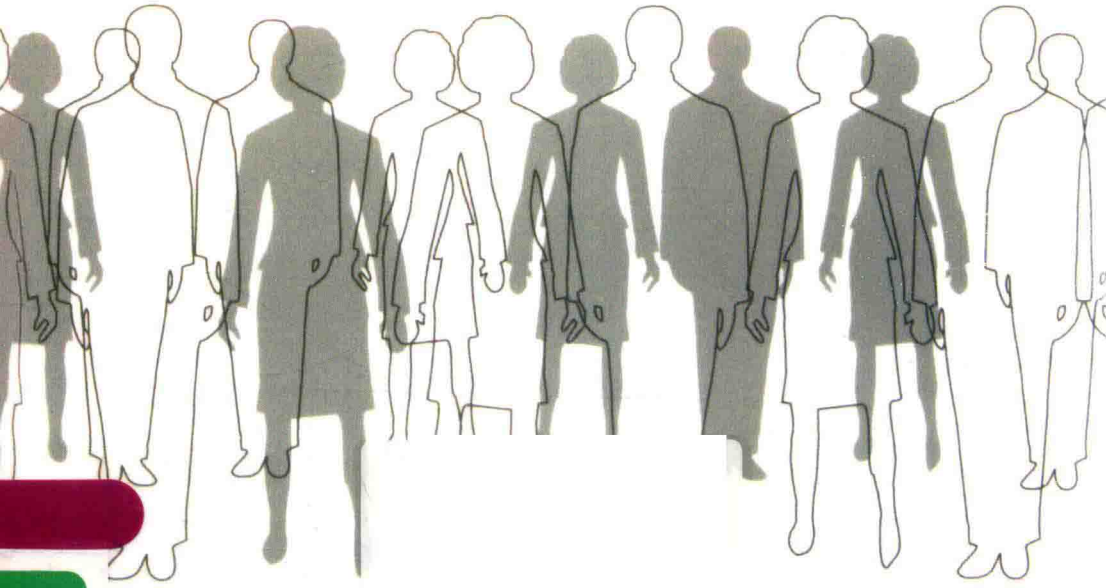
Adult Survivors of Sexual Abuse

Treatment Innovations



Mic Hunter
EDITOR

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SAGE Publications
International Educational and Professional Publisher
Thousand Oaks London New Delhi

For information address:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications Ltd.
6 Bonhill Street
London EC2A 4PU
United Kingdom

SAGE Publications India Pvt. Ltd.
M-32 Market
Greater Kailash I
New Delhi 110 048 India

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Main entry under title:

Adult survivors of sexual abuse: Treatment innovations / edited by Mic Hunter.
p. cm.
Includes bibliographical references and index.
ISBN 0-8039-7192-3 (hbk. : acid-free paper). —ISBN 0-8039-7193-1 (pbk. : acid-free paper)
1. Adult child sexual abuse victims—Rehabilitation. 2. Psychosexual disorders—Treatment. I. Hunter, Mic.
RC569.5.A28A34 1995
616.85'836906—dc20 94-49383

This book is printed on acid-free paper.

95 96 97 98 99 10 9 8 7 6 5 4 3 2 1

Sage Production Editor: Tricia K. Bennett

Adult Survivors of Sexual Abuse

This book is dedicated to Peter Dimock and Jim Struve.

"Imagine waiting thirty years
before finding these two brothers."

Foreword

There is a growing interest in literature on sexual abuse, to the point that new journals have been created that focus exclusively on topics related to sexual abuse. Yet we still have much to learn about the causes, effects, and treatment of sexual abuse.

As a result of the publication of *Abused Boys: The Neglected Victims of Sexual Abuse,* I have been invited to speak at numerous conferences and workshops. The most rewarding aspect of these experiences has been the men and women that I have met. The contributors to this book are among those who have been most helpful in advancing my understanding of the effects and treatment of sexual abuse. Their thinking has been so useful to me that I wanted to ensure that their thoughts were made available to other therapists. It was this desire that motivated me to invite them to become involved in this project. All of them are clinicians and know the experience of sitting in an office facing another human who has been severely abused. *Child sexual abuse* is not an abstract concept to them, but an all-too-familiar phrase that still causes a visceral response. In their quest to reduce human suffering, they have developed practical and effective methods of treatment. You will find much of value in what they have written. I am honored to have my efforts appear with their work.

The book begins with a chapter by Mark Schwartz, Lori Galperin, and William Masters. They lay the foundation for the remainder of the book by providing a theory for understanding the effects of child sexual abuse using an extreme stress response model. Effective and efficient

treatment ought to be based on a sound theoretical foundation so that the therapist has a mental road map to provide guidance through the often-confusing terrain of psychopathology and psychotherapy. Schwartz, Galperin, and Masters provide such a model. They are able to take the complex, overwhelming problem of dealing with trauma and describe it in a manner that the practicing psychotherapist will find practical. You will find that the remainder of the chapters build on this foundation and expand on the ways it can be applied in the clinical setting.

The book is divided into two main parts: helping adult survivors with sexual problems and helping adult survivors with special needs. Jeff Brown begins Part One, *Helping Adult Survivors With Sexual Problems,* with his chapter on interventions for treating couples whose sexual relationship has been damaged by a history of sexual abuse in the childhood of one of the partners. Brown wrote the chapter in such a manner that the material is useful regardless of the makeup of the couple seeking treatment. Those clinicians who work with same-sex couples as well as heterosexual couples will find the information valuable.

The second and third chapters focus on working with clients who exhibit compulsive sexual behavior. Schwartz, Galperin, and Masters again join forces to author a chapter on treatment with this population. As with their earlier chapter, they furnish a theoretical basis that clearly supports their therapeutic recommendations. Their work is followed by my chapter, in which I provide a method for making use of a client's compulsive sexual behavior pattern to determine if unresolved childhood sexual abuse is creating the need for the adult behavior pattern. You may be surprised when you notice how both of these chapters make use of very similar thinking to understand compulsive behaviors. In 1992, after I presented my thoughts on this topic at a conference in New Orleans, I was delighted to learn that Schwartz, Galperin, and Masters also had come to strikingly similar conclusions based on their own clinical experience. It is clear that our thoughts have continued to follow a parallel course.

Part Two, *Helping Adult Survivors With Special Needs,* begins with Robert Mayer's chapter on the struggles he has experienced while attempting to help clients with complex disordered personalities. In addition to providing treatment recommendations, his writing reveals the personal impact that working with these individuals can have on a therapist. Dr. Mayer's description reminds the reader that in some

cases, the therapeutic process may be nearly as upsetting for the therapist as for the client. I find it most refreshing that Dr. Mayer is willing to describe his failures as well as his successes.

I began my career as a professional helper in 1980 as a chemical dependency counselor. Nothing in my training had prepared me for coping with the overwhelming number of my clients who reported that they had been sexually abused as children. My desire for information and skills to help these people is what motivated me to return to graduate school for additional training. Unfortunately, coursework in the treatment of sexual abuse was nonexistent in any of the programs that were available at the time. Sadly, conditions have not improved significantly. Even recent research (Alpert & Paulson, 1990; Minnesota Higher Education Coordinating Board, 1993) notes the scarceness of graduate-level sexual abuse training. Chemical dependency counselors still yearn for practical information on the treatment of sexually abused persons who are struggling to recover from alcohol and other drug addictions. I wish Caryl Trotter's chapter on the stages of recovery and relapse prevention had been available when I faced all of those newly sober men and women who were recalling their childhood abuse experiences and struggling to avoid using drugs as a way to cope with their pain. She presents a model that ties together assessment and intervention. She is able to bridge the gap that often exists between those who treat the effects of chemical dependency and those who treat the effects of sexual abuse.

The chapter on psychotherapy with couples is written, appropriately enough, by a wife-and-husband team. Betty Button and Allen Dietz focus on providing couples therapy for adults who experienced childhood sexual abuse. They bring both their professional and personal experience to an area of treatment that has received very little attention in the literature.

Larry Morris brings the wisdom of his decades of clinical experience to the final chapter of the volume. He focuses his efforts on the importance of using a multidimensional approach when treating men who were sexually abused as children. Dr. Morris was the Chair of the Third National Conference on Male Sexual Abuse Survivors and has dedicated much of his professional life as a psychologist to seeing that damaged boys and men receive ethical and effective treatment. Because he has been hinting at retiring in the near future, I wanted to ensure that he was given a chance to update us on his thoughts since the release of

Males at Risk (Bolton, Morris, & MacEachron, 1989) before he spends every day hiking the Grand Canyon.

I am glad that people such as these authors exist and are kind enough to share their knowledge. I know that, just as I did, you will find these chapters useful and practical.

Mic Hunter
St. Paul, Minnesota

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Sexual Trauma Within the Context of Traumatic and Inescapable Stress, Neglect, and Poisonous Pedagogy

Mark F. Schwartz

Lori D. Galperin

William H. Masters

Posttraumatic Stress

The *Diagnostic Statistical Manual-III (DSM-III)* defines posttraumatic stress disorder (PTSD) as the result of a "recognizable stressor that would evoke significant symptoms of distress in almost anyone" (American Psychiatric Association, 1987, p. 236). The implication of this terminology is that the *natural* response to such trauma is PTSD—that the response is not an "illness" and that any person experiencing an event of that magnitude is likely to be similarly affected. Thus, rather than stigmatizing trauma victims by assigning to them a mental disorder, it might be more reasonable to categorize the adaptive and maladaptive survival strategies, describe such individuals as "survivors," and then

label the "pathological intensifications" (Horowitz, 1986) of such strategies as a mental disorder.

Because a child's natural defenses include dissociation—even amnesia—the cycling of numbing and intrusion responses that predictably occur following posttraumatic stress (Horowitz, 1986) may continue to cycle indefinitely. The numbing portion of the cycle involves a person feeling like an object, treating others like objects, and responding objectively without the use of emotions to guide actions and without the capacity for genuine caring and compassion for self or others. Therefore, the numbing results in restrictive, self-punitive responses, as well as constriction, isolation, and disconnection from others. Intrusion is the breaking through or flooding in of cognition or affect that overwhelms the individual. Typically, it is coded as anxiety, depression, or some other generalized distress, such as somatic complaints. Ritualized or compulsive behavior is often used to cope with this distress or to numb out further, which adds to the individual's disability. Specifically, when the intrusion phase begins, compulsive behavior may function as a vehicle for the re-creation of numbness. When the numbing becomes intolerable (i.e., when the person feels so removed, inhuman, or unreal that all connection to self, others, and physical reality feels lost), compulsive behavior or rituals are then used to reestablish feeling.

It is likely that without external guidance and support from caregivers, the result of early trauma will be pathological intensification or mental disorder. Thus the impact of trauma can be measured only by assessing both event and context (i.e., the presence or absence of nurturing and support from the caregivers). With sufficient support, the trauma may be "finished," "worked through," or resolved without any resulting pathological intensifications.

■ Disorders of Extreme Stress (DES)

Whenever a person experiences severe and chronic stress that is inescapable for prolonged periods, the resulting syndrome is predictably different from that of a posttraumatic stress, which consists of an overwhelming acute event that has a termination point. There is also a vast literature reviewed by van der Kolk (1989) that suggests that the physiologic concomitants of chronic, inescapable stress are different from those for acute stress. For many children who experience PTSD, there is a backdrop of stress in the day-to-day atmosphere of abuse,

neglect, and danger to which some children are subjected both in and out of their homes. Whenever children are afraid to walk inside their homes because of chaotic, unprovoked, and inconsistent rage and hostility randomly projected onto family members, the environment can be considered similar to inescapable stress (DES). For such children, witnessing molestation, seeing one parent beaten or raped by the other parent, being locked in hot cars on summer days, or almost being drowned in bathtubs culminates in a pervasive sense of unpredictability, danger, and terror. Whenever such episodic posttraumatic stress occurs in the context of this pervasive, overwhelming, chronic stress, the long-term effects will be much more devastating.

Judith Herman (1992) and Bessel van der Kolk (1993) have recently reviewed the existing literature and suggested that the distorted survival strategies that result from inescapable stress in humans include, predictably, depression and anxiety; somatic symptoms; dissociative symptoms; compulsive reenactment; susceptibility to revictimization; intimacy and relationship disorders; and some personality adaptation in the borderline, narcissistic, antisocial, or schizoid realm.

Children who are chronically traumatized by their caretakers may have experiences similar to those of torture victims.

Children who are chronically traumatized by caretakers in an environment of endemic family stress may have experiences similar to those of torture victims, which include the creation of dependency, intimidation, disorientation, and isolation (Suedfeld, 1990). Children are by definition dependent on caretakers. Abusive parents further engender torturous dependency by withholding basic care and opportunity. When children are forced to submit and obey as the price for being allowed cleanliness, food, clothing, access to friends, or just momentary respite from abuse, they are made into slaves. Their fates become entirely contingent on the whims of the captors/parents, and their realities reshape to fit the rules of the game. The name of the game is the subjugation of vulnerable, trusting, and ultimately desperate children by adults who are often powerless everywhere else in the world.

If children believe that they are in mortal danger and that the threat is embodied by the people on whom they are most reliant, the result is a feeling of such profound powerlessness that any will to continue is totally eradicated. Therefore, resilient children bounce back through an

instinctive reframing of their environments that restores hope: They conclude that they are bad and have caused their own suffering, that their caregivers truly love them, and that if they can only try harder or be better, everything will change. To wit: They are not without love and need only perfecting to be truly deserving.

The shame and isolation of "the secret" often compounds and reinforces these dynamics. When the secret is sexual abuse, children often have been told an array of confusing lies: "I love you best of all," "This is our little secret," "If your mother knew, she wouldn't love you—she would know you're a bad little girl," and so on. These confusional techniques occur together with the disorientation of overwhelming, incomprehensible stimulation, which is often accompanied by excruciating physical pain. The mood of the torturer changes radically from one moment to the next: A kiss on the cheek follows a pillow over the face that nearly ends life. The isolating shame and secrecy further reinforce dependency on the torturer: "You're my special one," "If anyone else knew, they would hate you, but you'll always have me."

The longer the abuse continues, the more bound to the abusers the children feel and the more removed they become from other potential connections. The longer the abuse continues with no intervention, the more certain children become that they are not worth saving. Our culture is one in which adults are deemed more aware and knowledgeable than children. Mothers in particular seem to know things magically that children think are unknown. Likewise, the God of Western culture is considered to be all-knowing—even Santa Claus has inside information and knows if you've been bad or good. Amid all of these mythologies and belief systems, how can children imagine that no one notices? When intact, a parent's position is in some measure a buffer or insulator between the child and the dangers of the world. A child being abused by his or her father can have one of two beliefs about his or her mother: "She knows but I'm not worth saving" or "She doesn't know and I have absolutely no one capable of protecting me." Again, it becomes more acceptable to feel bad and unworthy than at the mercy of all the world's dangers. The net effect of the required adaptations to this array of implicit double binds is comparable, in essence, to those arising from intentional brainwashing. The process is the same: Bonds are severed, disorientation is engendered by deprivation or overstimulation, confusion is engendered by double messages and contradictions without resolution, and dependency on the torturer for cessation of the suffering is implicit.

This result may be intended or merely a by-product of domestic cycles of abuse and neglect, but the damage is of at least comparable and perhaps greater magnitude in domestic circumstances because the children's/prisoners' ego formation is still unfolding and parents' access to the children is total. Virulency of trauma is increased by factors such as premeditation, maliciousness, and the possibility of recurrence. For natural disaster and kidnap victims, as well as POWs, there is the hope that one day the experience will end. There may be the remembrance of a time of normalcy or happiness. However, for the child victim of domestic violence, this is reality as far as the eye can see—both backward and forward. For child victims, even when the abuse stops, the cycle often does not because the chronic, learned helplessness still renders them targets for further victimization throughout life. Their capacity to say "no" seems to be permanently injured. Initially, there are cycles of protest, despair, and apathy (Bowlby, 1969) until apathy finally becomes a relatively constant state and the individual succumbs.

For child victims, chronic, learned helplessness often renders them targets for further victimization throughout life.

■ Neglect

Alice Miller (1983, 1986) has written about the hidden cruelties of our philosophy and practice of child rearing as a society—what she calls poisonous pedagogy. Underlying such philosophies is a belief that children are impulsive, out-of-control creatures who require discipline to rein them in and civilize them. Instead of recognizing their acting-out behavior as the result of not feeling loved, attended to, and nurtured, parents assume that the behavior is a result of "badness." Therefore, they feel entitled to punish, deprive, neglect, scream at, or threaten to or actually abandon such "bad" children. In so doing, they believe that they are acting in the best interests of the children. Children learn not to question such disciplinary tactics for fear that worse will follow. When the children respond with anger to being treated unfairly, they are often punished more and told by the angry and sometimes out-of-control parents (ironically) that anger is not permitted (i.e., "Don't you

talk back to me, young lady" or "If you cry, I'll give you something to cry about")—a compelling indication that no emotional response is permissible.

Therefore, children learn to suppress their natural responses to abuse, which creates a broadening of psychopathology. Paradoxically, health care workers can coconspire with families when acting-out children are scapegoated and taken to professionals to get "treated" or to be made "well."

It is only against the backdrop of poisonous pedagogy that the devastating impact of sexual and physical abuse, both acute and chronic, can be fully comprehended. To fully assess the extent of injury and the necessary and sufficient components of rehabilitation for the victims, we must consider the acute PTSD; the chronic, extreme stress that constitutes the context of the trauma and the neglect; and societal response. Children are totally dependent on adults for life itself, and society's attitude commonly has been one of ownership, that is, that parents have the right to bring up their children any way they wish. Within this pedagogical context, children assume that sexual abuse, for example, is a form of punishment, something they deserve for being bad—something being done "for their own good" by adults who know what's best.

In addition to the indigenous poisonous pedagogy, there is in our culture's conceptualization of child rearing a very poor articulation of what all children require to thrive. The result is that parents, children, professionals, and state agencies cannot define neglect adequately. Neglect is the absence of what all children need to thrive, but of what does that consist? When children are neglected, they feel unlovable. Typically, it does not occur to them to think that their caregivers are imperfect, incompetent, incapable of loving, or, at the worst, sadistic. To define a standard of comparison, one might simply ask: What is the impact on a child of having two parents, each of whom is tremendously selfish and self-absorbed, each of whom puts his or her needs above those of everyone else, 100% of the time? What is the damage, even though no overt abuse occurred? In some ways, neglect may be more pernicious than abuse, but because the two often occur together, it becomes quite difficult to determine which is most injurious or exactly where the damage of one ends and the other begins.

All children need respect, consistency, attention, support, role models, praise, protection, loving touch, assurance, and play as much as they need food and shelter. Children need opportunities to learn and make mistakes without pressure or punishment. They need to be accepted as