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Use of the Terms *Victim* and *Survivor* in the Grief Stages Commonly Seen During Recovery from Sexual Abuse

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Much of the nomenclature inherited from the women's movement is not fully applicable to and respectful of the individuality of our male clients. There is a need to expand and revise this nomenclature so that it is more gender appropriate. It is important to acknowledge that a significant number of females and males in our society are socialized differently. While a gender-neutral (humanistic) approach to sexual abuse may seem ideal, as a practical matter, we cannot ignore the gender differences that result from the socialization process. This process affects early development stages and this is applicable to treating males of all ages. The focus of this chapter is on the highly developed, covert, presexual conditioning process that is the mark of most sexual abuse of males.

Historical Perspective

Today maltreatment of children is generally defined as neglect and sexual, physical, and emotional abuse. In the first half of the twentieth century, child maltreatment, in the form of physical abuse, was brought to the attention of the justice system by the Society for the Prevention of Cruelty to Animals (later the American Humane Society). This marked the embryonic stage of public awareness of the problem, which evolved slowly and in a segmented fashion until the women's movement of the 1970s.

The women's movement clearly escalated public awareness and facilitated rapid change in legislation and research. Logically, since the majority of the members of the early feminist movement were women, the issues of female maltreatment became apparent first. The original focus of the women's movement was the disparity in the treatment of women in the adult population. The emphasis later expanded to include the issues of the maltreatment of children of all ages and both genders. The contemporary emphasis of child maltreatment has become highly focused on sexual abuse, particularly the abuse of females.

Due to their origins in the women's movement, the nomenclature and practice within the field of sexual abuse prevention, intervention, and treatment have a strong female orientation. Furthermore, until recently, research on the victimization of female children provided skewed data on the frequency, type, and gender preference of offenders. Current research is causing treatment professionals to reexamine the entire issue of victimization.

Gender Differences

Many authors (Courtois 1988; Bear and Dimock 1988; Herman 1981; Hunter 1990; Kempe and Kempe 1984; Lew 1988; Meiselman 1979) have already described the syndrome that frequently results from sexual maltreatment. The sexual maltreatment of children is visible by the distortion of human personality that often lies in its wake. Common symptoms include denial, repression, minimization, and self-blame. Self-defeating behaviors, such as poor school performance, the inability to maintain healthy relationships, addictive disorders, and repetition of the abuse scenario, also are observed frequently. Without appropriate intervention, these behavior patterns can be perpetuated long after the actual abuse has ceased. For the sake of brevity, the symptomatology that we describe here is not all-encompassing. There are as many responses to sexual maltreatment as there are victims.

The symptoms and behaviors previously described are manifested in both genders, but the socialization process of the broader culture results in gender-specific presentation of these symptoms. Early in life, male children are taught to individuate and separate. In contrast, female children traditionally have been encouraged to focus on relationships. Constant messages such as "Big boys don't cry," "You take care of your mother and sister while I'm gone," and "My little man" begin to erect barriers to intimacy and interdependency. The patriarchal family structure commonly found in the United States is apparent early on to male children, creating a false sense of power vested in them by virtue of gender.

This false sense of power and authority discounts the vulnerability and powerlessness of childhood. It is reinforced throughout society in books, television, films, and even toys. The dolls that male children play with are adult soldiers (for example, G.I. Joe) rather than babies whereas dolls made for female children are designed to be nurtured and cared for, their male counterparts need no such care, as they are armed and self-sufficient.

Negative gender roles continue to be reinforced throughout the maturation process. Sexism permeates the culture, including the treatment community. For example, we discuss the *male* sexual abuse victim and the *female* sex offender as if they were enigmas, much like saying *male* nurse and *female* physician. Current empirical data show that significant numbers of males are

sexual abuse victims (Finkelhor 1979, 1984). Until recently, they have been overlooked because of sexist attitudes and the manner in which they display their pain. This display is often described as a mask, since it fits the female victim response model.

Reasons Why Helping Professionals Overlook the Sexual Abuse of Males

As we have discussed, American culture is sexist. Helping professionals exist within this culture and are bombarded with this message. Further, we have begun to address the issue of the sexual maltreatment of children only within the past two decades, so relatively little is known and few professionals have specific or adequate training in the field. In addition, people attracted to helping professions often are in search of a resolution or validation for their personal issues. Finally, much of the abuse perpetrated against males, particularly by women, is of a more covert nature, making it even more difficult to recognize (for example, children being sexually fondled in the guise of bathing or toilet training or gay adolescents being "assisted" in "coming out" by significantly older men who are in reality using them).

The nomenclature widely used in the media, the court system, and some client service agencies continues to include phrases that create barriers to those whose sexual maltreatment came in the form of seduction rather than violence. The terms *sexual assault* and *rape,* which are defined as forms of violence (McKechnie 1979), do not take into account the seductive and manipulative nature of the predatory conduct that is so common in our society. Empirical data indicate that rape is one of the least frequent sexual offenses particularly when viewed in terms of the number of victims per offender (Abel et al 1987; Becker and Abel 1984). These data account for all types of aberrant sexual behaviors, including nontouch crimes as exhibitionism and voyeurism and touching crimes such as forteurism and child molestation.

The use of language that focuses primarily on assaultive, violent attacks creates seemingly insurmountable barriers to those persons who were victimized in a more seductive fashion. Whereas assault is an overt physical act, seduction is a more cognitive covert process. To seduce is "to persuade to do wrong, as by offering something, to tempt to evil or wrongdoing, to lead astray, to persuade to engage in unlawful sexual intercourse, especially for the first time; to induce to give up chastity. Syn. -lure, entice, mislead, corrupt, tempt" (McKechnie 1979, 1,096). Fortunately, in recent years, comprehensive legislation and service agencies have begun using terms such as *sexual misconduct* and *sexual offenses,* which more clearly account for the full spectrum of sexual maltreatment.

Victims versus Survivors

Use of the Term Victim

Classically, a dictionary definition of a victim is someone who is "killed, destroyed, injured or otherwise, harmed by, or suffering from, some act, condition, or circumstance" (McKechnie 1979)? Conventional victimology views the word *victim* as shaming and keeping the client helpless, passive, powerless, and trapped by the abuse experience. Many females react to the term as an extension or affirmation of their place in a male-dominated culture. Since the feminist movement sought to empower women, the term *survivor* became popular as a way to neutralize the power imbalance between the two genders. This term was used to reframe the aftermath of the abuse in a less debasing manner.

Rigidly subscribing to the view that the term *victim* is inherently demeaning can, however, result in gender-inappropriate clinical practices. Our position is that the term clearly describes the human condition as a result of the traumatic occurrence, places the responsibility on the appropriate person, and has a highly useful place in the evolution of the therapeutic process, particularly with males, since traditional males are conditioned to believe that by virtue of their maleness, they are impervious to victimization. In contrast, traditional females are less likely to see the term as a threat to their gender identity.

Just as women have traditionally been socialized to accept the role of passive dependence, men have been socialized to accept the role of aggressive independent. Although we acknowledge the reframing that takes place by using the term survivor for women recovering from the effects of sexual maltreatment, it is our clinical experience that it can be detrimental to males when applied too early in the treatment process.

Using the term *victim* at the onset of therapy frames the experience as "What was done *to* you was not okay, and it was not your fault." Since men traditionally have not thought of themselves as people who could be victimized, applying the word to themselves triggers profound emotional reactions. These include fear, anger, hurt, shame, and sadness. Access to these emotions is more easily attained when the term *victim* is used rather than the term *survivor*.

Use of the Term Survivor

The term *survivor* was coined in response to objections to the cultural implications of the word *victim*. It was designed to empower women and encourage them not to view themselves as passive, immature, dependent, damaged "goods," or susceptible to ongoing abuse. Survivorship speaks not

only to enduring but also to overcoming demeaning or destructive conditions. In an attempt to place the responsibility for the abuse with the offender, where it rightfully belongs, the term may inadvertently imply that because the victimized person was not at fault, he or she is not affected by it. Avoiding the term *victim* immediately sets up the potential for double message: If no trauma took place or no damage was done, there is nothing to survive.

Part of the task of the clinician is to identify sex negativity in the culture, particularly as it relates to one's sense of "maleness" or "femaleness," the propensity to blame those victimized, and other factors that contribute to the cllient's distorted view of reality. While a clinician is clearly a guide, there is an obligation to have a gender-specific knowledge base that allows one to teach and empower the client by transforming cognitive distortions into a more life-enhancing view of self. Our assertion is that there are utilitarian applications of both terms in the natural progression of addressing sexual abuse for both genders. Each word is representative of a growth stage. The ultimate goal of therapy ought to be to transcend survivorship and remove the abuse experience as an issue of identity. The individuality of personhood must be paramount. Again, the key is not only being gender respectful but also not replicating the trap of more dogma.

Assessment

During the assessment period, it is vital that the therapist give the client permission to disclose his history from his own vantage point. The therapist ought not to apply any labels. The therapist's task at this point in the relationship is to learn how the client cognitively and emotionally views his experiences. Due to the social training most men receive discouraging them from noticing their emotions and the defense of emotional numbing that victimized people often use to deal with trauma, the client may not be able to describe what he felt or is feeling concerning a given experience.

Taking a sexual history is a difficult task for many clinicians. By its very nature, it demands specificity that will be dulled by the client's resistance and the practitioner's level of comfort with the client's sexuality. This is further exacerbated by a need for the chronology to include the nuances of the history or the seemingly less germane issues in the endless quest for the traumatic events. The sum total of the client's experiences are relative, and the tendency to focus on the dramatic paints a distorted picture of the person's sexuality. For example, it is imperative to look at very early childhood memories of naive sexual experimentation. Intellectually, we are aware that children have a natural curiosity and participate in age-appropriate sexual experimentation, but how this is connected to a sense of shame or guilt is paramount in the

inquiry. Too often clinicians accept behavior at face value without detailed exploration of the client's reality in relation to issues of shame, guilt, arousal, and resolution.

Even if the client comes to the therapist with the presenting issue of having been sexually abused, other factors in the client's life need to be assessed before a treatment plan can be developed. The issues of chemical dependence, other compulsive/addictive disorders, acute anxiety, depression, personality disorders, physical handicaps, low intellectual functioning, and low ego strength need to be taken into account. Rarely is in-depth psychotherapy focusing on the effects of sexual abuse successful while the client is active in an addictive pattern, clinically depressed, highly anxious, or suicidal. These conditions usually need to be addressed prior to making sexual abuse the primary focus of the therapy.

An Overview of Therapy as a Grief Process

Denial

Once the client has been given the opportunity to describe his history without the therapist's interpreting its meaning and any issues that might prevent the client from being able to function adequately have been addressed, the therapist's task becomes helping the client to clarify details, reframe experiences, and pointing out cognitive distortions. If the therapist attempts these interventions too early in the therapeutic relationship, the client will likely view the therapist as not listening or not understanding. Much of what treatment professionals label as resistance in clients is the result of impatience and not taking the time to hear the client's view of his life.

The therapeutic process of healing from sexual maltreatment can be understood as a grief process similar to the five stages described by Kubler-Ross (1969). The first stage is denial. The client will make statements such as "Nothing happened," "I don't remember enough," or "I'm just making it up." At this point, it is the therapist's task to label the experience as abuse and to use the term *victim,* even if the client balks at it. This labeling must be reinforced by providing information to the client on the covert conditioning that frequently takes place prior to any sexual contact.

Bargaining

fear

In response to the therapist's use of the terms *victim* and *abuse,* as well as the additional information concerning sexual maltreatment, the client will begin to move into the second stage of grief. In the bargaining stage, the client will acknowledge that sexual contact has taken place and may even say that it was

sexual abuse but will want to deny or minimize any negative effect that it had on him. Commonly heard phrases at this stage are "It happened, but it didn't hurt me," "It happened, but I asked for it," "It happened, but I'm over it," and "We both wanted it."

As the client repeatedly describes the experiences, it is the therapist's task to help identify emotions and to point out examples of how the victim mentality is operating in the client's view of the abuse situation. Many victimized persons still have affection for the person who abused them. It is vital that the therapist not bind the client so that he believes that he must choose between his loyalty to the therapist and his loyalty to the person who abused him.

It is particularly difficult for a client who was abused by a loved one to move out of the bargaining stage. To facilitate this movement, the therapist must assure the client that even if he hates what was done to him, he need not hate the person who abused him. Therefore, the therapist ought to avoid labeling the person who abused the client as an offender or perpetrator. Rather than labeling the person, the therapist should label the behavior.

As the denial and bargaining defenses begin to lessen, the client often experiences fear or terror. Fear is an appropriate emotional response to being violated and the realization of one's venerability as a child and even as an adult. Since males are socialized not to acknowledge their fear, when they eventually pay attention to this emotion, it is unfamiliar and can seem overwhelming. Therefore, the therapist must respect the client's response to fear. This is a time in the therapy process when many clients resort to defense mechanisms such as self-mutation, alcohol and other drug use, compulsive sexual behavior, or compulsive eating. At this point, therapist must be careful not to focus exclusively on the acting-out behaviors but instead be sensitive to the client's fear. Inappropriate confrontation can be a replication of the abuse of power that the client experienced during the sexual abuse as a child.

Part of the covert presexual conditioning process involves the manipulation of the child's emotions by reframing his emotional response in a way that will enable the abuse to take place. Therefore, the therapist must avoid reframing the client's fear as another emotion. There seems to be a tendency among many therapists to encourage clients to express anger rather than to be aware of their fear and its significance. Fear is the emotion that informs us when we are in danger of being maltreated. The awareness of having felt fear prior to or during the sexual experience is a powerful validation that it was in fact abuse. Unfortunately, because of the carefully honed methods used by many perpetrators, the victim believes that he was a willing participant, so he discounts his fear.

It is during the bargaining stage that many clients are tempted to seek prematurely to forgive or reconcile with their offender(s). This response may be due to their desire to put an end to the discomfort they are experiencing, or it may be due to pressure from family members or others to put it all in the

past or to forgive and forget. At this point, it is the therapist's responsibility to take protective steps, even if the client is an adult. The victim may be repressing or minimizing the number and type of offenses committed. He is probably underestimating the offender's psychopathy. Many clients assume that sex offenders grow out of it and therefore pose no danger in the present.

Anger

During the anger stage, the client may be heard saying, "It happened, and I really didn't want it," "She had no right to treat me that way," "It did seriously affect my life," "I was tricked and lied to," "I was treated like an object," or "I was used." This is the stage when the therapist can safely begin using the phrase *recovering victim*.

When some clients become aware of the level of their anger, it triggers fear and shame. Many victims respond to their anger by fantasizing violence or other forms of abuse directed toward the person(s) who abused them or others in their environment. These thoughts frighten the client, who is afraid that he may act on these fantasies or that he is just as bad as the person(s) who abused him, which then triggers shame and self-loathing. Some clients then self-medicate by resorting to numbing behaviors such as the overuse of drugs, food, work, religion, or sex.

As children, most victims were told, overtly or covertly, that they had no right to be angry about the abuse since it never really happened or, if it did happen, it was not abuse. Even if it was abuse, they were told, they had asked for it. In extreme patriarchal systems, the message is that children have no right to be. In other words, children ought to be grateful for existing, they are property, and they can be treated in any manner that suits the parents, particularly the father or other men in the system.

At some point during the anger stage, a client often feels great anger not only toward the person who sexually abused him but also toward the adults in his life who did not protect him from the abuser. Even in cases where the perpetrator came from outside the family system, there is usually an aspect of victimization within the family in the form of neglect. Unfortunately, many families are so dysfunctional because of chemical dependence or other addictive disorders that awareness are generally dulled. The adults are so preoccupied with other matters that they overlook a stranger who is being sexual with one of the children, and the child falls prey to the overall superficiality of the parenting. Being a member of a dysfunctional family makes a child more at risk for being sought out by sexually exploitive adults. Since the child is unable to get his needs met within the family, he is more likely to seek adult attention outside the family, regardless of the personal cost to him. Succinctly put, exploitive attention seems better than no attention at all.

When the abuse is discovered or disclosed, parents often are more concerned that it will affect their family's image in the community than they are about the child's well-being. For example, they may be afraid that their child is, or will be thought of as being, sexually abnormal. Inappropriate responses often are born out of ignorance rather than malice.

Sadness

During the sadness stage, the client is becoming aware of the losses he has suffered as a result of the abuse and is saying, "I'll never get my childhood back," or "I guess we didn't have the special relationship she said we did." Sadness is an emotion not encouraged in American males. At the risk of sounding trite, the old adage "Big boys don't cry" is still alive in homes and institutions throughout our country. Even if the statement is never spoken, it echoes in the minds of parents, teachers, and coaches and is implied through their behavioral responses to youths. In the clinical setting, some therapists see sadness in males as self-pity and are intolerant of it, preventing their clients from fully grieving their losses due to the childhood abuse.

During this stage, the therapist can begin to stop using the phrase *recovering victim* and begin using the term *survivor.*

Acceptance/Forgiveness

In the acceptance stage, the client begins to reorganize his life so that he shifts his attention from the consequences of the childhood abuse to leading an enjoyable life. Physical, cognitive, or emotional scares may remain, but they will have a minimal effect on his ability to accept himself and interact appropriately with others. He may express the view that "the abuse happened, it affected me, I am a survivor, and I am healing" or "the abuse happened, it affected me, I have healed, and I am a person like any other." The therapist's focus is on healthy behaviors rather than on any label.

At this point, both the therapist and the client are comfortable using the term *survivor.* Signs that a client has not reached the acceptance/forgiveness stage are depression, bitterness, resentfulness, hypersensitivity, or vigilance for clues of abuse; a view of oneself as powerless or childlike; and self-destructive or other abuse behaviors.

Therapeutic Style

Some traditionally trained therapists wait for the client to initiate discussion of sexual abuse and other issues. Any attempt to lead the client to describe

sexual abuse is viewed as agenda setting and disrespectful. Further, use of labels such as *sexual abuse, victim,* and *survivor* also are viewed as disrespectful, limiting the client and even revictimizing him.

We have a different view of the situation and believe that the client can experience the therapist's lack of direction as disinterest. Issue avoidance can reinforce shame and give the message that the sexual abuse is not important enough to waste time talking about. We believe that the therapist has a responsibility to model willingness and comfort when talking about difficult issues and to provide information that the client lacks.

In light of this view, we propose a pace/lead model to use when working with people who have experienced sexual trauma. This model is taken from our hypnosis training and is very effective. According to this model, the therapist's mission is to encourage the client to focus on the painful experience of sexual abuse while still respecting the rate at which the client is able to tolerate his increasing awareness of memories and feelings. The client's defenses are not to be peeled away until such time as he has other effective coping techniques, so that he will not become overwhelmed.

In hypnosis, *pacing* is heightening the client's awareness of an event that has just taken place—for example, "You may have noticed that you just blinked." A *lead* is a comment that suggests that the client become aware of something new—for example, "You may find yourself becoming relaxed." The hypnotherapist uses a series of paces and leads to facilitate the client's obtaining a trance and then provides suggestions that are more likely to be entertained by the client due to his state of relaxation and focused attention. People who have been sexually abused are usually excellent hypnotic subjects, since they spontaneously dissociate and frequently are in trance states in session even when the therapist has not used formal hypnotic techniques.

When working with clients recovering from sexual abuse, the psychotherapist can use the pace/lead model by commenting on some aspect of the client's past experience that the client is likely to agree with ("So it was then that she began to fondle you") and then encouraging the client to reframe the experience by providing a lead ("And that is sexual abuse"). By shuttling between pacing and leading, the therapist is providing information to neutralize sex-negative cognitive distortions and shame-based self-talk, and he or she is helping the client to answer the universal question "Am I normal?" means "Am I acceptable as a person after what was done to me?" These techniques can be used to facilitate the client's moving from one grief stage to another: (pace) "So he denied that he had touched you"; (lead) "And you may now notice clues that you are angry." The pace/lead model also can be used to help the client change his self-image: (pace) "So you told him you wouldn't tolerate being treated disrespectfully"; (lead) "You are beginning to see yourself as a survivor."

The grief stages and pace/lead model are two ways of conceptualizing

the very complex dynamics found in clients who have experienced sexual abuse. They are useful tools but are not a replacement for a relationship with a nonintrusive, respectful person who listens and believes in the client.

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