

REFLECTIONS ON WORKING WITH SEXUAL ABUSE VICTIMS

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As we observe clinicians working with victims of sexual abuse, we can see their dedication, caring and love toward clients. But the therapeutic process requires more than clinicians' devotion to clients. It also involves a complex interplay of clients' behaviors, including client projection, displacement and other protective mechanisms. As a result, clinicians are faced with complex emotions and multiple dilemmas when working with these clients. In this paper we discuss these therapeutic dilemmas. By understanding the parallel client-therapist process we are better able to understand our clients' experiences. By doing so, we become better therapists.

Two are better than one, for their reward is in their toil and if they fall, one shall lift the other (Ecclesiastes 4:9)

Victims of sexual abuse suffer from multiple long term consequences of their traumatic experience: psychologically, physically, and on a functional and cognitive basis. Loss of control is inherent in the sexual trauma, as well as the syndrome of secrecy, which later affects interpersonal relationships and cognitive schemata's. These in turn, prevent victims from perceiving reality for what it is; instead they project their inner perceptions onto external events.

The Acute Center for victims of sexual abuse and the Multidisciplinary Treatment Center for long term therapy of sexual abuse victims were founded for the purpose of providing therapy for the victims, and preventing or healing the consequences mentioned above.

The Acute Center for victims of sexual assault and abuse sees the victim immediately after the assault, for medical treatment and examination (injuries, pregnancy, sexually transmitted disease) evidence collection and psychosocial intervention.

The Multidisciplinary Treatment Center for Victims of Sexual Abuse provides long term psychotherapy for victims of incest, as well as rape, either immediately after the sexual attack or years later.

In the following narrative we discuss the consequences of working around sexual trauma, on the professional care takers, as a

result of parallel processes between clients and staff.

The Dynamics of Secrecy

Secrecy results from external as well as interactive factors. External factors relate to multiple themes. Sexual abuse occurs behind closed doors, and therefore there are no witnesses to the act. There is also lack of evidence, because the victim does not approach the police or acute centers, immediately after the sexual assault or abuse. As a result, the victim realizes that she will have to confront the perpetrator directly, and it would be her words against his. She is also aware that due to the consequences of the abuse, she is emotionally unstable with symptoms of anxiety, depression, and dissociation. The perpetrator, in contrast to her vulnerability, feels empowered, due to use of minimization and denial. In this confrontation she believes he will have the upper hand.

In addition, she is aware of the accusations and minimization, she might face, from her family, as well as from the community around her. Sometimes she is threatened by the abuser directly, and even if she is not, she understands that the consequences of exposing the abuse will be harmful for her and her family.

All these factors affect her decision to keep the abuse secret. Yet there are other reasons for secrecy: interactive ones. These have to do with the parallel process that is

being created. The victim's room, an ordinary room during regular hours, becomes the abusive room in which the trauma occurs. The character of the abuser: his voice, touch and smell change when he turns from an ordinary human being into an abuser. Above all, there are beginning and ending ceremonies that repeat themselves every time the abuse occurs. They separate the acts of the abuse every time it happens, from the regular routine of the victim.

The combination of these external and interactive factors leads the victim to keep the abuse secret. As a result, she lives in two parallel worlds. This may result in dissociative processes later on.

It is important to observe the parallel process, between the abuser and the client, within the therapy room. The therapeutic setting differs from all other settings. It is secluded, private: no one enters the room, during the session. In that sense it resembles the room, in which the abuse took place. There are also beginning and ending ceremonies. When clients enter, we welcome them and lead them to our room. When the session ends, we set the next meeting, collect our fee, and accompany them to the door.

There is also the issue of confidentiality in therapy, which resembles the dynamic of secrecy (so familiar to the victim), from the sexual abuse. This dynamic leads to displacement processes, between the therapist and the client. At first, due to the similarity in the setting, the client is in touch with tremendous anxiety, which is displaced onto the therapist, either in avoidance, by testing, or by aggression.

We also have to consider the process of identifying with the abuser, which is typical of some of the victims. As a victim, the person being attacked, feels extremely helpless- a feeling, which is difficult to contain. The abused person tries to overcome this feeling, by identifying with the perpetrator, who is perceived to be in control. In this process the victim tends to behave with aggression, for the purpose of establishing control. For the therapist, coming to the session with best intentions, the aggression and the accusations are difficult to contain. That's where the

secondary traumatization of the therapist begins.

Protective Mechanisms

Feelings which are difficult to contain within oneself are often projected onto another human being, in an attempt to resolve those feelings. The person receiving those feelings might feel contaminated or overwhelmed, especially if he is not aware of the projection process. This process is important to notice, on both individual and organizational levels, so that receivers can contain those feelings which are directed towards them. Another option of protecting from one's own feelings is by protective mechanisms, which enable the person to distance from his feelings.

Within the Acute Center, the dynamic of perpetrator-victim, might be reenacted. The victim feels violated, on two levels: by the questioning of the social worker, as well as by the gynecological exam. The questioning is required, in order to get the information, necessary for the exam. The exam itself is required for the purpose of treatment and evidence collection. Even though the procedures are necessary, they are nevertheless intrusive. That most gynecologists within the Acute Center are men leads the client to emotionally re-experience the trauma. The painful experience of the client is often directed at the staff through client expressions of anger, mistrust and suspicion.

Another protective mechanism is splitting. Traumatic events affect cognitive schemata, and prevent victims from perceiving life in multiple colors and variations. Victims tend to perceive the world in "black and white," "good or bad." This split enables them to have a sense of control. The split is projected onto the staff. It is another hazard for the staff, because it may diminish the mutual support, needed for this kind of work. In many cases the boundaries between social workers and clients fade, and both client and therapist direct their anger toward the physicians, leaving themselves as well as the doctors feeling isolated and vulnerable.

Clients of sexual abuse always feel violated, as a result from their trauma. It is interesting to observe how this feeling might

find its way into the therapist. Evidence for this dynamic can be found in therapists' dreams, characterized by themes reflecting lack of boundaries and control, sexual abuse and fear. Therapists may also engage in avoidant behaviors: difficulty in joining with clients, fatigue, physical illness and distancing from staff members. They may find themselves coping with their own irritation, anger and sadness, as well as feelings of anxiety and violation, projected onto them by clients.

It takes experience, resiliency, containment and knowledge, to identify and cope with projective processes. Thus, it is important to recruit suitable professionals for this work, as well as to provide them with knowledge and supervision, to increase their therapeutic ability and prevent secondary traumatization of therapists.

Dilemmas Concerned with the Acute Center

On many occasions victims arrive to the acute center with no concrete memory of the sexual assault, due to alcohol use or ingestion of a rape drug. On these occasions, there is loss of time periods and loss of memory about events. The victims find themselves, in weird situations, many times partially naked, or in unfamiliar places. Upon their arrival, victims may hold the fantasy that the physician will be able to provide answers—especially with regard to whether the client was raped. Physicians cannot provide this answer and the clients remain with uncertainty and confusion. Victim frustration and anger follow this confusion and the physician becomes the target.

Another perspective of the clients in the acute center has to do with the process of reporting. In some incidents, the staff is mandated to report to the police or to external professionals, even if the client chooses not to file a complaint. When we realize that the client feels a loss of control as a result of the abuse, it is easily understood that the report amplifies these feelings. Although the reporting is done with the clients' knowledge, with explanations and transparency, mistrust often follows.

Some sexual assault victims who arrive at the center are residents of hospitals for the mentally ill or developmentally disabled. The

sexual abuse occurred within these institutions that were meant to protect their clients. Based on that experience, coming to the acute center—yet another “institution”—reignites clients' difficulty in trusting the staff or using their services. Clients' frustrations often result in a feeling of frustration among staff.

These examples present the parallel process in which clients experience the difficulty in the acute center, and the strain put on staff members. Both clients and staff pay a price for events of which neither group is responsible. The client is not responsible for the sexual assault and the staff has to receive the feelings projected onto them. The human soul of the client subconsciously finds a way to activate the caretakers' feelings.

Crisis Intervention within the Multidisciplinary Center

Victims of sexual abuse are violated profoundly. Many of them suffer from clinical depression, complex post-traumatic stress disorder (PTSD) and dissociative personality disorder. The abuse affects their emotional stability and coping mechanisms. These effects lead to many crisis situations that have to be handled outside the therapeutic setting.

During night times and holidays, our phones and emails are extremely busy. Loneliness and lack of structure, as well as internal pain makes it difficult for our clients to survive. During these times we are expected to provide support and guidance for our clients and to assess the danger to their lives. The responsibility placed on our therapists, combined with the absence of suitable places for client hospitalization, leaves the therapists with a heavy burden.

The therapeutic relationships which are close and strong have an additional effect on therapists, when dealing with crises situations. One particularly difficult situation arises when a therapist receives a message from a client, in which the client states she is about to commit suicide and then immediately loses contact with the center. The therapist faces a difficult dilemma: should she send the police to take the client to the emergency room and thereby threaten the therapeutic relationship? Or wait until the client contact us again? There are no

conclusive answers, and the responsibility for life is heavy. It is hard to put into words the emotional burden on the therapist in these all-too-common situations.

In some crises we have to get involved with clients' children. If we assess that children might be at risk, we have an obligation to report possible abuse or neglect to the authorities. In these cases we are breaking the therapeutic bond, which we have been developing for so long. The therapeutic principle of transparency requires that we communicate our actions directly to the parent. The parent may respond by directing anger and aggression at the therapist. The parent may feel betrayed by the therapist and may even project her own feelings of incompetence, on the therapist. The therapist experiences ambivalence, aware that any action will hurt either the parent or the child. On a professional level, it is possible for the therapist to survive this crisis, yet on a personal level we feel that we "messed up" and we experience sorrow and regret.

We have reflected on the dilemmas we face during our work at the centers. These reflections are the tip of the iceberg because we work with severely abused clients, who carry tremendous pain that has its effects on every aspect of their being. As we provide acute and long-term therapy for sexual abuse victims, clients project and displace their pain and difficulty onto their therapists. In the future we would like to devise organizational structures and policies that will take account of these therapeutic dilemmas in order to ensure optimal services to our traumatized clients.

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