

**Working with Survivors of Childhood Sexual Abuse from South Asian Communities:
Reflections and Practice Points to Consider**

Summary (40 words)

Ethnically dissimilar and similar therapeutic dyads can present different challenges to practice. Reflections (from a case study) are offered on cultural dynamics that can potentially influence developing therapeutic relationships, facilitating disclosure of childhood sexual abuse, and choice of psychotherapeutic interventions.

Introduction

There has been ongoing discussion regarding the lack of diversity in personnel within the profession of clinical psychology, and whether the profession needs to widen participation to meet the needs of individuals from different cultures and contexts (___REF___). One of us (Irram) is a trainee clinical psychologist from an ethnic minority, and both of our clinical experiences include working therapeutically with individuals from both culturally similar and dissimilar backgrounds. However, one of the most challenging experiences has been in a situation where shared cultural similarities between the client and Irram posed an initial obstacle to meaningful engagement. Reflections on this work and experiences more generally have identified many learning points for our future practice. Some of these are shared here as practice points worth considering when working with individuals from South Asian communities who have histories of childhood sexual abuse (CSA).

Therapeutic Relationships and Ruptures

Literature on Asian populations indicates this group is under-represented in engaging with psychological therapies, and services are often only accessed at crisis point due to shame and stigma attached to narratives of mental health within communities (Weatherhead &

Daiches, 2010). This can also be due to previously encountering culturally insensitive practice, possibly attributable to professionals failing to appreciate the complex dynamics arising from cultural values (Reavey, Ahmed, & Majumdar, 2006). Some research has indicated that Asian individuals prefer therapists from within their cultural groups as this facilitates development of therapeutic relationships (Weatherhead & Daiches, 2010).

However, other studies suggest that while ethnic matching of therapists and clients can promote trust and therefore improve outcomes, ethnically similar therapeutic dyads may only be beneficial when this is explicitly requested by the client (Farsimadan, Draghi-Lorenz, & Ellis, 2007). Some ethnic minority clients perceive ethnic majority therapists as possessing greater expertise and being more trustworthy (Farsimadan et al., 2007). There can be concerns about whether ethnically similar professionals have community connections potentially jeopardising confidentiality (Henretty & Levitt, 2010), therefore some Asian individuals prefer to engage with non-Asian professionals (Gilligan & Akhtar, 2005). Engaging in a low level of self-disclosure can resolve this, and may be an ethical obligation as clients are entitled to make informed decisions when consenting to engage (Henretty & Levitt, 2010).

Some clients may feel Asian professionals will be judgemental towards them and request a therapist from a different ethnic background. Such requests may be denied by services, but can nevertheless leave clinicians feeling rejected and judged. Familiarity with stigma associated with mental health difficulties in Asian communities hopefully encourages Asian clinicians to develop conscious awareness of personal values and beliefs around mental health issues, thus ensuring dominant cultural narratives do not impact adversely on these. Being perceived negatively in this domain by a client despite such efforts can therefore be particularly upsetting.

Anger, discomfort, self-criticism, insecurity, and guilt are common reactions to therapeutic ruptures, but reacting with hostility or avoidance, or taking comments personally is unhelpful and unproductive (de Oliveira & Vandenberghe, 2009). It is possible some clients doubt they can expect support and understanding from Asian professionals if their previous experiences indicate members of their ethnic background will be judgmental towards them. Such instances may lead to negative transference where those feelings are displaced onto the therapist (Lemma, 2003). This type of rupture can be one of the most difficult experiences to work through in the room (de Oliveira & Vandenberghe, 2009). Nonetheless, therapists who disclose feelings around ruptures report it enhances relationships and results in significant gains in understanding (de Oliveira & Vandenberghe, 2009; Henretty & Levitt, 2010). Moreover, linking such events to patterns of interpersonal interactions, if done with empathy and validation, can lead to further exploration of relational themes (Safran, Muran, & Eubanks-Carter, 2011). However, therapy does not have positive outcomes when such issues are not resolved (Safran et al., 2011).

Facilitating Disclosure

Adult survivors of CSA in general do not tend to spontaneously disclose this to professionals, and clinicians themselves can be reluctant to ask (Read, Hammersley, & Rudegeair, 2007). Barriers to enquiry include doubting whether there is sufficient rapport, concerns about suggestive questioning, or worries around precipitating deterioration in clients' mental health (Read et al., 2007). However, there is little evidence to suggest such enquiry is damaging if conducted sensitively and therapeutically, and a failure to enquire can trigger distress and anger (Lothian & Read, 2002). CSA enquiries within Asian populations can evoke even greater wariness due to professional uncertainties around understanding cultural values, such as parenting attitudes or differences in gender roles and associated power dynamics, hence clinicians may be more hesitant to explore such issues in an attempt

to avoid perceptions of stigmatising unfamiliar practices or behaviours (Gahir & Garrett, 1999).

Facilitating disclosure can be particularly challenging when clients are struggling with providing details to enable safeguarding concerns to be addressed if other children may be at risk. The Health Professionals Council (HPC) states psychologists must act in the best interests of clients (HPC, 2010) but there is also an ethical imperative for clinicians to protect vulnerable children who may be at risk (HPC, 2012). Insensitive or probing questioning might result in individuals feeling their own distress is no longer the focus of sessions, thereby experiencing invalidation or rejection. Moreover, individuals may disengage or becoming less willing to disclose further details if they feel compelled to discuss issues they are not ready to face. Although clinicians can feel pressured to gather as much detail as possible after a disclosure, this is undesirable and unnecessary, and it is recommended the focus remain on the client and the relationship (Read et al., 2007). Disclosure of personal issues can be facilitated by allowing clients to set the pace of discussions (Farber, 2003; Farber & Hall, 2002), since disclosures around CSA proceed slowly and with reticence as they often elicit distressing emotions (Farber, 2003). It is therefore essential individuals feel therapeutically safe enough to share such histories, but therapists can present as demanding when encouraging clients to disclose (Farber & Hall, 2002).

Moreover, Asian women can experience further cultural barriers to disclosure. A lack of knowledge about CSA, cultural dynamics around honour and shame, and a fear of public disclosure means abuse is under-reported in Asian communities, and individuals are less likely to be aware of services they can access for support (Gilligan & Akhtar, 2005; Maiter & Stalker, 2011). When professionals respond flexibly to disclosures of CSA from within Asian communities, individuals feel they are in control of the process and pace of events (Gilligan & Akhtar, 2005). This involves recognising concerns around consequences of disclosure and

engaging in open and collaborative conversations around this, as well as developing individuals' confidence that disclosure will be beneficial (Gilligan & Akhtar, 2005; Maiter & Stalker, 2011). It is of paramount importance that decisions to refer matters to external agencies are made collaboratively because cooperation often ceases if individuals feel pushed into doing so, and this does not serve the interests of children who may be at risk (Gilligan & Akhtar, 2005).

It may therefore be helpful to proceed by exploring an individual's disclosure with them at their own pace, whilst keeping safeguarding concerns in mind with a view to obtaining information needed. This highlights that although child protection training and teaching imply it is a straightforward process with little scope for individual decision-making, professionals are nevertheless required to use clinical judgement to determine how to proceed with referrals in the best interests of children who may potentially be at risk. When the child is not the client, this process must also balance the therapeutic needs of clients with professional responsibilities of protecting vulnerable children.

Intervention Options

Psychoeducation and formulation. Psychoeducation can facilitate the assessment and formulation process by providing a framework for increasing understanding of the impact of CSA (Lukens & McFarlane, 2004). A particular benefit of written / printed psychoeducational material is that it offers the opportunity for clients to highlight sections they identify with for discussion in sessions, thus facilitating further exploration. This can be especially useful when individuals find it difficult to articulate such issues, which may partly be due to distress and shame felt at recalling such memories, but can also be attributed to a paucity of language around CSA in Asian culture (Gahir & Garrett, 1999; Reavey et al., 2006).

Asian women who have been sexually abused often find it difficult to form coherent personal narratives, which can negatively impact on their mental health if they are unable to process such experiences (Reavey et al., 2006). The formulation process can therefore also be a valuable aspect of intervention, through deconstruction of presenting narratives to increase individuals' awareness and understanding of their difficulties and distress. Basing formulations on models such as Finkelhor's traumagenic dynamics (Finkelhor & Browne, 1985) enable a detailed assessment of the short and long-term impact of CSA through a systematic exploration of psychological injury within four traumagenic domains (sexual traumatisation, betrayal, powerlessness, and stigmatisation) (Finkelhor & Browne, 1985). Moreover, this model also allows incorporation of pre / post-abuse factors that can potentially mediate the effects of CSA, some of which may include specific cultural dynamics. A potentially complex formulation can therefore be easily shared and understood by clients and other professionals, facilitating development of coherent narratives encompassing critical aspects of individual experiences, as well as identifying therapeutic targets.

Therapy. National Institute of Clinical Excellence (NICE) guidelines recommend survivors of traumatic experiences should be offered trauma-focused cognitive-behavioural therapy (CBT) (NICE, 2005). However, trauma-focused CBT focuses on providing symptomatic relief from distressing interpretations of trauma and its aftermath (NICE, 2005), and this model does not account for diverse experiences of trauma or how cultural and interpersonal dynamics influence individual responses. Clinicians often struggle when working therapeutically with Asian women who have been sexually abused as complex cultural dynamics can make engagement, assessment, and intervention difficult (Reavey et al., 2006). There is a greater tendency to translate trauma associated with CSA into symptoms of mental illness such as post-traumatic stress disorder (PTSD), albeit for pragmatic reasons such as legitimising psychological difficulties (Reavey et al., 2006).

The aim of intervention therefore frequently becomes the reduction or elimination of symptoms, with little regard for contexts or systems maintaining and reinforcing difficulties (Reavey et al., 2006). Such approaches locate the cause of distress within individuals, pathologising coping strategies that may be responses to unresolved trauma. Moreover, framing trauma from abuse in diagnostic terms can intensify stigmatisation, as mental illness is a taboo subject in many Asian communities (Reavey et al., 2006; Weatherhead & Daiches, 2010). Indeed, the stigma associated with mental health difficulties may greatly exacerbate feelings of powerlessness, shame, and stigmatisation from the abuse itself.

Moreover, when trauma is associated with intense feelings of shame, trauma-focused CBT may not be effective (Lee, Scragg, & Turner, 2001). Lee et al. (2001) propose a shame-based model of PTSD based on Young's schema theory (Young, Klosko, & Weishar, 2003). This model suggests early maladaptive schemas shape perceptions of causality and meanings of traumatic events, therefore schema-focused therapy is required to address these before an individual can understand, process, and reframe traumatic experiences (Lee et al., 2001). Cognitive and behavioural techniques may therefore be insufficient to process traumatic memories if they are associated with maladaptive schemas in this manner. In the case of CSA, the trauma itself would be a formative factor in the development of shame schemas, as the core beliefs would be both a result of the trauma as well as perpetuating shame from it. Early traumatic experiences such as CSA often result in schemas in the domain of disconnection and rejection such as mistrust / abuse and defectiveness (Young et al., 2003). This fits well with the traumagenic dynamic framework, with mistrust / abuse mapping onto the domains of betrayal and powerlessness, and defectiveness mapping onto stigmatisation and traumatic sexualisation.

Conclusions

While ethnically similar therapeutic dyads may lead to greater understanding and empathy, therapists who respect cultural differences and accept universal humanness can overcome ethnic differences in the same way differences of gender, socioeconomic status, sexuality, and religion are overcome (Farsimadan et al., 2007). Clients may assume they will not be able to develop therapeutic relationships due to ethnic similarities or dissimilarities, and it is important to demonstrate in both instances that ethnic background is secondary to an effective therapeutic alliance (Farsimadan et al., 2007). Therapy can therefore create a space for a cultural test where a different type of relationship to that which the client expects can be modelled, helping to minimise potential barriers to future engagement (Gaztambide, 2012).

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