partially elucidates. The view from "the other side of the couch" is crucial to the production of an accurate and useful phenomenology of healing from trauma, because so much of that healing

takes place within a system that has its own language, rules, and roles that can be confusing and intimidating (Burnard, 2007). Having the perspective of both client and counselor, and having navigated a path between those two worlds, was central to my overall purpose, and consistent with the values and assumptions of autoethnography (Duncan, 2004; Muncey, 2005; Muncey & Robinson, 2007).

The genre of portraiture was the qualitative approach that resonated most for me, mainly in that it intentionally blurs the boundaries between art and science, and rejects the notion that either form of knowing is more real or more important than the other. Portraiture concerns itself with an in-depth exploration of a subject, actively pursuing the particular as a portal to the universal (Lawrence-Lightfoot & Davis, 1997). Another aspect of portraiture that appealed to me was its emphasis on positive phenomena, not just problems or pathology. This was very important to me, because it was not my intention to simply produce a recitation of things that have happened to me, but a meaningful exploration of one example of the real harm done by sexual abuse, and the complex mechanisms of healing. The product of portraiture, like all art, is more than its constitutive elements, just as a painting is more than its brush strokes and a song more than its notes. This emphasis on the "aesthetic whole" (Hackmann, 2002, p. 51) appealed to me and was consistent with my holistic framework.

Portraiture also places a heavy emphasis on voice as a research tool; the voices of my self situated in specific places, times, and circumstances were my subject, my process, and my product. It is in the interaction of the three "selves" I described earlier – the subject-self, the researcher-self, and the remembering self – that I think the real value of this work lies. As a core value of feminism is recognition and respect for the voices of women, this self-portraiture was intended to capture these phenomena in a way that would be true to feminist, as well as

constructivist, philosophies and epistemologies. Portraiture was also an appropriate method for research on the kind of data I had, in that it encouraged interaction and negotiation between and among researcher and participants (Hackmann, 2002). How I intended to interact and negotiate with a stack of journals will be explained soon.

Research Questions

I explored three general questions in this study:

1. How is the self expressed in therapeutic writing, such as journals, internal dialogue exercises, and poetry?

2. How does CSA inform the adult survivor's sense of self?

3. How does the survivor's sense of self shift or change in the process of recovery?

Participants.

The participants in my study were all some aspect of me. I noted in Chapter One that my researcher self was joined by my remembering self in analyzing and interpreting the writings of my subject self. However, even this trilogy of selves is an oversimplification; within the over 2,500 pages of written work produced over those years of my life were embedded numerous selves, manifestations of me as they emerged, interacted with, and became parts of the broader authentic story of my life. While I recognized that such a strict constructivist orientation carried with it the risk of creating practical confusion for the sake of conceptual purity (Raskin, 2008), failing to acknowledge this complex interplay of internal and external elements carried the more serious risk of failing to capture the depth and richness of experience that I hoped to convey.

All of these exchanges among aspects of my self were performed in the service of examining my individual experiences in a way that would inform and provide insight to whoever reads my dissertation. As they, too, will bring their own worldviews and experiences to the

process, they actively shape the meaning of the final product. In this sense, I consider them to be participants in the process as well. I am appealing to the shared knowledge of myself and my readers as a framework for understanding my particular experience (Creswell, 2007).

Data collection and organization.

The data in this study consisted of written artifacts of my own experience of recovering from childhood sexual abuse, which began with the sudden emergence into consciousness of abuse memories in 1999 and continues to the present. The most intense period of change and resolution, however, came to an end in 2007; therefore I used this marker as an end point. The artifacts consisted of journals, poems, and other writings such as letters that I generated throughout this healing process. Some of the writings were structured as therapeutic exercises, while others were spontaneous. The poems, as well, were generally spontaneous although a few of them were created in a poetry workshop for women survivors of sexual abuse. The letters were all written as therapeutic exercises; they were not sent to the person to whom they were written.

In order to organize and manage the large volume of data, the writings were kept in chronological order, and each page was placed in a plastic sleeve, then into ring binders, and numbered sequentially. Because my goal was to explore the process of self construction, and I assumed this to be a process that occurs over time, I was careful to consider chronology in the data analysis. Most of the material was hand-written with the exception of several poems. I used the handwritten text rather than a transcription with the expectation that this would enhance the development of thick description of the artifacts (such as changes in handwriting, drawings,

and margin notations). Transcriptions of selected excerpts, labeled with their corresponding dates, are provided when appropriate for the purposes of illustrating or expanding specific findings.

Data analysis and interpretation.

The methods by which the data were examined, codified, analyzed, and interpreted incorporated elements of several qualitative research methods. Methodology in qualitative research is generally not stringently defined; instead, it reflects and responds to the data and the findings as they emerge and evolve throughout the process. However, this does not mean that I approached the data with no sense of structure or expectation. In the review of literature, I identified several major concepts that contributed to the overarching construct of the self, as well as concepts that informed the descriptions and understanding of the effects of CSA upon the self. These "sensitizing concepts" (Bowen, 2006) were used as means of initially scanning and sorting the data, and as I expected, they were adjusted as this process continued. Concepts that shared significant elements were organized into themes, and the data were re-examined for their adherence to these themes. It was my expectation that these themes would be of sufficient substance to coalesce into a coherent description of the subject under study, that is, the construction of self throughout the healing process.

During this process of reading and classifying the data, then returning to the data with the classifications I had identified, and adjusting classifications in response to re-reading the data, I began to feel lost in the terminology. For example, at what point does a cluster of similar concepts become a "theme?" Is it the number of times the concept is mentioned in the text, or is

it the degree of similarity of meaning among or between concepts? How do I measure this? Although I expected fluidity and reflexivity in my data analysis, I did not want it to deteriorate into chaos.

I returned to Lawrence-Lightfoot and Davis (1997) for guidance, and followed their process of organizing my expectations and ideas, what I had been referring to as "themes," into dimensions, which were the broader categories of related ideas and questions that I, as researcher, had brought into the process. Themes were those sets of related concepts that emerged from the data, and could be sorted and included within these dimensions.

I anticipated that I would initially sort and encode content in three major domains. The first domain consisted of sensitizing concepts derived from the literature, e.g., embodiment, autonomy (Diehl & Prout, 2002), control, blame, shame (Daigneault, Tourigny, & Hebert, 2006), and hope (Fivush & Baker-Ward, 2005). The second domain included narrative structure, such as dialogue or poem, and literary devices for self-reference, or "I" statements. These included direct self-reference or "I am" statements, indirect or experiential self-reference such as "I feel, I think, I wish," and metaphorical self-reference such as "I am like, I feel as if." The third domain addressed contextual information, including life events, relationship events, the emergence of memories, and the passage of time.

While I found these processes of sorting, coding, identifying themes, and arranging shifts in those themes in subjective experience across time and events to be fairly illuminating, I also found them to be reductive, pulling me farther away from the aesthetic whole I had hoped to create. This kind of data dissection also left me feeling that my analysis had no borders, and that the final product could be flung far beyond the confines of my original proposed focus. There

were other questions that could be posed to these data and answered, but I had to be able to keep my focus on the questions at hand.

In order to return the data to a living, organic whole, I had to find a bridge that would bring the data back to the form of a rich narrative, one that would reach the level of portraiture. In order to accomplish this, I took the snippets of data and the bundles of themes back to their origin – back to a narrative form. This intermediary field text form, based on the practices recommended by Clandinin and Connelly (2000), became the nexus of the recursive interaction between the original data, my researcher self, and my remembering self. Once that level of interaction between me and the original data had been reached, I found that I could then return my focus to the original research questions and my thinking back to the sphere of portraiture.

Trustworthiness and credibility.

All narrative research should be produced and communicated in ways that maximize its veracity, meaningfulness, and transferability (Malterud, 2001), even when the study is unique and not at all replicable. There were numerous methodological challenges and potential pitfalls in conducting this research. First, I had to maintain an awareness of the multiple roles I played in this process, and how each of these informed and shaped my perceptions (Hoskins, 2000). Again, this multiplicity of perspectives was very intentional and, I think, at the heart of the potential value of this work. At the same time, I have been vigilant in recognizing and communicating which voice is active at any given moment (Johnston & Strong, 2008). I have tried, as I described and analyzed a concept or process, to declare or otherwise make clear the perspective from which I was so doing (Norum, 2000) without allowing the narrative product to be reduced to a script, with each "character" having its own set of "lines."

Another challenge in doing this work was to avoid, as much as possible, skewing my interpretation of the data to support a predetermined conclusion or agenda. While I naturally had certain expectations regarding what I might find, I have consciously sought to keep the exploration open, and to be willing especially to include and address the unexpected or inconsistent elements. This openness to the possibility of "deviant voices" (Lawrence-Lightfoot & Davis, 1997, p. 187) is important in that it allows for the emergence of perspectives that run counter to conventional wisdom, which is a stance that I vigorously embrace. I have tried to develop clear strategies for sorting, analyzing, and reporting information, and to make those processes known to my readers as well. This kind of transparency enhances the truthfulness and utility of the researcher's findings (Malterud, 2001). My methods and tools for data analysis are further described in Chapter 4.

The recognition and acknowledgement of bias is important in any qualitative research, and particularly tricky in a study involving one's own life experiences. Postmodern researchers reject the notion of objectivity as irrelevant and fictitious, focusing instead on the importance of being open and explicit in claiming the researcher's subjectivity (Hackmann, 2002). This rejection of the quest for pure objectivity is also consistent with feminist approaches to epistemology, as feminist research actively seeks and embraces the subjective voice (Brown, 2004).

In their description of the process of portraiture, Lawrence-Lightfoot and Davis (1997) emphasize the importance of actively involving the subject's input into the narrative, as well as clearly defining the researcher's own position, personal impressions, and responses. Because my "subject" was not able to engage in this kind of discourse, I have had to find other ways to authenticate my impressions. One was what I am calling "temporal triangulation," or a triadic

view that comes from my past self as expressed in the writings; my memory of myself during that time; and my current self, who was the researcher self who organized and analyzed the data. Another source of validation I used was the solicitation of the informal feedback of my peers and a practicing psychotherapist with substantial experience in working with adult survivors of CSA. Finally, I examined my findings against the backdrop of the existing professional literature describing the process of healing from CSA.

The trustworthiness of the data as true and accurate expressions of my experience is enhanced by the fact that these writings were never intended for any use other than personal development and healing. I did not write them in the form of a memoir or other narrative for public exposure; my intended audiences were my therapists and fellow members of my therapy groups. This reduced the likelihood that the writings would be censored in favor of any particular hypothesis or expectation.

Privacy and confidentiality.

All research should be designed in a way that the privacy of the subjects is protected. While I am free to choose what to disclose of my own experiences, I sought to avoid identifying others in any way that might cause them harm. Foster et al. (2006) emphasize the importance of anticipating such potential harm and weighing it against the good that the research may accomplish. This balance of harm and potential good were the guiding force in making decisions regarding disclosure of specific information. Ellis (1999) suggested the use of several devices including compression of multiple events and changing identifying details. I used these techniques to some extent as well as pseudonyms in order to protect the privacy of others without compromising the integrity of the data.

Because of the nature of the sources of data for this study, that is, existing documents of my own creation, the Institutional Review Board of the University of New Orleans declined to review my proposal because it did not meet the criteria for human subjects research.

Chapter Four

Results

The purpose of this study was to explore and describe the construction of self as reflected in the written artifacts produced during my own recovery from CSA. Specifically, I intended to answer three broad questions:

1. How is the self expressed in therapeutic writing, such as journals, internal dialogue exercises, and poetry?
2. How does CSA inform the adult survivor's sense of self?
3. How does the survivor's sense of self shift or change in the process of recovery?

Processes and Elements of Data Analysis

These questions were explored along three dimensions that I had identified as relevant based on my own prior knowledge and my review of literature. These dimensions included the narrative self, the self as autonomous or relational, and the self as embodied or transcendent/rational. These dimensions merit a bit of further discussion as they pertain to the genre of portraiture, and my adaptation of this genre to self-portraiture. According to Lawrence-Lightfoot and Davis (1997), relevant dimensions are those constructs that the researcher brings into the study. These dimensions arise not only from formal preparation such as the review of literature, but from the researcher's own worldview and life experience. Relevant dimensions create a space for the emergence and development of themes, which reside in and emerge from the data. Themes can be organized within the relevant dimensions but may arise in multiple dimensions. Themes that are found to resonate across multiple dimensions contribute to the authenticity and relevance of the portrait as a whole.

The narrative self, which is central to my constructivist and feminist orientations, can be considered the scaffolding upon which my self-portrait is built, in that it is both the source of my data and the form of my analysis and reporting of results. The other dimensions, the autonomous vs. relational self and the embodied vs. transcendent self, not only provided focal points for the emergence of themes, but themselves represented "generative tensions" (Lawrence-Lightfoot & Davis, 1997, p. 162), or opposing polarities which, through dialectical processes, could be brought into the foreground and engaged. This dialectical dynamic came to life as I moved deeper into the processes of reading, sorting, coding, and interpreting the data. The theoretical framework of the dialogical self (Cooper, 2003; Hermans, 2003) also supported and contributed to this very dynamic process of constructing a meaningful self-portrait.

Data analysis and interpretation in narrative research is, by nature and necessity, fluid and self-responsive. I began my analysis by reading all of the artifacts and highlighting those passages that I thought were relevant to the dimensions of the self that I had previously identified. I listed thematic elements that I expected could be used for coding the journal entries selected for analysis and created a visual display of my conceptualizations of the relationships among these thematic elements (Appendix A). I then used this thematic structure to create a coding tool (Appendix B). The data were sorted, coded, and analyzed in a multistep process as described in Chapter Three.

From Data to Portrait

The visual image of a portrait, that is, a painting that captures and conveys the essence of a person, has certain structural requirements. It has a frame, a border or edge of some sort that contains it in space. It also has a background, perhaps a setting that offers clues pertinent to the

identity or stature of the subject. Finally it has the subject itself, the person whose self is represented in the portrait. Together, these structural elements combine to become the aesthetic whole – the portrait.

My conception of a coherent and meaningful narrative portrait had similar elements. The frame defined the boundaries of the study and was important for me in that I sometimes found it too easy to stray from my defined research questions. The background, from which the primary subject emerges, was my own story of sexual trauma and recovery. While I considered this background to be integral to the meaning of this work, I did not intend to dwell on traumatic events to any extent beyond that which was necessary and appropriate to illuminate the processes of healing and self-construction.

The subject of this portrait was the process of self-construction, as it emerged from the background of sexual abuse and recovery. The subject was derived from my analysis of journal entries and other writings, the identification and descriptions of themes found within those writings, and my interpretations of this material. In order to create a self-portrait that accurately depicted and communicated the phenomenon of self-construction, I had to engage in ongoing dialogues among the selves of subject, rememberer, and researcher, and among the subsystems of selves that exist within each of them throughout the processes of scanning, extracting, sorting and coding, and re-narrating the journals. I found the philosophical and theoretical models of the dialogical/polyphonic self (e.g., Cooper, 2003; Hermans, 2003) to be informative and affirming, as I proceeded to co-create this verbal self-portrait. Approaching the data as a dynamic product of ongoing internal discourse allowed me to explore deeper meanings, and to accept or reject these in response to such dialogues.

Frame: Defining the boundaries.

The frame within which this study is situated is the construction of self during my own process of recovery from the effects of CSA as expressed in written artifacts that I produced during that recovery. Because the processes of therapy both prompted and were reflected in these writings, an overview of sexual trauma therapy might be useful to the reader.

The healing process for adult survivors of CSA varies according to the theoretical orientation of the therapist, the specific problems and needs of the client, and the severity of the client's distress. Herman (1992) and other early trauma therapists proposed a three-phase model that has been modified but maintains its basic structure to the present (Courtois, 2004). The first phase is the establishment of physical and emotional safety, which includes ensuring that the client is not currently in an abusive or otherwise dangerous environment and is able to use basic coping skills in order to deal with crises and self-destructive urges. Emotional safety is achieved primarily through the development of a trusting, empathic relationship between the client and the therapist, allowing the client to disclose events, thoughts, and feelings that may be experienced by the client as shameful or dangerous (Courtois, 2004; Herman, 1992). One aspect of safety that is often a challenge for survivors of CSA is the ability to tolerate and modulate strong, sometimes destructive, emotions. Emotional tolerance and regulation can be quite difficult to attain, and these skills generally need to be reinforced throughout the therapeutic process (Linehan, 1993).

The second phase involves remembering the abuse – not just the traumatic events themselves, but the feelings and beliefs that were incorporated into the survivor's self-structure as a result of the abuse. This trauma-informed self, built on a foundation of toxic beliefs and unrelenting fear, anger, and shame, must be deconstructed in order to allow the survivor to

construct a truer, healthier, and more balanced self – no small task indeed. The act of telling one's own story, often re-telling that story many times, is in itself therapeutic in that it allows the survivor to reject deeply engrained messages of silence and shame, and to claim her long-suppressed voice. The third phase involves the integration of the client's trauma narrative into a broader self-story, one that acknowledges, but is not dominated by, the traumatic material (Bernsten & Rubin, 2007).

It is important to recognize that this is not a linear process; it is more accurately imagined as a spiral, as client and therapist revisit already-processed material, but with each reworking being approached – ideally – from a healthier and more integrated state of emotional development. In this kind of an upward spiral, the client moves toward a greater ability to feel, tolerate, and modulate emotions, recognize and challenge trauma-based beliefs systems, and reconstruct a truer and healthier self-narrative over time. Progress is likely to be interrupted by periods of apparent deterioration, triggered perhaps by internal events such as newly recovered memories, or external events such as the death of a perpetrator. At times the survivor may step away from the memories and their attendant feelings, perhaps in response to feeling overwhelmed. As an example, I wrote in February of 2002:

> Memories have faded, shifted to a silhouette. I know what happened, in a general way, but I can't recall details. I can't recall in a first-person way. [It's] as if I'm just recounting a story and not my own life.

These temporary episodes of what might be perceived as backsliding may, in fact, lead to new insights that could ultimately contribute greatly to the client's recovery. However, such periods of increased symptoms of distress (in the example above, increased dissociation) can be discouraging for both counselor and client. I found through my journals that every substantial

move forward was followed by a backlash of emotional and behavioral disintegration; it was not until my therapist and I very carefully found and challenged the beliefs that triggered these episodes that I was able to move more consistently forward.

Background: My story.

One night in March of 1999, I very suddenly and vividly remembered that the psychiatrist who had seen me through most of my teenage years had also had sexual intercourse with me weekly for at least two of those years. I had always "known" that my behavior in adolescence had been severely disturbed, and this doctor, to whom I will refer as "Dr. X," was revered in my family as a caring and devoted caregiver. When I was 17 years old, this same psychiatrist diagnosed me with schizophrenia, undifferentiated type, and that label became the major constituent of my identity. I spent most of my time over the next two years in psychiatric hospitals. I received at least 30 electroconvulsive therapy (ECT) treatments and thousands of doses of antipsychotic drugs. I did not, at the time, remember the sexual activity with the psychiatrist; in fact, I remembered very little of my own past, recent or distant. I relied on the stories of others as my autobiographical narrative. I had very little sense of a personal history of my own.

After about two years of having received (or so I was told) the best that conventional psychiatry had to offer, I was enrolled in an experimental protocol with a doctor at the University of Louisville. I moved to Louisville, participated in the treatment program, began making friends and taking college courses, and my symptoms gradually disappeared. Eventually, I returned to New Orleans, believing that I had been the beneficiary of a medical miracle. I went about the tasks of building my life. I still had huge gaps in my autobiographical memory, but I attributed these to my schizophrenia and to the ECT and drugs. Mostly, I tried to focus on the

future and hoped that the past would stay just that – the past. But I was always haunted by the fear that the schizophrenia was not cured, but simply in remission, and that it might at any time recur.

The sudden memory of the sexual abuse by my doctor immediately called into question the veracity of everything I thought I had known about my life and myself. I knew, although I could not yet articulate why or how, that my "insanity" had been a response to the inappropriate sexual activity. What I did not yet know was how many other lies were embedded in my life story. I began to remember bits and pieces of my childhood, including multiple episodes of abuse at the hands of several perpetrators. I immediately entered counseling with a female counselor. I had a very strong and frightening sense that my identity was crumbling, and thus began the immense job of reconstructing a true and meaningful self-story.

I did not begin journal writing until about a month after the emergence of the memories. Rather than write, I walked, sometimes for hours, ruminating over what had happened, asking myself why he would have done such a thing and why I would have allowed it. I felt his presence following me everywhere, and I became more and more distressed. My view of the world shrank into a narrow beam of bright light that shone on him day and night. I stopped eating entirely. I slept very little. I could hear, but often could not understand, what my husband, children, and friends were telling me. I sank into a deep sense of hopelessness that eventually evolved into a suicide plan, and, for the first time in about 25 years, I re-entered a psychiatric hospital (something I had sworn I would never again do). While there, I began to keep a journal. Later, I transferred to hospital that had a specialized program for survivors of sexual trauma, and journal writing was an integral part of the treatment protocol. The journals that constitute the data for this study include those written spontaneously and those written as

parts of therapeutic exercises. I reviewed and analyzed a total of over 2500 pages of journal entries, letters, and poems for this study.

As my memories continued to emerge, I became aware of different personas or self-states that seemed to have highly specialized functions in my overall self-structure. For example, there were self-states that could recall certain memories but not others. There were some that contained destructive impulses, some that served protective functions, some that held memories unavailable to my primary consciousness, and others that kept secrets from each other. In psychiatric terms, I diagnosed with dissociative identity disorder (DID), along with post-traumatic stress disorder (PTSD) and depression.

As a counselor, I hesitate to focus on formal psychiatric diagnoses. Although I do not dispute that mental illnesses exist, I prefer to view human experience through a different lens. I believe that many emotional "disorders" are manifestations of once-adaptive responses to stress that have since lost their usefulness or become maladaptive.

As a feminist and postmodernist thinker, I also believe that many emotional, behavioral, and relational problems are rooted in social structures that assign value to some identities and statuses over others, and that constructed meaning has more to do with a person, event, or condition than do objective facts. The diagnosis of DID is especially sensitive, in that it seems to have enjoyed a wave of popularity on the one hand, along with some strong professional attacks on its validity, or even its existence as a true entity on the other (Pica, 1999). This sort of schism in the mental health arena has interesting social and political underpinnings that are beyond the scope of this study, and it is not my intention to delve into the subject any more than is necessary for the purposes of this study. However, my experience of fragmentation was severe enough that it became a major focus of my healing work, and to ignore it would be to deny my readers the

very perspective that is the heart of this work: the construction (in my case, preceded by a deconstruction) of selves in the process of healing from CSA.

I see the arrangement of my self-structure as a creative and powerful way of surviving experiences that would otherwise have killed me, and for sequestering memories, feelings, and impulses that I was not yet ready to bring into full consciousness. In the dialogical theory of the self, a type of narrative theory, it is maintained that all individuals contain multiple selves, often in conflict with each other and containing their own memories, emotions, and psychological functions (Cooper, 2003; Friedman, 2008; Hermans, 1996). In most cases, these self-states operate outside of everyday consciousness but can be called into the forefront for self-reflective or therapeutic purposes. Clinically significant sequestering of these selves, to the point that the person meets diagnostic criteria for DID (APA, 2000), has been approached in different ways by various authors (e.g., Herman, 1992; Pica, 1999; Straker, Watson, & Robinson, 2002; van der Hart, Nijenhuis, Steele, & Brown, 2004). Within narrative/constructivist paradigms, DID can be seen as representing a more extreme version of this experience of multiple internal selves. Interestingly, Hermans (1996) conceptualized DID not as a dialogical structure or process, but as a series of disconnected monologues, or self-states that have lost (or perhaps never had) the ability to communicate with each other. Because narrative and dialogical models are central to my constructivist view of the self, this notion of sequestered self-states as monologues rather than dialogues appeals to me. However, I do not intend to speculate on the mechanisms by which DID develops; I have chosen to disclose the existence and degree of my dissociative experiences because they are integral to my story of healing. In order to avoid, as much as possible, a focus on the phenomenon of dissociation as pathology, I will refer to my distinct experiences of self as self-states rather than parts or alters.

Subject: The construction of the self as expressed in written artifacts.

I agree with Brison (2002) that rape creates a kind of death; I would add that remembering long-forgotten rapes has a similar effect. The self who had existed before the abuse, and the self that I had constructed before the recovery of the memories, no longer existed, and yet their passing went unnoticed by most people in my life. No funeral, no flowers, no remembrances – there was no real acknowledgement of the loss.

Furthermore, the person who had existed prior to the abuse was, in my case, itself very incomplete and fragmented. I spent much of my time in therapy searching for a "before" – that is, searching for the self who had been present before the abuse began. I believed that, if I could find her, I could connect with my true, untainted, uncontaminated self. But I have never been able to find her. And the person who remained, the raped one, the person whose deepest and ugliest wounds were invisible, was encouraged to just move on, just get over it, get back to my "old self." But the old self was dead, and before I could bury her I had to know what happened. In that sense, trauma therapy is like a necropsy, and healing is as much a process of grieving the lost self as it is one of creating and strengthening the new self. In this study, I am attempting to describe in a meaningful and clinically useful way the processes involved in my own deconstruction and reconstruction, a process which, I must admit, continues, and which I expect to continue for some time to come.

Overall Structure of the Data: Journal Entries and Other Writings

My journal entries can be grouped into three major categories. First, there are pure narratives, that is, stories of what happened, what effect these events had on me, and my feelings and beliefs about these events and their effects. These narratives were written repeatedly over time, usually for the purpose of sharing in a therapy group. Over time, the narratives

demonstrated not only a deepening of insight but a filling in of gaps in my autobiography, thus gradually evolving into a more coherent self-story.

The second category of entries consisted of internal dialogues between and among my internal self-states. These were often contentious and painful, in that self-states that had been created for opposing purposes had to be convinced to communicate and share information and feelings – something antithetical to their very reason for existing. Although these dialogues were among the most difficult of my healing work, I believe they contained the core of my transformation and integration.

The third type of journal entries was written for the purpose of emotional expression. One of the legacies of my early life experiences, as is common among survivors of CSA, is that intense, almost unbearable emotions rise up from some deep, primal source and demand expression. They insist that we, who had learned so well and so early to be numb, feel agonizing pain, anger, fear, and grief. They command that we, for whom silence had always been a matter of survival, express these emotions. If we attempt to ignore or deny the demands of these emotions, they find other ways to make their presence known, often through dangerous psychopathologies that only serve to temporarily satisfy the insistence of emotional expression, but soon contribute to the cumulative misery and shame. Recognizing and expressing positive emotions, such as love and joy can, paradoxically, be as difficult and frightening as the darker emotions (Courtois, 2004; Herman, 1992; Williams, 2006). Healthy emotional expression, as impossible as it may seem to the trauma survivor, is essential to healing. In my experience, expressive therapies using a wide range of verbal and nonverbal modalities were key components of trauma recovery work.

My expressive work consisted of writing, both in narrative and poetic forms, visual arts, physical expressions such as dance and kickboxing, and verbalization of feelings. I often found that listening to music could serve as a catalyst for emotional expression, and I used it for that purpose. Because of the boundaries of this study, however, I will limit my analysis and discussion to written expressions of emotion, specifically those writings that informed my sense of self. These entries allowed me to purge myself of intense emotion, at least to some extent. They also allowed me to communicate experiences that had been entombed in silence for decades.

I must mention that there were some pages missing from the notebooks I had used for journals; the reasons for these gaps were sometimes apparent but not always. I made every effort to collect and organize every page I could find; however, I maintained my own boundaries and the privacy of others by excluding elements of the narrative that I prefer not to disclose, as well as those that were not germane to the topic of this study. I did not edit or remove any process elements, as these are the central focus of this study.

Identification of Themes

After several rounds of data analysis, I was able to identify nine major themes related to the construction of the self, each of which could be connected to the original relevant dimensions of the self as a narrative construction, the self as embodied vs. transcendent, and the self as autonomous vs. relational. I found that there was a good deal of overlap among these dimensions, which did not surprise me. However, even with that overlap, I did find the relevant dimensions and their constitutive themes to be distinct enough that each could be explored and analyzed. Within the dimension of the narrative self, I will discuss my findings related to narrative coherence and re-storying. With regards to the embodied self, I will discuss the themes

of body-blame and body ownership and control. In the dimension of the autonomous self, I will describe the themes of power, diagnosis as identity, and redefining relationships and roles.

Themes related to the narrative self.

Narrative coherence.

Narratives – that is, stories – require certain elements in order to be considered whole and coherent (McAdams, 2006). They must have some sort of a plot line, and the sequence of events must occur in such a way as to make sense to the listener. The story has a beginning, middle, and end; it has some sort of crisis, obstacle, challenge, or other event of interest to the protagonist. The characters in the story, including the narrator, must be considered credible, even if only in the form of a fantasy. The human tendency to impose order and narrative "rules" onto an incoherent or incomplete story is strong. Gaps in the construction of the story must be filled in, and this might be accomplished by relying on information provided by others. This was true in my case; most of my self-story until 1999 consisted of people, events, causalities and effects told to me by others. It was, to say the least, an unusual story, but it the met the criteria listed above. When that story crumbled, my need for narrative coherence compelled me to find and understand my true self-story.

Furthermore, stories exist to be told (McAdams, 2006). The telling of my mythological story had never been something that came easily to me, so I went through my adulthood unheard and, it seemed to me, unseen. The self that I had presented to the world, the one that others defined me by, had always felt to me like a lie, and I had never understood why. When my true story began to emerge, it was met by many of the people in my life with strong resistance; I was given implicit as well as explicit messages that I should keep this story, the ugly, true story, to myself. These messages, along with the secret-keeping that I had learned since childhood,

converged into a powerful force that pushed against not only the telling of my story to others, but even the knowing and remembering of my story within myself.

In order to create a portrait based on narratives over time, I chose to focus on a series of narratives of my experiences with the psychiatrist written over a period of several years. This process of repeated telling of the same story is a key element of narrative therapy, in that it eventually allows for new meanings to emerge (Straker et al., 2002). I chose to use repeated narratives of the same story, rather than those of different events in my life, with the expectation that changes in self-representation would be easier to follow when the overall topic of each narrative is the same. However, certain other narratives that held important information related to the abuse by the psychiatrist were included as well, as they served to better illuminate the story. For example, my memories of being confined to mental hospitals as a teenager, and my return to that status as an adult, contributed greatly to my story in that they, usually out of necessity but often out of ignorance, re-created the same subjective experiences I was trying to overcome. This will be explored in more detail later.

As mentioned earlier, my first memory of abuse came to me suddenly and with piercing clarity: Dr. X had been having sex with me for two years or so before diagnosing me with schizophrenia and discarding me to the trash-heap of the hopelessly insane. I remembered not only that it had happened, but I knew immediately that it meant I had never been schizophrenic. The impact of that realization, that the thing that had been my identity, my greatest obstacle, and eventually my triumph, was a lie, was overwhelming to me. I quickly realized that I had, at the time of my diagnosis, only two choices: Either I could continue to be a full-time rape victim, or I could be crazy. Of the two, being crazy was the more attractive option.

Of course, the dynamics of the abuse and its effects on me were far more complex and less conscious than a simple decision to be crazy; but in its simplest terms, that's what had happened. Being crazy had been my means of escaping being raped. At that time, and in those circumstances, the idea of other options – such as refusing his advances, or telling someone what he was doing, or simply refusing to see him anymore – did not seem possible to me.

The implications of this simple yet crushing realization were staggering. What might my life had been like if he had not done this to me? What other choices might I have had? Would I still have lived my life with the nagging fear that something was out there, waiting to spring out on me and take away everything I had worked so hard to build? And underneath all of these questions was the biggest question of all: Why? Why had he done this to me? What had I done to allow it, invite it, or encourage it? What was it about me that made him think my life was disposable? What was it about *me* that left me with so little ability to defend myself or even to ask for help? What was wrong with me?

These were the question that would lead me down many previously unseen paths into my past. These were, on the one hand, irrelevant questions. People don't get raped because there is something wrong with them. They get raped because they happen to encounter a rapist. But, on the other hand, these were questions I felt compelled to ask and find answers to. There must have been something about me that made me, if not culpable, at least vulnerable. And I knew that the almost total void that was my self-story probably held a lot of the answers.

The first journal entry I could find was dated April 1999 and had been written on the computer. One of the first statements I made in this entry was that I did not know what I hoped to accomplish by writing, except perhaps a sense of getting the pain and distress out of myself

and onto paper. I realize upon reading it that this function – what I am referring to as a purgative function – is repeated, although not specifically identified as such, throughout the many pages to follow.

The first entry is also remarkable in its emotional dullness and detachment; while it tells the basic story of what happened and how I believed that it affected me, the intense emotions of anger, betrayal, and grief were glaringly absent from the written account. It was more of an accounting of events than an expression of my feelings. This is a passage from that first journal entry:

> When I first started seeing him, his office was attached to his home and was a single room. A few months later, he moved to another office. This one had two rooms. One was furnished with the usual couch and chairs. The other just had large pillows all over the floor. He said that room was for group therapy.
>
> As time went on he encouraged me to sit with him on the floor of the "group room" rather than on the chair. He said I could relax better that way. I went along with whatever he said. As well as I can remember, the sex started sometime during my junior year…(I go on to describe the sexual encounter in this matter-of-fact, detached way).

This kind of dissociation of story from emotion would recur numerous times throughout the retelling of my accounts of the abuse. I remember that in therapy groups, I would often read my trauma narratives in a detached manner, seldom shedding a tear for my own pain; when other group members shared their stories I could, and often did, weep for them.

This kind of separation of the one's self from traumatic events or memories is called depersonalization; in this state the trauma victim is able to acknowledge that the event occurred

but experiences it as if it is, or was, happening to someone else (van der Hart, Nijenhuis, Steele, Brown, 2004). Depersonalization occurs in people without, as well as with, DID; I believe that the depersonalization I experienced was at least partially because the self-state that had gone through the events of my story had not yet emerged. In a very real sense, I was telling her story, not my own.

Early in therapy, I was given the assignment of writing a life history. In reading it for the purpose of this study, I found it to be sadly comical in its emphasis on how normal and happy my childhood had been; clearly at that time there was only one villain in my mind – the psychiatrist. I still held on to the happy family myths, no matter how implausible they were becoming. While this and the remaining journal pages were hand-written, this section was in a very neat, controlled penmanship and was free of grammatical, spelling, or punctuation errors (perfectionism in some areas, such as schoolwork and later in my professional life, was often a compensation for the utter chaos that characterized my life). As the journal continues, the physical appearance of the handwriting varies from this same kind of neat, clear penmanship to an almost illegible scribble. Paradoxically, in many cases, stories of my most painful and poignant accounts of self-loss and deterioration were written in this neat and proper penmanship, as if the handwriting could somehow mitigate the disorganization in my mind. My belief in the myths that had been my life story, and my (always tenuous) experience of myself as a single intact entity was quickly diminishing. I wrote,

> I feel myself coming further and further away from myself. I know that doesn't make any sense, but I don't know who I am anymore. If I kill myself, who am I really killing? Is it me or is it her or them or does the world just end? I just don't know.

In his description of the self as polyphonic, that is, a theater of voices or "I" positions all existing within a single person, all capable of independent voices, all capable of moving around in time and space, Hermans (1996) reflects on two "I" positions first proposed by William James and based on the philosophical influence of Martin Buber. In this conceptualization, "I," the self as knower, is distinguished from "me," the self as known, based on whose construction the self reflects. The "me" position can be created by outside influences, people, events, and other elements of the environment. The "I" position, as the knower and narrator of the self-story, can construct the "me" as the protagonist of the story "because I as author can imagine the future, reconstruct the past, and describe [my] self as an actor" (Hermans, 1996, p. 32). It struck me that a person stripped of memory, despairing of the notion of a future, and having no idea how or why her life came to be what it is, cannot possibly occupy a viable "I" position. This notion of having no sense of myself in the "I" position resonated very strongly with me when I read Hermans' work. This absence of an "I" position, I think, was the essence of my experience in the early days and months of my recovery work. Having no "I" position is the equivalent of having no voice, and having no voice is the equivalent of having no self. In October of 1999 I wrote,

> Losing my sense of self is probably the hardest to express in words or even pictures. I feel like shattered fragments of a whole person and I'm desperately trying to glue them back together but some of the pieces are so damaged and tiny that I don't know if I'll ever be able to put them back.

As I was left with no choice but to confront and, in many cases, reject the mythology of my past, I became increasingly aware of the huge gaps in my autobiographical memory and I felt

an urgent need to fill them. I wanted to remember everything, immediately, because I believed that if I could just find out the truth and deal with it, this interruption in my life could be neatly and quickly dispensed with, and I could return to my husband, children, and career. I did not expect it to be easy or painless, but I approached it in what I thought to be an efficient, pragmatic manner.

I was wrong. The memories did not come upon my command. They seemed to me, at the time, to have a timetable of their own making; I now am convinced that the timing of memories was controlled by my own inner wisdom, something that I can neither manipulate nor take any real credit for. It seems to me that we all possess an intuitive knowledge of when this kind of self-exploration must be done. I could neither induce memory retrieval nor impede it; the best I could do was to be as ready for it as possible by learning coping skills and having a reliable support system.

As time went on, I became increasingly frustrated that telling my story over and over again was not producing the kind of results I expected. Every retelling had that element of depersonalization, regardless of how hard I tried to connect emotionally with the events of the story. I remember the group therapist encouraging me to speak more slowly, and to pause after certain statements in order to allow them to sink in. He helped me develop the ability to call the sexual encounters "rape." But I continued to feel nothing for myself in groups, as I also continued to feel deeply for my peers. The feelings that did emerge after telling my story in group often came up after the group in the form of a sort of backlash against myself; often I would cut or burn myself as a kind of punishment for the crime of revealing my secrets.

My stories did not become real to me until they were told by the self-states who had, themselves, experienced them. In other words, the various "I" positions that held the stories of

my life had to be given voices of their own. This occurred, bit by bit, over many months – even years for some selves. The shift from monologic narrative to dialogic discourse was by no means smooth or easy. It required that secrets be revealed, that beliefs be expressed and contested, and that emotions be honestly felt – all of these communicative acts that had been forbidden in my previous self-system. In several narratives, I shift from first-person to third-person voice periodically, as if to step away from ownership of the story. I think of this as the difference between knowing (a third-person experience) and remembering (a first-person experience). Remembering is infinitely more painful. The beginning of internal communication also revealed the profound loneliness in which these self-states had been living for so many years, even decades, and the sense of timelessness and non-belonging that had always been just under the surface of my own consciousness, even when I could not articulate it. In April of 2002 I wrote:

> Pastpresentfuture – time is circular, this constant recycling of memory and experience and right now I have trouble making any distinction between past and present. There is even an element of prescience, in that young parts can see and feel not only what happened before they were created but now know what happened after they were put away into my unconsciousness.

It was not only the memories of traumatic events that were inaccessible to me, but many of the other memories that constitute the life of a teenager that were lost. In 2004, I realized that one of the memories that had been stashed away was a simple but important adolescent rite of passage:

I can't remember my prom. Tonight is [my son's] prom and all day I've been trying to remember mine but I can't. I know I went to the prom as a Junior because there is a picture with me and [my date].

It's not about the stupid prom. It's about having all these holes in my life. Lots of people forget where the prom was, or where they had dinner, or even who they went with. That's not it. The problem is that if it weren't for the picture I would have no idea whether I went or not.

The resistance to full expression of my inner selves came from within myself – from the internalized taboos and attendant shame, fear, and anger associated with revealing my stories – but also from others. Not only friends and family, but in some cases therapists and psychiatrists, discouraged these self-states from speaking in their own voices. I was able to trust my intuition and insist on being allowed to speak in all of my voices, even when that meant distancing myself from some friends and relatives or terminating treatment with certain professionals and finding others with whom I could effectively work. I "fired" two therapists and a psychiatrist because I did not believe that they were hearing or respecting my insights or opinions. I also had numerous confrontations with hospital staff when they treated me in ways I experienced as disrespectful or dismissive. I realize now that my ability to insist on getting the kind of therapy I really needed was improbable to say the least, and that many CSA survivors would not be able to be that assertive.

In February 2001, I decided to terminate with a hospital-assigned therapist because I felt the same power dynamic that I had with Dr. X beginning to form. Although there were never any sexual overtones in our interactions, I felt a need to please him but never was sure what he wanted. I wrote, "…it means showing up for therapy every week having no idea whether what

I'm doing is what he wants, and sometimes leaving therapy still not knowing." Later I wrote about the same therapist, "I could not allow [myself] to be put in a submissive position again. That's just too triggering and dangerous for [me]."

While I acknowledge that there were real mismatches between myself and certain professionals, I don't believe that my disputes with therapists or doctors were entirely about my specific disagreements with them. I am the first to admit that I have a particular problem with allowing myself to trust psychiatrists and psychotherapists, particularly males. Additionally, however, there is a well-recognized negative attitude among many mental health professionals toward women survivors of CSA, particularly those whose abuse has resulted in multiple and persistent problems. Judith Herman, one of the pioneers of modern sexual trauma studies, wrote:

> Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties in close relationships, they are particularly vulnerable to revictimization by caregivers. They may become engaged in ongoing, destructive interactions in which the medical or mental health system replicates the behavior of the abusive family (Herman, 1992, p. 123).

In spite of these disputes, and in some cases because of them, my various self-states have been able to tell their stories over the course of several years, which opened lines of communication among my internal self-states and slowly, very slowly, shifted my experience from having a fractured, second-hand self-story to having one that, while it still has some holes, is authentic, true, and reasonably complete. This gradual construction of a coherent self-

narrative is, I think, at the heart of healing from CSA. From as early as July of 2000, I was able to recognize that

> [My] healing has to be self-directed, rather than other-directed, in order to really take hold. I am grateful for the help I am getting… but the primary force for change has to come from my center. And in order for that to happen, I have to find my center.

In my present-day memory, I see those acts of rebellion against authority, even when they were not as gracefully articulated as the passage above, to be the force that kept me alive. I was ornery, but often for a good reason. I was argumentative, but often right. I was angry a lot of the time, usually justifiably. But every time I stood up for myself, I was able to shake off a little more of the debris of victimhood that still clung to me.

Re-storying.

The theme of re-storying, or creating new meanings or outcomes in one's narrative, is also a major focus of narrative therapy. I found that the process provided many of the pivotal events that were essential to my healing. In my analysis of the data I became aware of two major types of re-storying. The first was the ability to apply new meanings or insights to existing events, often resulting in a therapeutic turning point or a shift in momentum. This was often a deliberate act of reframing done in the course of internal dialogue work.

One of the most painful aspects of coming to know and remember all of my selves was to acknowledge and accept self-states that held self-destructive or otherwise unpleasant beliefs, feelings, and behaviors. These encounters with my "shadow" selves seemed at first to be nothing more than rubbing salt into an already agonizing wound, until I began, under the guidance of my therapist, to recognize and appreciate the role these self-states played in my survival. Slowly,

deliberately, and very carefully, my self-system began to bring these shadow selves into the light.

I recognized that my anger, so big that it usually terrified me, was part of the same energy that allowed me to survive, express my (completely appropriate and justified) outrage at what had been done to me and taken from me, and to challenge the authority of those professionals who expected me to subjugate my own reality to their authority. I was able to reframe the sexual hunger I experienced in adolescence as an attempt, although misguided, at achieving genuine intimacy. I learned to see my ongoing sense of guilt before God as the only thread of faith that I could, at the time, maintain.

My tendency toward self-blame, thinking that there must have been something about me that allowed him to rape me, had allowed me to avoid the experience of utter helplessness that was the truth. Helplessness is much more terrifying than self-blame (van der Kolk & McFarlane, 1996), and I was not able to acknowledge this helplessness until I had developed enough ego-strength to do so.

Even my chronic suicidality, with which I had struggled for so long, gradually shifted from an expression of self-hate to a kind of emergency escape hatch, an emotional ejection seat if you will. Having that option allowed me to go into the darkest and most frightening reaches of my buried memories. While I would not recommend the possibility of suicide as an escape hatch for clients, I had to find a positive function for the suicidal urges that were part of my everyday thinking, and this strategy worked for me.

Creating and sustaining these shifts in the nature and purpose of different self-states were, again, not simple or smooth processes. These issues had to be identified, acknowledged, negotiated, argued, and finally agreed upon. Even after that work was done, self-states to whom

these new interpretations of their identities had been assigned had to learn how to live within these new meanings and interpretations. They had to learn to shed inappropriate shame while working through appropriate and inevitable regret and remorse. They had to learn to allow their own voices to enter the reconstructive self-discourse. Self-states who had been harmed, frightened, or otherwise victimized by other self-states had to learn to forgive and eventually trust previously destructive others.

Ironically, one of the most difficult aspects of reframing the roles and functions of these self states was resistance on the part of several of the hospital staff, because part of the process of re-assigning roles was first to honor them. I had to recognize each of them as who they were and accept them fully before I could ask them to be something else. I knew, somehow, that my shadow self-states had to be allowed to "come out" and be seen. The self-state in charge of this work, who was and is infinitely wise, wrote, "I need to be able to express my reality and have it believed, even if my reality is distorted. I can only challenge distortions if I don't have to defend them."

There is a self-state who we call "the shadow," and he is the most terrifying of all. The shadow was always present in flashbacks of being raped by the doctor, so I thought that he was some manifestation of the doctor that I carried with me. Eventually, I came to realize that the shadow was part of me, one of my internal voices. After having tried for a year to get rid of the shadow, in May 2000 I wrote,

> So if the shadow is part of me, maybe I can't banish it. Maybe I need to learn to accept it as part of the fabric of me, the part that feels so much guilt and self-hate, the part that wants to cut and burn me, the same part that sometimes wants me dead. If I can reframe

> my view of myself (admittedly no small task), maybe shadow will not go away, but at least become a benign presence.

This process of reframing and assigning new roles to self-states is an ongoing process; like all of these healing actions it is fluid and dynamic. But there have been more and more times when I felt that, overall, I was getting there. At one point in this reframing process, I wrote, "For so long I've been trying to forgive myself when actually I should be thanking myself."

The second type of re-storying that appeared throughout my journals, from very early in the recovery process, was the ability to imagine how my story might evolve in the future, that is, to imagine an ending of my own making. This ability became, for me, a source of meaning-making and a strong motivation to keep moving forward despite periods of overwhelming fatigue and frustration. I realized that, if all I could hope for was to survive this ordeal, it would not have been worth the pain. I knew that I needed to find a way to make something more out of my healing than simply to emerge from it with a pulse.

Eventually this desire evolved into the decision to become a counselor and the commitment to live "out loud" – that is, to make no secret of my abuse, to be proud of the work I have done to recover, and to use what I have learned in the service of others. In my review of my journals, I was surprised to see how early my healing process these ideas began to emerge. In October of 1999, in the midst of doing some deep exploration of feminist spirituality, I wrote,

> I know that all of this has to lead me into what I am to become, that healing is not just a matter of getting back to where I started. If there is not a truly new and different life for me as a result of this, it will not have been worth the pain. I will use what I am learning in some arena beyond myself. How or when is yet to be seen.

Over time, I realized that my desire to become a therapist of some sort would only be possible after I had done a lot of healing work. But the idea of using my experience to help others, and especially to provide a clear and credible voice for victims, served as a sort of beacon for me, a goal to work toward. When I reached the point of being able to hear others' stories in groups, and feel empathetic toward them but recognize that this other person's pain was not my pain, I knew that I was getting close to being ready to pursue my new profession, and I began looking into graduate schools.

Another way I was able to influence my story was by deciding to bring a lawsuit against Dr. X. This was not a decision to be made lightly, so it is probably good that I was a little crazy when I made it. But again, the processes of discovery and giving depositions, which had the potential to compound the trauma (and did so, temporarily), ultimately helped me to strengthen my resolve and reclaim a sense of personal power and voice. There were times when my resolve was severely tested, such as when the defense lawyers pawed through my journals and when I went through two days of deposition taken by three lawyers with Dr. X in the room. When I walked out of that deposition, though, I knew that I had won. Whether we went to court or not, whether the jury found in my favor or not, I had won. I had stepped away from the shame and the fear and spoken my truth to a room full of men, including my perpetrator. I had found and used my voice. The suit, by the way, was settled out of court for a satisfactory amount of money.

Themes related to the embodied/transcendent self.

Body blame.

As I have previously discussed, the female body has been both revered and vilified for its ability to cause sexual arousal in men, and I would assert that the confusion this creates in

women is magnified exponentially in adolescent girls. I remember the deep need that I felt to feel attractive – the popular girls were attractive. They wore short skirts and opened an extra top button on their school uniform blouses. But they weren't considered sluts. No one whispered about them behind their backs. The message delivered to me repeatedly by my perpetrator was that I was beautiful and sexy, and that I was much more mature than anyone my age. While the message that I was attractive was pleasing and reassuring to me, I also felt that my attractiveness "caused" his sexual advances. In my journal I wrote:

> I remember his eyes, his big bulging eyes, always staring me down, making me feel naked even when I wasn't, and I remember him shifting in his chair as [his erection became visible] and making no attempt to hide it, and the stare would get more intense and he would smile at me like some kind of animal about to attack… [He would] tell me I was beautiful and I would think, then why do I feel so ugly and disgusting?

I had absorbed contradictory and shame-inducing beliefs about my body for my entire life. I "knew" that being sexy was good, but being sexual was bad. I had absorbed the contradictory cultural messages that female sexuality held some mysterious power over men, but we were to "act like ladies" and the religious (in my case, Catholic) view that sexuality for any reason other than procreation within marriage was sinful. On a social, rather than religious, level, I learned that boys were stronger, smarter, faster, and could take what they wanted. Sexually, boys were studs; girls were sluts. In one journal entry I simply wrote, "Being a girl isn't safe."

Another aspect of body blame that I found in my journals was the belief that I had "allowed" him to rape me by failing to use my physical ability to get up and walk away. This failure to leave the abusive situation was partially due to dissociation, but it had more to do with

my fear of losing him. Despite what he was doing to me, I believed that he was the only adult in my life who understood me. Because of what he was doing to me, and his position in the world, I did not think any other adult would believe me or, if they did, they would blame me. The intense need I felt for him compounded my sense of guilt. From the first time I saw him, I liked the (nonsexual) attention he gave me, the fact that he listened to me non-judgmentally, and that he seemed to be the only adult who really understood me. In my journal, I wrote, "He didn't treat me like a freak."

This belief, that he truly understood me and cared about me, was completely incongruent with the sexual abuse. I couldn't reconcile these two opposing realities, so I escaped them as well as I could. In June 2000, I wrote about a memory of being in his office, really crying about something that was going on at the time (I don't remember what) and that he proceeded to undress me as I was crying:

> I was really crying hard now and I was very confused. But the whole time he kept telling me he loved me. I didn't try to stop him. He started taking my clothes off…and then he stood there looking at me like he had just unwrapped a present…I was thinking, this can't be happening…It didn't hurt. I didn't feel anything.
>
> I couldn't risk losing him. I felt like he was the only person in the world who understood me and loved me. I was willing to give him my body to keep that. I didn't know it would cause so many problems. I'm sorry. I'm so, so sorry.

I often had a sense of leaving my body during the rapes, and I saw this, for a long time, as an act of willingly giving my body over to him, to use as he pleased. I wrote that I felt "like an object being fucked," not like a person at all. The very worst of this failure to use my body for my own protection occurred when I was 17. I was hospitalized at the time, but he had instructed

a staff member to bring me to his office, which was in the next block, for a session. He raped me there, and I left my body and could not get it back. I couldn't move, speak, eat or drink, or do anything except breathe. At that point he diagnosed me as catatonic. That condition of extreme dissociation (which is how I now interpret it) lasted two weeks and very nearly killed me. But the important thing is that not only did I live, but that was the last time he raped me. In my deepest despair, my most profound loss of self, paradoxically came my source of survival. It has taken years for me to truly see the power that came from this psychic death, but eventually I did. In one of my more recent journal entries I wrote, "The Phoenix is impressive, but it owes its very existence to the ashes."

Another aspect of body blame that is a common source of confusion and shame for victims of CSA is the natural tendency of the body to become sexually aroused even when the sexual activity is not invited or desired. In my writings, I expressed the belief that this physical response to sexual touch was proof that I must have wanted the sexual activity, and therefore I was at least partially to blame. I expressed hatred for my body, believing that it was dirty and had betrayed me. It took a tremendous amount of internal dialogue work, processing with my therapist, and confronting these deeply entrenched beliefs to even begin to chip away at this shame.

Not only did I remember feeling some aspects of the sexual abuse as physically pleasant, but I experienced body memories that occasionally contained elements of arousal as well. Body memories are physical sensations that feel like the original abuse, but without the full sense of being back in the traumatic situation as would occur in a flashback. In my experience, body memories were usually painful and very distressing, but at times they contained elements of sexual pleasure as well. Those were the ones that caused me the most confusion and shame. The

self-state that most fully remembers the abuse at the hands of the psychiatrist, and had the most intense and painful body memories wrote,

> I keep trying to figure out if it felt like rape. I mean, some of it felt good and some of it felt bad but I don't think it felt violent. But the body memories sometimes feel violent. They feel like rape.

When I read this statement, I felt infuriated to know that I had tried to classify what he did as rape or not by whether it "felt like rape." I was 15 years old and emotionally vulnerable, and he was an adult and my doctor. Of course it was rape.

Ownership and control of the body.

There are two elements within the theme of body ownership and control that emerged from the data. The first is fairly straightforward, in that the body is held captive during a rape, and when a child or adolescent is being raped on a regular basis, it is easy to come to believe that the body is not hers but her perpetrator's. This belief runs counter to the self-blaming belief, but the rules of logic don't always apply in experiences such as this. The same self-state mentioned in the preceding paragraph expressed the feeling that Dr. X owned her body, not just in the past when the abuse was occurring, but in the present when body memories have dominated her experience. She expressed the feeling of not really being in her body, but at the same time not being able to get him out of it.

I have experienced that sense of his lingering presence as well, as if he had infiltrated and contaminated me in some irreversible way. Not long after I began to remember what he did, I would check the obituaries every day, hoping to find his name, believing that maybe if he was dead, the remnants of him that had seeped into my being might be released. When he did finally

die, I did not find the release I had hoped for. Getting rid of him was, and would continue to be, my work and my responsibility.

The second element of body ownership, however, is probably more difficult for someone who has not experienced it to understand. This is the feeling among younger self-states of not having a body of their own, and having to "borrow" the adult self's body when they want to be in control of the self-system. In one journal entry, a teenage self-state wrote, "When I look in the mirror, I don't really know who is looking back at me. I just know that it's not me." Another expressed the experience as having no body of her own, just borrowing "my" body and "putting it on and taking it off like socks."

Themes related to the autonomous/relational self.

Power.

The power differential between myself as a teenager, already very troubled by past trauma and very emotionally needy, and the doctor charged with helping me is quite large and, in my opinion, self-evident. Even so, I have had a tremendous amount of trouble relinquishing self-blame. My journal is filled with agonized litanies of all the things I thought I should have done: Why did I let him do this? Why didn't I just get up and leave? Why didn't I tell someone what was happening? On an intellectual level, I can understand the power dynamics that prevented me from doing anything to stop the abuse. But on a deeper level, where that self-state still struggles to occupy a strong "I" position, these questions continue to haunt me, and continue to be a focus of therapy work.

I stated earlier that I "decided" to go crazy as a way of escaping the rapes. I would like to believe that I had enough power in that situation to make such a choice, but I honestly don't know if I did. By the time I was first diagnosed and hospitalized, my ability to function in the

world had deteriorated dramatically; I was highly dissociative, profoundly angry, and dangerously self-destructive. I have also described my prolonged out-of-body state that was, at the time, diagnosed as catatonia. None of these states or events was consciously chosen, and while they did have the effect of ultimately ending his sexual abuse of me, they were also the direct result of that abuse. I cannot consider any of these events or states to be an exercise of power on my part. To the contrary, the diagnosis of schizophrenia and the resultant hospitalization, along with the attendant major tranquilizers, ECT, and procedures such as restraint, served to take away whatever remaining personal power I might have had.

Returning to a psychiatric hospital 25 years later, even though it was a different hospital and a unit that dealt exclusively with trauma-based disorders, repeatedly brought back those feelings of powerlessness at the hands of the staff. Most of the incidents that triggered those feelings would seem, at the surface, to be small, even trivial. But it was the power difference, the fact that the staff held power over so many aspects of my activities, and the fact that power had been used in the past to do such tremendous harm, that magnified these incidents in my mind.

One example of a seemingly small but subjectively huge misuse of power is something that occurred during my first admission to the trauma-specialized hospital, and I recorded it in my journal but will paraphrase it here. The tiny screw connecting the temple to the frame of my eyeglasses had fallen out. This screw also held the lens inside the frame, so one of my lenses kept popping out. I called my mother and asked her to buy a repair kit and bring it to the hospital. The usual procedure for something like this was that the package would be left at the front desk, and the receptionist would call the unit staff to come retrieve it and give it to the patient. I asked several members of the unit staff if my repair kit had been delivered, and for two

days they either said no or that they would find out. Meanwhile, my lens kept popping out and falling to the floor as I went about going to groups and activities. When someone finally bothered to look, it turned out that the kit had arrived the day I called my mother and asked for it. This miniscule event, or what would have been miniscule in the outside world, served to underscore my status as "patient" and was a reminder of all of the power struggles I had had in the past, and was a premonition of those I would have over the next several years.

I have a self-state who refuses to surrender her dignity to anyone. Her ability to articulate righteous indignation in a way that did not diminish her credibility – by that I mean, her ability to get angry without appearing insane – was vital to my ability to reclaim my power when events such as the one described above happened. This ability to speak up for herself, as we gradually shifted from a monologic to a dialogic self-system, has become increasingly available to my overall self as a means of reclaiming my power.

Diagnosis as identity.

The notion that a person with a mental health diagnosis becomes that diagnosis is one that many mental health professionals would vigorously deny. We are urged to avoid such thinking, for example by using language that separates the person from the disorder. For example, the *Publication Manual of the American Psychological Association,* 6th ed. (APA, 2010) states that we should use the term "a person with schizophrenia" rather than "a schizophrenic" (p. 72). But we still, in casual as well as professional discourse, sometimes refer to clients as "bipolar" or "autistic" or "borderline." While changing the language is commendable, it falls far short of removing the diagnosis from our conceptualization of the person. This phenomenon of seeing the individual as a personification of some distinct psychopathology is still very present, particularly in inpatient settings (Johnstone, 2001).

Resisting the connection of my diagnoses to my identity was especially important to me because I had already experienced it as a teenager when Dr. X diagnosed me as having schizophrenia. That label had enormous power. It took away my credibility as a person – something that would have served the doctor well if I were to tell anyone what he had done to me. That label took away my dignity, as people began to see me as an insane person, to be pitied, feared, or made fun of. It took away my range of emotional expression, as I discovered that everything I said, did, and felt was perceived through the lens of my diagnosis. For example, what might be normal, appropriate anger in someone else was seen as "acting out" in me. If, in response, I narrowed my expression, I could have been seen as displaying the "flat affect" that was considered to be characteristic of schizophrenia. I remember my former life in that world as like being in a game, for which I did not quite know the rules; I never knew when I might screw up, or what the consequences might be. My ability to process information and respond to it was slowed almost to a stop by the psychotropic drugs. I felt, as I have expressed elsewhere in this paper, like an object. When contemplating the idea of what I might want to do or be when I was healthy, I wrote, "I don't see the point in having any ambitions – objects don't change or grow. They just sit there." The self-state that holds the memories of my years in hospitals, including frequent flashbacks of being raped by a shadowy, indistinct but very strong man, wrote this poem:

> There is this place called Normal
> I can't find it
> I search, and always
> I miss the road signs
> and end up in Crazy
> such an awful place to be
>
> crazy girl, you've got to talk
> crazy girl, you've got to quiet down
> crazy girl, you'd better move

crazy girl, you'd better stop.

Don't act out, crazy girl,
or on goes the leather
click go the locks
slam goes the door
and your tears
run into your ears
crazy girl

When my abuse memories resurfaced, I was given a new set of diagnostic labels. The hardest, by far, to accept was the diagnosis of DID. PTSD and depression, in my estimation, were not crazy, just "troubled." But DID was all-out crazy and the idea that I was returning to the life of a crazy person was repugnant and terrifying to me. At the time I was diagnosed, I knew very little about DID beyond its portrayal in movies such as *Sybil* and *The Three Faces of Eve*. I was afraid of being taken over by alien identities that existed in my own mind. I was afraid of the realization that my physical self could (and did) engage in actions that were outside of my awareness. I was afraid of what these selves might know, and of coming to know these things myself. One of the poems I wrote attempted to express these fears:

Living in shadows
where light and sound
are muffled and muted
though voices abound
in the distance
and sometimes they cry
but I cover my ears
and I cover my eyes

Now the light, it stings
my eyes and it brings
into focus the pictures
from so long ago
and the things that I knew of
but never did know
in a way that is real,
of blood and of flesh

and those who once stood
alone start to mesh
into someone brand new –
Is it me?
Is it you?

So walls come crumbling
boundaries melt
and all that I ever knew
or thought or felt
spreads like a disease
through all of me
the shadow is lifted
and so I must see.

While I was afraid of going through the feelings and experiences of DID itself, I was equally afraid of how returning to the role of "mental patient" would bring me back to the helplessness, despair, and indignity that I had known when I was thought to have schizophrenia. I knew that world; I had lived there before and had fought hard to escape it. Returning to it, or more specifically my fear of returning to it, was immensely demoralizing. Becoming a crazy person again was like falling into a hole – a sickeningly familiar hole. McFarlane and Girolamo (1996, p. 139) acknowledge that "the experience of a psychological disorder can itself create the same sense of powerlessness and threat of disintegration that confront the victims of traumatic stress." In other words, the psychological distress created by remembering trauma is, in itself, traumatic. This kind of multilayered distress, composed of the recovery of traumatic memories as well as the experience of becoming psychologically disordered, along with the memories of prior mental illness, is almost impossible to describe.

Redefining relationships and roles.

Because healing from CSA required that I deconstruct, then reconstruct, my self, many of my relationships with others were, inevitably I believe, changed. Some of these changed for the

better, but many were eroded and some were lost altogether. Likewise, my professional self-image and roles changed drastically as I went through this transformative process.

At the time that I began to remember my abuse, I was fairly successful and well-regarded as a Clinical Nurse Specialist in critical care. I had published in professional journals and written a textbook chapter, and I had coordinated as well as presented at numerous conferences at the local, regional, and national levels. I was in the act of pursuing a contract to write a critical care nursing book. About six months after I began to retrieve memories, I attended a regional conference of the critical-care nurses association. This had been my territory for years, and the previous two or three years I had coordinated this 3-day conference. When I returned home, I wrote:

> I just got back from *Currents* .The best way I can describe it is like visiting a foreign country. That used to be my world. I was up in front, making it happen, and now I feel like I don't even belong here. I feel so incomplete, and I don't know who I even am any more.
>
> People were nice. They said they missed me and were glad to see me and I knew they meant it. But I know how far I've travelled from the life I used to have and I don't know anything about the life ahead. I feel lost.

In retrospect, I can easily see that I had suppressed the reality of my trauma, and even my memory of it, in part by becoming so deeply involved in work. I always felt compelled to do more, to do it better, but I never felt good enough. Within my healing process, I have found the freedom to choose who and what I want to be, and let go of the need to be perfect.

Certainly the most painful relationship changes were those with my husband and children. In the interest of protecting their privacy, I have chosen not to go into any great detail

regarding them, but I will say that they suffered right along with me, and in many cases because of me. The disruption was especially painful for my children, as they essentially lost their mother for about two years. In a very real sense we have had to heal as a family; while we all have wounds that have been slow to heal, but we also all have sensitivity and insight, wisdom and compassion that have been, at the very least, amplified by our experiences.

The Overarching Theme of Voice

> If I could scream
> enough to satisfy
> buildings would shake and crumble
> the earth would shudder and split
> rivers change course
> if I could scream.
>
> If I could scream
> enough to express
> the very sky would tremble
> clouds would crack and weep
> tidal waves would roar and crash ashore
> if I could scream,
> if I could scream.

This poem, which I wrote but did not mark with a date, was my best attempt at expressing the immensity of rage, terror, grief, and sorrow that built up in me as my memories began to return. I would like to say that I have done all of the screaming I needed to do, that I have somehow reached the bottom of this pit and come back out, once and for all. On some days, more now than ever, I might even believe that myself. But the truth is that, there will never be enough tears, never enough screams or moans or sobs. The experience of having one's body invaded, one's mind ambushed, and one's self shredded is not something from which I ever expect to fully heal. So what do I do with this? How do I finally put it all in the past tense? How do I ever find a satisfactory answer for the agonized questions I have screamed to the night sky?

I believe that the only answer, and the one unifying theme that I can draw from my experiences and my journals is that now I have a voice. My story has awful things in it, shameful things, but I can tell my story and confidently declare that the shame is not mine. My ability to make my own choices, to live the life that I planned and hoped for, was for so long taken from me, but I have firmly taken it back and I can declare it as my own. My ability to love, to truly love without losing myself, without falling at the feet of some tyrant, has somehow been restored. My body has been invaded, torn and vandalized, cut and burned, but it is here, and it can speak the truth. My spirit has been tested to its limits, but I can dream and I can see myself as having something of value to share with the people I encounter. As long as I can speak, and speak the truth, my life has value and meaning.

Chapter Five

Conclusions

Summary of Findings

This study was intended to explore three broad questions: (1) How is the self expressed in therapeutic writing, such as journals, internal dialogue exercises, and poetry? (2) How does CSA inform the adult survivor's sense of self? (3) How does the survivor's sense of self shift or change in the process of recovery? While the answers to these questions have been presented as they were found, woven through the tapestry of self-experience, story, and dialogue, I think it would be useful to reiterate the findings related to each of these specific questions.

In response to the question of how the self is expressed in therapeutic writings, I found that my self was expressed as the protagonist of narratives, as the actors in intricate internal dialogues, and as an entity with a fragile, but steadily increasing, ability to name and articulate powerful emotions, through poems and narratives. My narratives, as they were told and re-told numerous times over several years, reflected a self who was able to develop a more complete and coherent self-story over time, and able to shift blame and shame from myself to my perpetrators.

Regarding the question of how CSA informs the adult survivor's sense of self, the self that began this healing journey had been fractured, and so infused with shame, secrecy, and fear that I could no longer function. This pile of shards that I called my self were the ruins of what had been, itself, a false and poorly constructed façade. This fracturing, the inability to recall my own life story, the intense shame and sense of self-blame, and the terror of knowing that more memories would be coming, consumed me for almost two years, and was, for that period at least, the sum total of my existence.

Regarding the question of how the self shifts and changes over time, as I continued to face and articulate my memories, learned to tolerate and, at times, to modulate my emotions, and form connections with others, I began to believe in the possibility of a future self, and that I could decide who this future self might be. Having the ability to apply meaning to experiences that previously could only mean, to me, the willful wrath of a vengeful and merciless God or the randomness of a godless universe, gave me a perspective that included the hope of making something good.

In the earlier writings, my journal entries were more focused on the perpetrators and what they did to me; for several hundreds of pages I ruminated and ranted over the harm that had been inflicted on me and the things that had been stolen from me. I suppose that I need to do that, just to say and write over and over what had been held secret, even from my self, for so long.

Later in the journals, the focus gradually shifted to my self and my challenges, frustrations, periods of self-doubt, and victories. In dialogical terms (Hermans, 1996), this could be interpreted to represent a shift from a "me" position, which is one that is defined by others, to an "I" position, which is defined by my self. This is the only self-position in which growth can happen. This is the only position that has a voice.

Likewise, the internal dialogue work demonstrated a shift from an "I –me" to an "I – I" stance, as various self-states, including those that had held intensely negative emotions and self-destructive urges, learned to allow themselves to be seen, to give voice to their memories, feelings, and beliefs, and to accept those same elements of discourse from other self-states. While this movement was excruciatingly slow, painful, contentious, and at times dangerous, it was central to my healing.

Another change in my self, reflected primarily in narrative and poetic elements of the journal, was in the form and nature of my anger. Early in the processes of remembering and processing the memories, most of my anger was directed back at myself in the form of self-harming and other dangerous behaviors. As time went on, I learned to transform my angry energy into a powerful force for healing. I used it to sustain me through the process of bringing a lawsuit against my perpetrator. I learned to use it to effectively voice my perceptions and make my needs clearly known to professional and paraprofessional hospital staff. In short, my anger, which could have eaten me alive, gave me back my voice.

Another shift in my sense of self over time was movement away from a contrived, insecure façade of self-esteem, toward a more secure and authentic sense of dignity and value. What had been really a thin veneer of accomplishment that barely covered the always-afraid, often confused self inside, moved through a period of exterior as well as interior degradation, in order to claim a true voice, an authentic "I" position. Whatever I accomplish now belongs to me, even if I am still unaccustomed to feeling secure in my successes.

Implications for Future Research

As I reported in this paper, I selected only samples of my own writings as data for my research. There is much more that I, or I with another researcher, could explore and analyze. I would also like to analyze the journals of other CSA survivors – not as an attempt at replication, but to discover and learn about other people's paths to healing.

There are more specific and delimited research questions embedded in this work as well, and not all of them are directed at the healing processes of survivors per se. In my experience, and in the professional literature (e.g., Herman, 1992; Krawitz, 2004), there is recognition that the complex and frustrating clinical presentation of CSA survivors triggers negative, even hostile

reactions on the part of mental health professionals. I would like to see research conducted on the beliefs and attitudes of mental health professionals toward adult survivors of CSA, and how these may impact their provision of care. Perhaps a survey or structured interview of a group of providers, conducted at the same time as a content analysis of client record written by the same individuals would yield significant results. Even more telling, I think, would be to enter the inpatient care environment as a participant-observer, although the ethical and practical hurdles would be substantial.

There are numerous other research questions suggested by this study. The ones that come most readily to mind are:

1. What specific problems are likely to occur in survivors of adolescent, as compared to earlier childhood, abuse?

2. How can therapeutic writing best be used in the process of healing from CSA?

3. What are the characteristics of an emotionally safe and effective counselor-client relationship from the client's perspective? From the counselor's?

4. What factor(s) might indicate a readiness to bring "shadow selves" into the therapeutic work?

5. What is the nature of shame in survivors of CSA, viewed from a narrative/dialogic perspective?

6. What elements of traditional mental health care may be experienced by the client as re-traumatizing? How can these effects safely and realistically be minimized?

Implications for Counselor Education, Supervision, and Practice

Considering the prevalence of childhood trauma, including CSA, in virtually all populations of mental health and substance abuse clients, I would advocate for some course

content on the mechanisms of traumatic stress responses in all programs that prepare mental health care providers. I would like to see counselor educators seek and use first-person accounts of emotional distress whenever possible, and to generate class discussions that place the student in the "shoes" of the other in order that they may develop a more accurate and genuine empathy for the clients, not only in their dysfunction but in their tenacity and the strength of their survival.

If I could choose one effect that my study might have on the practice and teaching of counseling, it would be that counselors strive to connect with the dialectic of humility and knowing. This is not a dimension that I expected to explore in my research, but it is one that became more and more apparent to me as I went through this process. The depiction of my self and my healing process, as presented in this study, will provide insight to counselors if I have done my job well. But insight without action is useless. This realization led me to the big question that springs up from many a dissertation: So what? What do I do with this once I have read it? Where does its usefulness lie?

These questions led me back to my research processes of identifying relevant dimensions for study, and the dimensions of humility and knowing as dialectical positions in the counseling process and in its teaching became a compelling focus for me. It is, I think, within this dimension that counselor and client (as well as educator/supervisor and student/supervisee) can meet and develop an "I-Thou" relationship. In such a relationship, the counselor can see and honor the inner wisdom and inherent dignity in any client, regardless of how dysfunctional the client's behavior might be. It is in this kind of relationship that the counselor can find and acknowledge the client's strengths and assets, and bring these into the honest, meaningful dialogue that comes from such a relationship. This is the position of meeting, from which the counselor can acknowledge, without the fear of crossing an arbitrary line of professional

distance, those essential elements of humanity that the client and the counselor share, and where humility lives (Birrell, 2006; Freedberg, 2007; Spinelli, 2001). The likely result, then, would be that in such a space, the client could begin the long but potentially transformative process of rediscovering her or his own humanity, and recognize and honor the innate knowledge and wisdom that allowed her or him to survive in the first place, and use those assets to begin healing.

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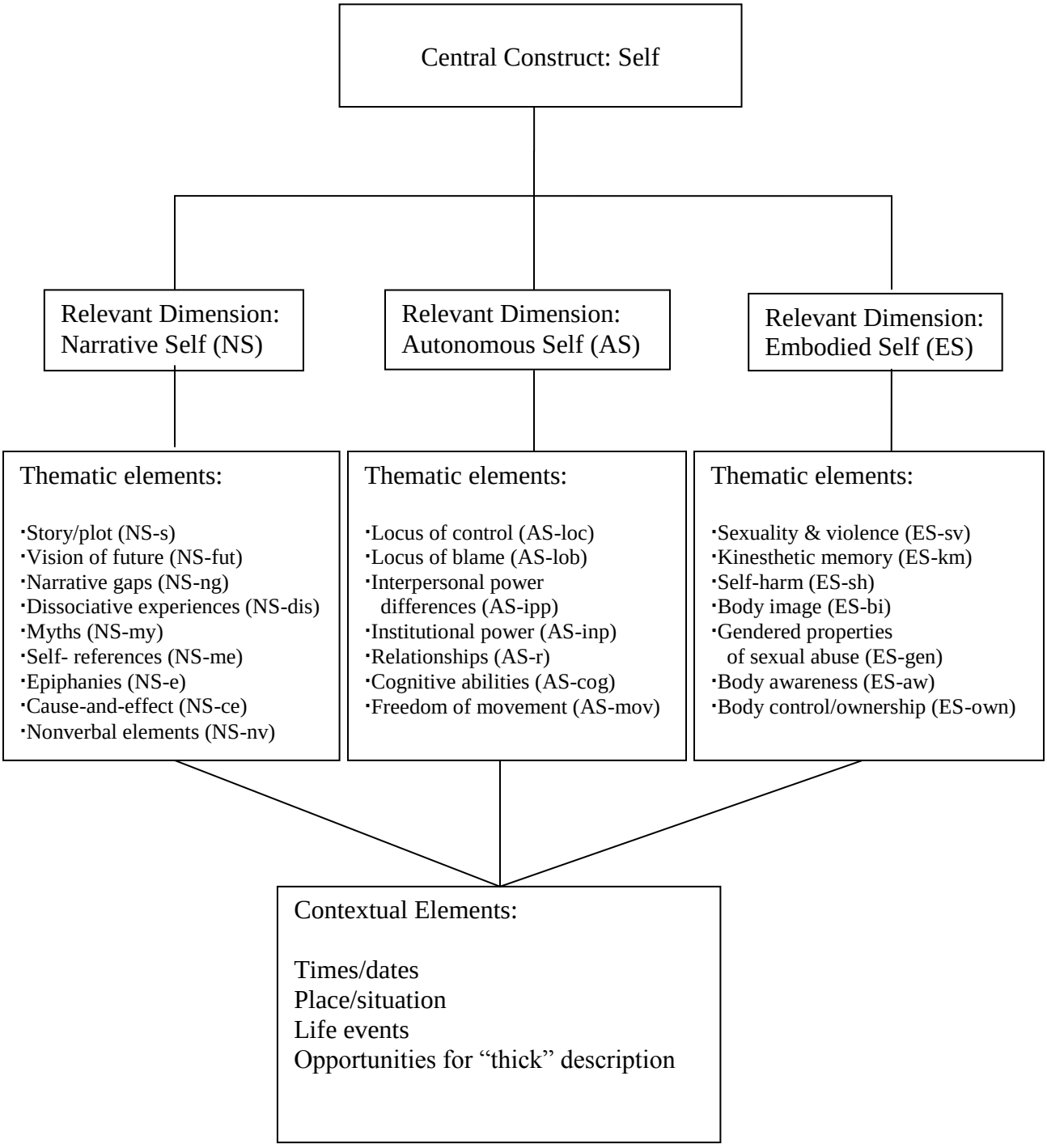
Appendix A: Thematic Structure

Construction of Self in an Adult Survivor of Childhood Sexual Abuse: Thematic Structure



Appendix B: Coding Sheet

Date/Page	Narrative Self	Autonomous Self	Embodied Self	Contextual elements/events/comments

Reflections/impressions/notes:

Vita

The author is a native of New Orleans, La. She received a Bachelor of Science in Nursing from Louisianan State University Medical Center in 1984 and a Master of Nursing from the same institution in 1989. She specialized in Critical Care Nursing, and obtained Advanced Practice recognition from the Louisiana State Board of Nursing. In 2004, she decided to change her profession, and earned a Master of Arts in Community Counseling from Our Lady of Holy Cross College in 2007. From There she began her Doctoral work at the University of New Orleans.