TRAUMA, SHAME, AND SECRET MAKING

BEING A FAMILY WITHOUT A NARRATIVE

Francis Joseph Harrington

ROUTLEDGE

Trauma, Shame, and Secret Making

Trauma, Shame, and Secret Making provides a descriptive, qualitative inquiry into a family's unsuccessful attempts across generations to repress the memories of an early life trauma. Broad in its scope, *Trauma, Shame, and Secret Making* explores more than one hundred years in the life of a single family, offering students and professionals invaluable insight into the consequences of prolonged narrative suppression in the social life of people. The book models a converging interdisciplinary approach to inquiry across specializations spanning traumatology, family therapy, psychology, psychiatry and social work. The model is consistent with an evolving paradigm of medical, public health and social service practice based on biopsychosocial evaluation of all patients.

Francis Joseph Harrington, MDiv, MEd, has spent more than three decades working closely with individuals and families adapting to stress, first as a priest in the Archdiocese of Toronto, and later as a staff psychologist in the department of psychiatry at the University of Massachusetts Medical Center and as a school psychologist in Maryland.


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Trauma, Shame, and Secret Making

Being a Family Without a Narrative

Francis Joseph Harrington

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With loving gratitude to my wife, Marian, my champion of children, women and men who face the disadvantages life is all too happy to impart;

To my daughter, Kat, and son, Dimitri; each has become a person who cares for others, treating them with empathy and fairness;

And in loving memory of Rose, Aileen and Mary Anne, who shared with me the trauma, shame and secrecy that was our family narrative.


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Preface

One Hundred and Thirty Years of Secrecy

> Ten years ago, I was at Harvard Medical School performing research and teaching young professionals about the human brain. But on December 10, 1996, I was given a lesson of my own. That morning, I experienced a rare form of stroke in the left hemisphere of my brain. A major hemorrhage, due to an undiagnosed congenital malformation of the blood vessels in my head, erupted unexpectedly.
>
> Jill Bolte Taylor (2006, p. XIII)

In her book, *My Stroke of Insight: A Brain Scientist's Personal Journey*, Jill Bolte Taylor provided an excellent account of her stroke and the recovery that followed. The PhD neuroanatomist described the experience of watching her own mind collapse; within hours of the stroke, she could not "walk, talk, read, write, or recall any of (her) life" (p. XIII). Readers familiar with her book will understand the personal journey I am taking within the realm of my professional expertise. With a background in child development and mental health, I questioned whether or not a long ago trauma might have lingered in the psyches of myself and my sister. Dr. Bolte Taylor's trauma was acute; the initial crisis played out over the course of one morning. My grandmother's was prolonged and kept secret across the two following generations. My sister and I each stood speechless and paralyzed at points in our lives when we most needed to speak and act on our own behalf. Did trauma play some nefarious role in our personal dramas?

To cover the time span from 1876–2007, I divided the book into six time periods, placing the experiences of each generation in their historical context. Each period is divided into three chapters. One explores theory related to trauma while a second considers its impact on family; a third looks at the personal, borrowing a concept from anthropology in which I assumed the role of "participant observer." In his 1922 classic work of ethnography, *Argonauts of the Western Pacific*, the anthropologist, Bronislaw Malinowski (1922) reminded the participant observer that "there is a series of phenomena of great importance which cannot possibly by recorded by questioning or computing documents, but have to be observed in their full actuality. Let us call them the inponderabilia of actual life" (p. 18).

Amid the scattered experiences of youth I remember the morning after the night my mother treated my ear ache by putting me to sleep with my infected ear resting on a hot water bottle. When I awoke that next morning the pain was gone, but so was my hearing in the left ear. I looked in astonishment at the blood and puss that had soaked into the pillow case. On proper medication the eardrum did slowly heal, but I still remember the sudden feeling of being cut off and alone each night when I rolled in bed onto my good ear. Suddenly the sounds of the TV downstairs in the living room or parents chatting over a cup of tea in the kitchen were gone. No matter how tired I was I had to lift my head so my hearing ear could confirm that my social world still existed. The episode was not without impact later in my life. When college years came I jumped at a volunteer experience to work with deaf and hearing impaired adults and children. The experience had made me aware of my personal need for human communication, and inspired me to help others overcome obstacles that threatened to isolate them; it steered me into careers as a priest, teacher, staff psychologist in a child mental health unit and a school psychologist.

There was, however, an older silence at play, one that somehow related to the childhood of my maternal grandmother, Rose. This book is the result of the second silence and the profound influence it had over my life and the lives of three generations of my family. In the decade following the loss of my sister I set out to break the code of silence. The first breakthrough came while I browsed in a nearby bookstore. I gravitated to the behavioral and social sciences shelves, stopping at psychology. My eyes settled on Judith Herman's classic, *Trauma and Recovery: The Aftermath of Violence* (1997). I stood and read the Introduction. In it Dr. Herman proposed a possible answer to my core question. She wrote the following:

> The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma. People who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner which undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy. When the truth is finally recognized, survivors can begin their recovery. But far too often secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom.
>
> (Herman, p. 1)

Could the absence of family narrative on my mother's side suggest a concealed history of trauma? I bought Dr. Herman's book and plunged into the first chapter that detailed the forgotten history of psychological trauma beginning with a section she titled "The Heroic Age of Hysteria," a short period in the late 1800s, the years of my grandmother's youth.

In each of the periods I was faced with making selections among the array of voices ready to tell me about psychological trauma and its persistent consequences. Picking some meant leaving out others. For example, in the first period

I chose to explore the work of Pierre Janet instead of that of Sigmund Freud; yet in the second period I focused on Abram Kardiner, a psychoanalyst who trained under Freud. I did not make my choices based on academic discipline or school of thought. The field of trauma, or "traumatology," has grown into a vast interdisciplinary endeavor. I wanted to hear from medical doctors, psychiatrists, psychologists, sociologists, anthropologists, social workers, psychotherapists, neuroscientists, researchers, philosophers and most of all from people who had experienced the insidious psychological effects of prolonged trauma.

In this undertaking, I received incredible support from many people to whom I am indebted. Trusted friends, colleagues and strangers read and discussed early drafts, providing much needed encouragement and criticism; among these, I am especially grateful to Martin Helldorfer, Terri Moss, Colette Horn, John Belcher, Sue Mosteller, James Hannah and Brian Henry. Archivists and librarians provided essential assistance; three stand out for particular recognition: Ms. Linda Wicks, the archivist of the Sisters of St. Joseph of Toronto; Mr. Domenic Rizzuto, the human resources manager at Porcupine Gold Mines; and Mr. Jerry Hodge, a cousin I most happily rediscovered in the course of my task. Jerry is the avid archivist of my maternal grandfather's extended clan. Above all, I thank my family for their unwavering patience and good humor over the decade I committed to this work.

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Part I

1876–1909

When Men of Science Listened to Women


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1 Pierre Janet's Inquiry Into Hysteria

> I maintain to this day that, if hysteria is a mental malady, it is not a mental malady like any other, impairing the social sentiments or destroying the constitution of ideas. . . . Hysteria is a form of mental depression characterized by the retraction of the field of consciousness and a tendency to the dissociation and emancipation of the system of ideas and functions that constitute personality.
>
> Pierre Janet (1920, p. 332)

Apart from primary sources, this chapter on Pierre Janet (1859–1947) and his theory of dissociation draws heavily on two major books: Judith Herman's *Trauma and Recovery* (1997), and *The Discovery of the Unconscious* by Henri Ellenberger (1970). Three articles, all published in 1989, also proved invaluable. The first article, authored by Onno Van der Hart and Rutger Horst, "The Dissociation Theory of Pierre Janet," appeared in the *Journal of Traumatic Stress*. In the second, "A Reader's Guide to Pierre Janet: A Neglected Intellectual Heritage," authors Van der Hart and Barbara Friedman reviewed a number of Janet's major publications; the article appeared in the journal *Dissociation*. A third outstanding article appeared in the *American Journal of Psychiatry*; authored by Bessel Van der Kolk and Onno Van der Hart; it was entitled "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma." The year 1989 was a celebration of the rediscovery of Janet's contributions to the field of traumatology, and the centennial of the publication of his first book on psychology in 1889, *L'Automatisme psychologique*; in which he introduced his theory of dissociation.

In the year 1862, the author Victor Hugo published his classic novel, *Les Misérables*; that same year in Paris Jean-Martin Charcot, a renowned man of science, assumed directorship of a medical clinic at the Hospice de la Salpêtrière, and with it the care of a number of Hugo's miserable ones. Known at that time as the Hospice Vieillesse-Femmes, the wards contained more than 1400 beds for mentally deranged women, many suffering from hysteria, and some 2900 more beds for indigent or epileptic women (Poirier, 2003). Among the students and colleagues who came to the Salpêtrière to witness Charcot's skills in neurology and neuropathology were the Frenchman, Pierre Janet; the Austrian, Sigmund Freud; and the Americans, William James, Morton Prince and James Mark

Baldwin. Janet, Prince and Baldwin became close friends. Freud and Janet, on the other hand, became intense rivals, each with the goal of being the first to scientifically demonstrate the cause of hysteria (Herman, 1997, p. 10). In 1889, Charcot named Janet to head a Psychology Laboratory at the Salpêtrière where he pursued his study of the mystery disease.

In the late nineteenth century, hysteria was considered to be a broad class of mental disorders, embracing conditions that more recently have been included under the dissociative disorders: somatization disorder, conversion disorder, borderline personality disorder and posttraumatic stress disorder (Van der Hart & Horst, 1989, p. 1). In her book, *Hysteria: The History of a Disease* (1993), Ilza Veith stated:

> The term "hysteria" is obviously derived from the Greek word, *hystera*, which means "uterus." Inherent in this simple etymological fact is the meaning of the earliest views on the nature and cause of the disease. It was formerly believed to be solely a disorder of women, caused by alterations of the womb. . . . But these concepts go back to man's earliest speculations about health and disease. . . . They are documented in the first recorded medical literature of ancient Egypt.
>
> (Veith, p. 1)

Post-mortem autopsy made possible the study of the brain after death, but nineteenth century investigators lacked tools to understand the living brain. Earlier discoveries provided some options, the major one being artificial somnambulism, what we know as hypnotism. Ellenberger wrote:

> We can hardly realize today how incredible and fantastic Puységur's assertion must have seemed to his contemporaries (in the late 1700s) that somnambulism (sleep-walking) could be induced and stopped artificially almost at will and used in the investigation of the most hidden secrets of the human mind.
>
> (1970, p. 112)

In a subsection entitled "The Royal Road to the Unknown Mind: Hypnotism," Ellenberger added, "From 1784 to about 1880, artificial somnambulism was the chief method of gaining access to the unconscious mind. . . . (It) was given the name of hypnotism by Braid in 1843" (p. 112).

As I read the material on somnambulistic states I recalled a story that began as a simple workplace conversation. A colleague arrived at work one morning; I noticed and commented that she looked unusually tired. She agreed and filled me in on the previous night. The young woman's husband was a police officer assigned to patrol a stretch of nearby highway known as a major transit route for drug dealers moving large shipments of illegal substances. As he slept beside his wife he suddenly jumped up on the bed, reached down and flipped her over onto her stomach; he proceeded through the motions of handcuffing her hands behind her back. His task completed, he laid his head back on the pillow; the following

morning, he had no conscious recollection of the incident. He had conducted his late night arrest in a state of spontaneous somnambulism. It was not terribly difficult to imagine how the incident might have included elements of a flashback to a stressful encounter the officer experienced on the job. Nor was it difficult to understand that the man was not unconscious as he moved through the precise procedures of cuffing his wife. It was this border territory between conscious and unconscious that Janet and Freud set out independently to explain.

Janet, in one of his later books, stated that an individual who was subject to spontaneous somnambulism was also easily hypnotized. He noted that rapport could then be established with the person, making it relatively easy to transition him or her from the spontaneous somnambulism into typical hypnotic sleep. Though the sleepwalker could not remember the event in the waking state, she could recall it when hypnotized. (Ellenberger, 1970, p. 113; Janet, 1919, pp. 267–271) Janet demonstrated that a hypnotized person might remember forgotten incidents of childhood or describe forgotten experiences that occurred during bouts of intoxication. In a state of hypnotic sleep he or she could perceive stimuli that otherwise fell outside normal thresholds of perception; she might spontaneously remember things that had apparently escaped her notice. Hypnotists discovered that subjects might, spontaneously or on command (suggestion), "turn deaf, blind, hallucinated, paralyzed, spastic, cataleptic or anesthetic (insensitive to pain.) The anesthesia may be so perfect," Ellenberger noted that, "surgical operations have at times been performed without pain under hypnosis" (p. 115).

Hypnosis was a necessary but not sufficient tool for Janet and Freud in their competition to demonstrate the cause of hysteria; they would need to observe, listen to and talk with hysterics, leaving Herman to comment:

> For a brief decade men of science listened to women with a devotion and a respect unparalleled before or since. Daily meetings with hysterical patients, often lasting for hours, were not uncommon. The case studies of this period read almost like collaborations between doctor and patient.
>
> (pp. 11–12)

Janet maintained a collection of more than 5000 case histories recorded in his own handwriting that eventually occupied a full room in his apartment (Ellenberger, 1970, p. 349). To ensure the confidentiality of his patients, his will directed the executor to destroy this invaluable collection on his death; his wish was carried out. Ellenberger recovered a number of case summaries from Janet's various publications for inclusion in his book. These included the cases of Achilles, Irène, Justine, Léonie, Lucie, Madame D., Marcelle, Marie, Meb and Nadia. I found Marcelle's story particularly relevant; it provided one of the first examples of Janet's process of analysis and synthesis.

A 20-yearold woman, Marcelle, was admitted to the ward of Dr. Falret at the Salpêtrière in 1889; Janet's services were required. Her symptoms of mental illness had first appeared at age fourteen and continued to worsen. These included severe disturbances of memory, thought and movement. Marcelle exhibited

particular difficulty moving her legs though she was not clinically paralyzed; she cited her difficulty with movement as her primary concern. Janet began his observation of her behavior focused specifically on her difficulties with movement.

Following his process of analysis and synthesis, Janet reconstructed the development of her illness. At fourteen, Marcelle, the youngest of ten children, suffered a severe bout of typhoid fever; she remained in a delirious state for a month recognizing no one. "When she did recover, Marcelle demonstrated a noticeably diminished capacity to adjust to novel situations. Being unable to adjust normally she withdrew into her daydreams, creating a cycle of ever increasing maladjustment" (Ellenberger, 1970, p. 365). A second adverse event followed a year after her illness; her father, a paraplegic for two years, died. And yet a third, a failed love affair, became the event that precipitated the onset of suicidal thinking and amnesia for recent events, necessitating her admission to the Salpêtrière. By the time of her admission four of her nine siblings had already died (Janet, 1898, p. 3). Marcelle's layered emotional stressors impacted not only her, but also the remaining members of her family.

In addition to these personal and familial events, there was another possible source of significant stress in the social and historical context of Paris at that time. Considering her age and the date when she was admitted, Marcelle, was likely born in or about 1870 in the midst of the Franco-Prussian War (1870–1871), an event which ended with devastating outcomes for France, and the citizens of Paris in particular. The swiftly moving Prussian and German armies laid siege to the city with its fall coming in January, 1871. Men from the Paris National Guard, the majority of whom came from the city's working class, subsequently seized control in an uprising that came to be known as the Paris Commune. In May, during what would be remembered as the Bloody Week, the French regular army attacked and regained control of the city. During the fighting and the massacres that were carried out on men, women and children, an estimated 6,000–10,000 Parisians were killed (Rougerie, 2014, p. 118) with some 40,000 arrested. Somewhere in the smoke, chaos, terror and the aftermath, Marcelle's family attempted to cope. Collectively, such layers of stress can inflict a toll on the human capacity for adaptation.

In her sessions with Janet at the Salpêtrière, Marcelle sat immobile in her chair. Janet recorded her responses when he directed her to pick up a pen-holder or a glass from the desk. Willing to comply, she would begin her attempt only to withdraw her hand; she might continue her efforts for periods lasting anywhere from fifteen to thirty minutes before she achieved her goal. Yet Marcelle would swat an annoying insect, a habitual behavior, without hesitation. Commenting that an act is only voluntary when it poses some element of novelty, Janet's case notes read, "The essential symptom of this malady truly merits to be called a loss of will, or abulia" (my translation) (Janet, 1898, p. 12). While habitual movements came easily, the most obvious problem appeared when Marcelle attempted to act in response to a voluntary decision.

Janet's approaches to treatment with Marcelle were met with increasing resistance and hysterical crises. As these crises intensified, however, so did the flow of

fixed ideas (traumatic memories) otherwise squirreled away in Marcelle's mind; these emerged in succession from the most recent to the earliest. "By removing the superficial layer of the delusion," Janet wrote, "I favored the appearance of old and tenacious fixed ideas which dwelt still at the bottom of her mind. The latter disappeared in turn, thus bringing forth a great improvement" (Ellenberger, 1970, pp. 365–366). Janet noted that Marcelle showed no sign of relapse a year after her discharge from the Salpêtrière, and that she had married (Janet, 1898, p. 66).

In their review of Janet's first book of psychology, *L'Automatisme Psychologique* (1889), Van der Hart and Friedman described Janet's model of the mind and the two different ways it functions. The mind acts to preserve and reproduce the past in ways he described as reproductive, and also in ways aimed at synthesis and creation which he labelled integrative. These two types of action are interdependent and mutually regulate one another; working together, they produce normal thought. Integrative activity "effectuates new combinations which are necessary to maintain the organism in equilibrium with the changes of the surroundings." Integration organizes the present while "reproductive activities only manifest integrations that were created in the past." In his patients who suffered hysteria Janet observed that the integrative activity was significantly diminished, "causing the development of symptoms that appear as magnifications of the activity designed to preserve and reproduce the past." Most of these patients, Janet discovered, preserved and reproduced "unresolved, and therefore dissociated, traumatic memories" (Van der Hart & Friedman, 1989).

In her book, Herman described the importance of the findings that emerged in the early to mid-1890s as a result of the feud between Janet and the team of Freud and Breuer. Independently, they had reached a similar conclusion. "Hysteria was a condition caused by psychological trauma. Unbearable emotional reactions to traumatic events produced an altered state of consciousness, which in turn induced the hysterical symptoms" (p. 12). Discussing their approach to treatment Herman wrote: "Hysterical symptoms could be alleviated when the traumatic memories, as well as the intense feelings that accompanied them, were recovered and put into words. This treatment became the basis of modern psychotherapy" (p. 12).

Janet described the symptoms of hysteria in his book entitled *L'état Mental des Hystériques*. Published in 1893, part one of two addressed the symptoms that were essential to the diagnosis of hysteria. These stigmata, which patients were less likely to recognize or report, included anesthesias (insensitivities to sensation, pain), amnesias (memory problems), abulias (degeneration of the will leading to hesitancy, indecision and impotence to act), disorders of movement, and modifications of character (Van der Hart & Friedman, 1989). The second part published the following year dealt with contingent symptoms, "accidents," that were more easily recognized and more likely reported by sufferers. These accidental symptoms (Janet's term) included suggestion and subconscious acts, fixed ideas, convulsive attacks, somnambulisms and deliria (Veith, 1993, pp. 249–250).

Among the stigmata, Van der Hart and Freidman singled out abulia for added attention, recognizing that present-day psychiatry and psychology pay it little

note. This in the face of Janet's insistence that his patients had "a disturbance of action as well as a disorder of memory, and that hides the most serious trouble: that of will" (Van der Kolk & Van der Hart, 1989, p. 1532; Janet, 1911, p. 532). Informally I quizzed a group of eight fellow school psychologists if they had encountered the term in their training or practice; none had. I came upon it once; it was the subject of an article in a rehabilitation journal dealing with traumatic brain injury.

In the case of Marcelle, Janet's patient discussed previously, an understanding of psychological abulia was a necessary part of her analysis and his approach to her treatment. Abulia described a degeneration of a person's will which, as the authors noted previously, manifested itself in hesitancy, indecision and impotence to act. As a patient's mental state declined, abulia increased in dominance. The authors compared what contemporary clinicians have observed in treating chronic PTSD patients with this loss of vitality Janet observed in his patients as their abulia intensified. (Van der Hart & Friedman, 1989, citing Van der Kolk, Brown, & Van der Hart, 1989). The authors summarized the concept of abulia as a pattern involving three critical areas of an individual's behavior: a weakening of the person's will, decisiveness and ability to initiate activity; an increase in day-dreaming and apathy; and, simultaneously, the emergence of exaggerated emotional responses. Abulia will prove to be a major player in the entangled family relationships that will be explored in the chapters to follow.

Janet's Theory of Dissociation

Herman wrote:

> A century ago Janet pinpointed the essential pathology in hysteria as 'dissociation': people with hysteria had lost the capacity to integrate the memory of overwhelming life events. . . . Janet demonstrated that the traumatic memories were preserved in an abnormal state, set apart from ordinary consciousness. He believed that the severing of the normal connections of memory, knowledge, and emotion resulted from intense emotional reactions to traumatic events. He wrote of the "dissolving" effects of intense emotion, which incapacitated the "synthesizing" function of the mind.
>
> (Herman, p. 34; Janet, 1889, p. 457)

Janet formulated two core themes that reflected the basic characteristics of hysteria, the narrowing of the field of consciousness and dissociation. Within the first theme, he addressed the field of consciousness, psychological automatisms, consciousness and the subconscious. In their 1989 article Van der Hart and Horst followed the development of Janet's theory of dissociation over the course of his publications; they likened the field of consciousness to an individual's visual field. While the periphery of the visual field registers vague stimuli that may not be consciously perceptible, the center registers focused conscious perceptions.