

# **SPEAKING THE UNSPEAKABLE: AN EXPENSIVE TRUTH**

## **AN EXPLORATION INTO THE DYNAMICS OF SADISTIC AND NON-SADISTIC SEXUAL AND PHYSICAL VIOLENCE**

by Diane Poole Heller, L.P.C., Ph.D  
MAY 4, 2000

*"The greatest tragedy is not the brutality of the evil people,  
but rather the silence of the good people."*

Martin Luther King, Jr.

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## **Biography of Diane Poole Heller, MA, LPC, NCC**

Psychotherapist Diane Poole Heller specializes in helping clients work through the aftereffects of life-threatening events to a restored sense of resiliency and well being.

Diane received her master's degree from the University of Northern Colorado, and is a National Certified Counselor (NCC) and Licensed Professional Counselor (LPC.) She is in the process of completing her Ph.D at the Western Institute for Social Research in Higher Education and Social Change. She completed a certification program and then affiliated professionally with Peter Levine, Ph.D. on the biological/physiological approach, Somatic Experiencing he designed to help resolve Post Traumatic Stress Response.

From 1992 to the present, Diane has been a faculty member of the Foundation for Human Enrichment, specializing in training for therapists and health care professionals related to treatment of Post Traumatic Stress Disorder. She teaches ongoing monthly training classes, "Therapeutic Interventions for Trauma Recovery for Professionals," regarding application of theory and clinical client management. She serves as a clinical consultant to the Rocky Mountain Survivors Center that serves international political refugees seeking asylum and survivors of torture.

Her videotape, Columbine: Surviving the Trauma features an interview with Columbine survivors and their family and education regarding trauma responses and was aired on CNN internationally. She taught a two year trauma training series including "Auto Accident Recovery Program" at the Boulder Community Hospital Mapleton Center for Pain and Trauma Rehabilitation," and has published numerous articles, manuals, and video training tapes.

Diane has done several community service presentations including "Non-Drug Approaches to Trauma Recovery" for psychiatrists at St. Joseph's Hospital, Denver and "Interrupting Cycles of Violence" at the Metro Denver Gang Coalition.

Diane teaches trauma intervention internationally, most recently in Denmark, Italy, Germany, Spain and Switzerland. She also has a private practice in Louisville, Colorado.

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**SEXUAL AND PHYSICAL VIOLENCE RECOVERY PROGRAM**  
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**May, 2000**

**PROJECT OVERVIEW AND INTRODUCTION:**

Specifically, this project develops specific strategies for the Sexual and Physical Violence Recovery Program. I will briefly discuss clinical insights and personal observations regarding sexual and physical assault, battered women, childhood incest and abuse as well as applications of a relatively new understanding of the distinction between sadistic and non-sadistic forms of abuse and violence.

I intend to explore our attraction as well as our aversion to traumatic events as a society and as portrayed in the media, particularly in the popular film culture, and in the therapists' as well as the clients' personal experiences. There appears to be a paradoxical need to tell and need to keep silent regarding atrocity.

In this paper, I will attempt to span an even broader continuum to reference the understanding and treating the wounds of war veterans, political refugees and torture victims. In the interest of gaining and providing greater clarity about these complex topics as well as utilizing educational materials I've provided in a variety of contexts, the components of this project include:

1. The presentation and videotapes of a three day workshop on this topic including interviews with the participants
2. Several conference presentation videotapes from the US, Israel, and Denmark
3. A 26 page training manual for professionals that can provide personal and clinical observations to aid therapists and other professional caregivers to understand and to treat victims of abuse and torture.
4. I also included this extensive paper in the most recent two presentations I gave on the subject related more specifically to tortured political refugees in May 2000 in Denmark. The first set of handouts will be given as a response to the Danish Professional Somatic Experiencing™ Trauma Training Groups' request last year for more in-depth explanations of Sadistic and Non-sadistic Torture Dynamics and Treatment applications. Secondly, the body of this paper will serve as a resource at a lecture that I gave at the Danish Psychologists Union Meeting in Copenhagen also in May 2000.
5. Within this paper I provide an extensive list of useful films relevant to exploring victim-perpetrator dynamics as well as many other relevant topics that can provide the reader/viewer a more direct experiential window into

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this complex and often disturbing world where torturous acts dominate or obliterate human compassion.

Personally, I have long been a curious student exploring extreme life events that often occur in the course of our mysterious and complicated human journey. I distinctly remember struggling with the intense suffering I observed and was very sensitive to as a young 5-year-old child in backwoods Pennsylvania. By the time I was 12, I had had encounters with a short abduction from which I eventually managed to escape as well as varying degrees of brutal violence outside the home in what appeared to be an "Andy-of-Mayberry" neighborhood, a testament that bad things can happen anywhere.

I saw relentless suffering inside my home, too. Because of these readily available affronts, a sense of safety escaped me. I began to study patterns of suffering, partly motivated by survival needs and partly because I carried with me deeper questions about the nature of suffering. I had a naggingly deep desire to learn about what might help to alleviate pain and to further understand the possibilities that promote healing.

Living the day to day life there brought many teachings on the origins of suffering and the avoidance strategies that worked better when trying to calculate the precise timing necessary to organize a disappearance before the next major onslaught. I also began to perceive a distinction between necessary suffering and unnecessary suffering inside this human dilemma.

How can human beings be aided in their search to rise out of the ashes like the mythic Phoenix after debilitating devastation that can befall any of us at any time within a frame of an infinite number of circumstances?

We are physical beings on a physical planet and therefore physically, emotionally, cognitively and spiritually vulnerable. We are susceptible to problems when two objects attempt to defy the laws of physics by occupying the same location at the same time such as in auto, train, or bike accidents. Gravity puts us sharply in our place during slips and falls. Natural disasters or "acts of God" such as hurricanes, avalanches, earthquakes, floods, disease outbreaks, and droughts wreak havoc on many of us as a global human species. Surgeries, illnesses and many medical procedures can feel invasive and terrifying to us. Loss of a loved one or abandonment with neglect in childhood may cause failure to thrive. War, torture, rape, assault, and sexual and physical violence injure and violate us. This last grouping constitutes the situation in which humans are intentionally harming another in the context of a distorted relationship and I refer to these very damaging interactions as "Relational Trauma".

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In this exploration, I am particularly focusing on aspects of treatment of severe trauma between human beings that I feel are significant and relevant but infrequently referred to, if at all, in the available published literature to date. I will discuss and discriminate between sadistic and non-sadistic acts of abuse and the abusers, explore the "fusion" that can occur between perpetrators and their victims, and discuss many of the significant symptoms that victims display after experiencing extreme relational trauma. This paper, the manual, and videotapes provide several general guidelines to therapists for treating victims related to these topics, and also caution against any induction of the false memory phenomenon. I delineated some suggestions on what I think may contribute to the false memory possibility and how to avoid becoming derailed there.

### **RELATIONAL TRAUMA: MAN'S INHUMANITY TO MAN**

In the abstract humans are fascinated by abuse, torture, and unspeakable violence. Witness the popularity of films and books such as Silence of the Lambs, Kiss the Girls, Seven, Misery and the Faces of Death. We seem to enjoy being vicariously titillated and creatively frightened.

However, when confronted with these abuses on a personal level, involving self, family, or friends, the picture changes. These same crimes, which inspire a rush to the theater or bookstore, create the totally opposite reaction. They often evoke a conspiracy of silence. We want to avoid these realities. They carry a social stigma and are often considered taboo subjects. It may become almost impossible for us to find a voice to speak of such atrocities much less take pro-social action against them.

Abuse and torture are realities that afflict people at the roots of their humanity, and cause them to become socially isolated, psychologically fragmented, and physically dissociated. It is crucial to understand the impact of abuse and torture on victims and how to effectively offer useful and compassionate treatment.

This paper delineates personal and clinical insights that may assist this difficult healing process toward recovery for victims of extreme relational trauma. Relational trauma means trauma induced by man's intentional inhumanity to man such as war trauma, acts of sexual assault and physical abuse as well as torture that occurs in the context of human relationship versus other types of overwhelming events such as natural disasters, illnesses, medical procedures, falls or accidents. This type of trauma requires understanding and awareness of the innate human capacity for evil. When we as human beings experience or bear

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witness to the horror of intentional atrocity, we confront a taboo and we often lose our individual or collective voice. Silence must be broken and the unspeakable spoken.

### **FACING FACTS OR FORGETTING:**

Speaking the unspeakable. Teaching and speaking the unspeakable is a challenge I will be facing throughout this paper. In this inquiry, I wish to explore "terrible knowledge", a term coined by Dr. Anngwyn St. Just, Director of the Colorado Center for Social Trauma, that aptly describes the victims' experience related to bodily violation and psychic injury occurring during sexual and physical violence including torture. I would also like to consider why remembering such traumatic events and finding an individual or collective voice to report, expose, and express appropriate outrage against them is so often "unheard of".

Finding the needed voice to speak out against man's inhumanity to man can be expensive in terms of potential losses to the truth-teller. There can be a "shoot the messenger" mentality when you break the code of silence that often comfortably surrounds and attempts to suffocate the mere mention of atrocity.

### **Risk to reputation and relationships:**

To overcome the need to look away when confronted with atrocity one must become comfortable enough with the very real possibility of damaging one's reputation and personal relationships. This damage may occur whether you are dealing with the reality and details of an atrocity from your own experience as the victim or if you are in the role of a witness, researcher, therapist or caregiver. Perhaps Mark Twain's insight is useful here as noted in his remark, "The greatest freedom is gained in losing one's reputation". implying relief at not having to prove or defend it any longer. Therapists trained in trauma work must find ways to deal with sharing the burden of pain with their clients and find ways to empower themselves as well as their clients in this important healing journey.

The book and subsequent movie, Nasty Girl, is a good example of a whole town going underground about the pro-Nazi activities that the townspeople from Passau engaged in during World War II. "Nasty girl" refers a local student, Anna Rosmus, who exposed the Bavarian town's

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involvement while doing research for a high school essay contest. Anna was severely ostracized there and refusing to be silenced, became an outcast from her home. I recently saw her interviewed on a US news program and discovered that now, thirty years and several more published books later, she is still relentlessly fighting anti-Semitism and working tirelessly to discover and report the truth. Her two daughters are helping her in her continuing search and she has moved to the States to escape being further harassed or harmed in Germany.

In a more clinical example, one of my clients began working on her personal torture history and her husband began having terrifying dreams about being Jewish during World War II. Seemingly stimulated by her retrieval of early childhood torture memories, he dreamed of being caught naked by the Gestapo and tortured in the concentration camps. He became less than enthusiastic about her healing process because it became so uncomfortable for him.

### **TRAUMA EXPERIENCE PERCEIVED AS CONTAMINATION**

There are many reasons that revealing trauma brings noticeable risk and potential personal losses for clients, researchers and therapists. One is that people often respond as if the mere mention of horrible events has a contaminating effect: that the knowledge itself is contagious. Many people prefer a sort of "information quarantine" about personal traumatic experiences from the family or friends closest to them. Granted it's hard to hear about painful realities, but avoidance won't bring answers, accountability or healing. Even when we are spared being the actual victim, witnessing or hearing about severe traumatic events can be extremely activating and overwhelming. On the receiving end, it can feel like receiving an unwanted "activation injection". Unfortunately, this activation injection can set off the same PTSD symptomatology in the witness as in the original victim. This inheritance of symptoms is termed "secondary trauma".

At times we may also want to protect ourselves from the impurity or messiness that may be projected on the victim for having been involved in a traumatic event at the hands of another human being. Instead of supporting an injured person with compassion, we, individually or collectively, may condemn the victim as "damaged goods" and want them to take their problems somewhere else or at the very least, have the "common courtesy" to keep quiet about it. Unfortunately, due the intense experience of shame

involved in relational trauma, far too many victims suffer in silence and never access the help they need.

An extreme example of this kind of thinking occurs in the Middle East where any woman who has experienced rape can legally be put to death by her husband or her own family because she is seen as impure. In a less direct way, in our culture, we attempt to put relational trauma to sleep through silencing it and sentencing the victim to alienation, shame and social isolation. "Sexual assault is a strange psychic hurricane in which the victim must, despite the evidence of uprooted trees and roofless houses, argue to the disbelieving that something happened." (Salter 1995, pg.34) Where we usually rise to the occasion during a natural disaster such as sandbagging the Mississippi against floodwaters, personal traumatic experiences of sexual assault, incest, beatings and torture seem to embarrass or overwhelm us in such a way that often renders us unsupportive, avoidant and tongue-tied.

It doesn't have to be this way. In many "primitive" cultures such as among the Australian aborigines, any personal loss or trauma is seen, experienced and grieved collectively by the community as a whole. From the perspective of interconnectedness, they understand the injury of the individual is an injury to the community and surround the victim with love and support and actively participate in the healing. I cast my vote for the "primitive" perspective.

### **FEAR AND TRAUMA AS NEWS AND ENTERTAINMENT**

Yet, interestingly enough, many in our society are glued to the television and worldwide news media that relentlessly exploits the latest horror. Loss of life comes first in importance, serious injury and financial disaster follow as second and third choice as the most "newsworthy" topics, Ed Sardella, newscaster for Denver's Channel 9, told a gathering of public relations experts. Common comments reflect a "blood sells" or "if it bleeds, it leads" journalistic mentality. Even on the highway, traffic will slow to a crawl to facilitate "rubber-necking", or the need to view the body count, injury or wreckage, that most drivers engage in for the smallest of accidents.

In effect, we can be seduced by our own fears. In some instances, we seem to enjoy the "drama of trauma" while at the same time with other scenarios, we may be repulsed and upset by it. This reflects an interesting dilemma: our aversion as well as our attraction to trauma.

“Cartoonlike entertainment trauma” or entertainment featuring violence and terror is regularly bought and sought out. We spend millions seeking out thrill seeking movies, books and Internet sites (sights) where characters are blown away and destruction explodes in written material or over the news, TV, or theater screen.

Consider the movie, The Fugitive, where at the end, Harrison Ford as the hunted down protagonist, drives away in a cab with the now believing detective for a friendly cup of coffee. He appears relaxed, jovial and completely unaffected by any of the numerous traumas he’s faced. The traumas include: the murder of his wife, his indictment for murder, a harrowing escape from prison, a jump off the Hoover Dam, nearly drowning in the river, dodging bullets from the real killer as well as the police force and many tough months on the run, etc. Yes, this “cup of coffee” outcome is incredible. It reflects the common circumstance that for most films we have to stretch or suspend credibility to become absorbed by them and entertained by them.

As long as it doesn’t feel too real or get too close, we can remain effectively de-sensitized, distanced and disconnected from these experiences in films. Often we seem to enjoy the ride and the rush of adrenaline. Do we need this fear to feel alive? If so, why? Has the harshness or routine responsibilities of life numbed us? Or is there a part of us all that needs to face dangers and deal with prey and predator dynamics? Do we need to practice outwitting threats and overcoming villains to exercise and try out our instinctual survival plans?

The facing of these types of challenges may also explain the popularity of scary fairy tales such as Hansel and Gretel where children struggle with ideas of death in the oven and intentional abandonment by parents. Interestingly enough a friend recently informed me that the original fairy tales described acts of the real mother but were later revised due to popular distaste. Consider that the poisoning of Snow White, the abandonment of Hansel and Gretel and the mistreatment of Cinderella could have been at the hands of the biological mother, not the “evil” stepmothers. In fairy tales and movies, the characters often come out undefeated and relatively unscathed. Not usually so in the world we really live in.

### **MEDIA AS EDUCATION WITHIN ENTERTAINMENT**

Unlike entertainment trauma such as The Fugitive, serious and accurate portrayals of trauma and its potent effects provide important

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insights into the realistic and often predictable aftermath of extreme life events. All of the following films are very disturbing if we remain sensitive to their content and message. Some of these film examples have been widely seen and others are relatively unknown. Nearly all of the films listed below are produced by famous directors with successful, well-known screenwriters and accomplished actors.

Such films include:

- Fearless: This film portrays with great accuracy the PTSD symptoms that occur in the aftermath of a plane crash, especially dissociation, trauma bonding, complex grief, disconnection from self and family, trauma re-enactment, delusional fearlessness, obsession with death and eventual restoration.
- Death of a Maiden: A torture victim, years afterward, suspects she's found her torturer from hearing his voice alone since she was blind-folded and has never seen him. Is he the torturer or is she paranoid? This film offers an excellent exploration into "victim becomes perpetrator" to meet her need for the truth and acknowledgement and the perpetrator's denial, insistence on lying about his innocence and his eventual confession and remorse at cliff's edge.
- Closetland: An innocent woman who is a children's storybook writer is captured, interrogated and tortured for unfounded political subversiveness. The entire film involves only two people and the complex interaction between the victim and the torturer. Expert manipulation, unpredictability and pain, as well as alternating cycles of trust and betrayal are implemented to ensure psychological and physical breakdown.
- Down Came a Blackbird: Set predominantly in a torture survivor's rehab center run by a Holocaust survivor, this film explores the profound experience of shame, extreme grief, drug dependency, insomnia and the need for secrecy and denial occurring after political torture. The film explicitly reveals details of torture, the victim's experience of flashbacks, modalities used for treatment, and the complex dynamics when the survivor's center is infiltrated by a curious perpetrator disguised as one of the victims who is eventually discovered.
- Misery: Car wreck turns to capture and abduction when a famous writer falls victim to a sadistic fan who hobbles him when he attempts escape. This film highlights complex victim – perpetrator dynamics, distortions of an obsessed, paranoid mind, and the use of violence for domination and control.

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- Silence of the Lambs: An imprisoned cannibalistic serial killer, Hannibal Lector, is interviewed in hopes of finding out valuable information to decipher complex clues in the FBI's search for another murderer. Hannibal reveals to us the inner workings of a brilliant serial killer's mind including his use of exquisitely refined empathetic attunement to plumb the depths of the interviewer's psychological self. He also uses sadistic manipulation and extreme violence to successfully escape.
- Sleeping with the Enemy: This film discloses dysfunctional interactions between a controlling, punishing batterer and a wife who cleverly fakes her demise to escape and is later discovered and stalked by the abusive husband. She calls 911 to report killing him as an intruder in her new home before she then pulls the trigger.
- Sophie's Choice: After making a soul-destroying decision about the life and death of each of her children in a concentration camp, a woman displays many significant trauma symptoms years after the war.
- Schindler's List: This film is based on the true story of Otto Schindler. Schindler began WW II as a pro-Nazi industrialist using Jews as a cheap labor force in the interest of becoming wealthy. Midstream, he switches his life focus to rescue as many Jewish people as he can by buying them from the Germans. He uses the ploy that he needs more workers for his factory and successfully saved over 5000 Jews. Note: He never recovered from the horror of the war and his earlier participation in it. He died feeling a failure even though he is still revered by the Jewish community today.
- Saving Private Ryan: American troops invade the beaches of Normandy. The film puts the viewer "up close and personal" to the bloody reality of war. The film chronicles survivor guilt, tremendous loss of life, and several symptoms of war neurosis.
- The Insider: A difficult moral dilemma befalls a fired tobacco industry scientist. This film highlights the loss of relationship, career, and family from his decision to expose a dangerous truth that powerful forces attempt to suppress. He speaks an expensive truth.
- Zentropa: This film highlights powerful corruptive forces alive and well in post war Germany including a focus on idealizing war criminals, suicides and Nazism gone underground.
- Nasty Girl: A German high school student researches her small hometown's involvement in WWII to discover a widespread but

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denied pro-Nazi activity and support. She is ostracized and becomes an outcast and is still, 30 years later pursuing her research.

All of these films offer a valuable contribution by educating us about authentic human atrocity and vulnerability. They teach us some of the more realistic experiences and reactions involved when confronting trauma personally and publicly.

However, there is nothing we are personally called upon to do when viewing violence as entertainment. We get vicariously scared versus personally scared, we catch the temporary thrill of a two-hour action movie without being moved to any personal action. But, what if these dramatized traumatic events were actually occurring in front of us in real life instead of in "reel life"?

### **HUMAN VULNERABILITY AND THE REALITY OF EVIL**

Our reactions as a culture vary greatly when confronted with the actual plight of an abused child or other human rights violations such as the torture of political refugees or mass rape of women as a tactic of war and political repression. Some people are incredibly brave and creative in their fight against injustice. Many show tremendous compassion and courage in the face of great odds.

#### **Blaming the Victim: the Stockholm Effect:**

Some of us become numb and perhaps even condemning. The Stockholm Syndrome studies report the general human tendency to blame the victim. The example often used tells the story of a young boy sent to the grocery to buy bread. On the way back, he is beaten and robbed of his remaining money and the bread. Arriving home the parents, seeing their small son beaten and bloodied, ask him questions like "Why did you come home that way?" "Why didn't you run?" – all implying that he had simply made poor choices and was somehow responsible for his troubles. This reaction is not caused by a lack of love and concern on the parents' part, but more likely reflects their reaction to intolerable feelings of being totally helpless, out of control, and extremely distressed at not having been able to protect their son.

#### **Encouragement of Stoicism:**

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In much the same way that, in our culture, nobody likes a loser, not many of us seem to be fond of the victim either - especially one that has trouble rising above his or her circumstances. We entertain the stoic Monty Python English ideal portrayed in Search for the Holy Grail when the black knight has increasing numbers of limbs hacked off and continues to fight in good humor, referring to his injuries as "not a bother". Victims bother us, however, because they put us in touch with our own potential helplessness. Most of us need to feel in control to protect our sense of safety in the world and we often don't like people reminding us that that safety bubble can be burst.

### **Releasing the Fantasy of Invincibility**

To effectively study and work with trauma, we must face undeniable human vulnerability as a natural phenomenon in the real world that is representative of all of us, not just the "unlucky ones". Our unfounded fantasy of invincibility is confronted and exposed. We may bear witness to horrible unspeakable events but can we dare to speak? To act? It is especially difficult if the events are happening to us or in our own family. It "ups the ante" significantly to see ourselves, a significant other or close friend endure tremendous hardship. We cannot stay as neutral as we might like in holding tightly onto the literal remote control and viewing an atrocity happening to strangers somewhere else. In relational trauma, we get pulled in to the dynamics of the victim and the perpetrator. We have to choose to look at or to look away. We have to choose to act or to stand by.

Perpetrators promote forgetting and greatly minimize the reality or impact of their acts and/or their accountability. (Note: Throughout this paper I use the convention of "he" to reference the perpetrator and "she" to reference the victim. This is not only for stylistic convenience and continuity of discussion, but also as a reflection of the statistical fact that more, but not all, perpetrators are male and more, but not all, victims are female.)

"Secrecy and silence are the perpetrator's first line of defense. If secrecy fails, the perpetrator attacks the credibility of his victim. If he cannot silence her absolutely, he tries to make sure no one listens. After every atrocity one can expect the same predictable apologies: it never happened; the victim lies; the victim exaggerates; the victim brought it upon herself; and in any case it is time to forget the past and move on." (Herman, 1992 pg. 8)

## **AMNESIA AND ATROCITY; A COMMON PACKAGE DEAL**

At times, as a people, we respect and encourage denial and forgetting atrocity. Then we seem to cycle back through a periodic serious and intensive remembering such as the revival of Holocaust interest at the 50th year anniversary of World War II, or the war tributes and memorials related on the 25<sup>th</sup> anniversary of Vietnam. Anniversaries in general are powerful reminders of traumatic events and often trigger an upsurge of symptoms for the witnesses and victim that survived them.

It's not just the difficulty of facing facts but of staying in contact with them long enough to promote pro-social activity or personal healing. I feel we need to compassionately understand the challenging nature of developing a genuine "trauma tolerance" in the face of overwhelming events especially when they become "up close and personal". Biologically, amnesia comes with atrocity as a protective shielding device whether we are participants or witnesses. We all have special needs that must to be met in order for it to be safe enough to keep our eyes open and our awareness alive. This is far from an easy task.

### **Pacing and the Need for Body Awareness:**

We need to expose and integrate traumatic experience gradually and at a pace that is tolerable to us. We need an empowering approach that fosters developing clients' capacities and promotes renewing a sense of safety and resiliency. We need internal and social support. Healing is expedited by facilitating psychotherapy that includes a body awareness to aid re-embodiment and discharge of excess activation or charge bound in specific symptoms. Facilitating completion of thwarted instinctual survival mechanisms mobilized by facing threat aids this capacity for discharge and consequent reduction of related symptoms. Dr. Peter Levine has designed a highly innovative and effective approach called Somatic Experiencing®. It is described at length in his book, Waking the Tiger: Healing Trauma.

### **Need for Social Context to Support Trauma Research and Healing**

Judith Herman discusses the importance of social context related to traumatic events in her insightful book, Trauma and Recovery. She tells us that "To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in a common alliance. For the individual victim, this social context is created by

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relationships with friends, lovers, and family. For larger society, the social context is created by (and dependent upon) political movements that give a voice to the disempowered." (Herman, 1992, pg.9)

For example, for war trauma to be recognized, studied and treated, we must, as a society galvanize a political movement that questions the sacrifice of young men and loudly objects to the horrors they are forced to endure. In addition, we must become familiar with the secondary Post Traumatic Stress effects on their families when soldiers return home terribly harmed and most likely unhealed. Dr. Anngwyn St. Just discusses the ongoing psychic fallout including drug addictions and incest, trauma re-enactment and other transgenerational difficulties caused by unresolved war trauma for relationships and families in her highly perceptive tape series on Men, Women and War.

There is a South American proverb that states, "Eyes that remain open never grow old". That is perhaps true if what you are seeing can be digested, integrated and transcended. All of us have a varying degree of how much overwhelming stimulus or activation we can tolerate before we literally need to shut down. If we take in too much at any one time, we can suffer the consequences of increased Post-Traumatic Stress symptoms on our own personal healing journey.

### **Caregiver's Vulnerability to Compassion Fatigue**

Overcome by too much traumatic exposure and too little support, many bystanders or professional caregivers also experience secondary traumatic stress responses echoing those listed for survivors in the DSM-IV. Caregivers involved with trauma in an ongoing way may eventually experience "compassion fatigue". This results from bearing witness to trauma to the extent that we can no longer stay healthy and emotionally responsive ourselves as therapists. Compassion fatigue is well researched by Charles Figley in his book bearing the same title and a recommended read for anyone in the trauma recovery field.

Inger Agger, a thoughtful Danish writer, experienced researcher and trauma therapist, poses important questions in her book, The Blue Room, "How can therapists contain the (client's horror) stories and manage our own pain? How can we convert our (individual and collective) pain into pro-social struggle?" Dr. Agger suggests a therapeutic use of narrative to aid the healing process. When trauma is recognized and given its due, we begin to approach or accomplish transcendence; clients as well as therapists often

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find ways to contribute to society from the depth of their new healing and hard won wisdom and understanding.

## **SADISTIC AND NON-SADISTIC ABUSE AND ABUSERS**

In this section I will explore two identifiable types of abuse and abusers: non-sadistic and sadistic. In the following pages I will draw on the excellent and relevant research denoted in Anna Salter's book, Transforming Trauma. "Of the different typologies for classifying offenders, the division of the sub groupings into sadistic and non-sadistic has the most salience for understanding victims because of the dramatic difference in the victim's experience."(Salter, 1995. Pg104) I will attempt to clearly describe and discriminate between these two types of abuse from my personal and professional observations regarding the experience of non-sadistic and sadistic abuse from the perspective of the perpetrator and the victim. I will also clinical treatment implications for therapists working with both types of abuse.

### **THE PERSPECTIVE OF THE NON-SADISTIC PERPETRATOR**

#### **Lack of Empathy, Attunement or "Perspective-taking" Ability:**

The non-sadistic perpetrator has very little or no empathy with his victim; he cannot "see" his victim. "In one study, empathetic concern did not differ between sex offenders and a matched sample of non-offenders, but 'perspective-taking' did. In other words, even individuals with a capacity for empathy were unaffected by the pain of others if they did not take the others' point of view and correctly identify the feelings. Without effective perspective-taking, empathetic concern is as useless as a smoke detector with a working siren but a broken sensor."(Salter, Kairys, & Richardson, 1990 pg.115-116)

The non-sadistic perpetrator has little capacity or interest in understanding his victim and engages in thinking errors such as believing that the victim deserves or desires the abusive activity or invasive contact. This rationalizes his behavior so that he can continue to only consider his own pleasure, needs and desires. The victim is used and ignored and often comes out of the experience believing that she doesn't matter, her feelings, needs and desires don't matter, and that the experience itself wasn't even important because she is so insignificant.

#### **Abuser's Blindness to Victim's Aversiveness and Arousal Patterns:**

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The non-sadistic perpetrator will not acknowledge the child or adult victim's lack of consent or choice. He will not perceive the victim's aversiveness, pain or fear regarding the abuse. "The typical child molester wants to believe that children want to have sex with him because he is not sadistic. Recognizing the child's aversiveness would be a turn off, that is, would decrease his arousal rather than increase it..." (Salter 1995, pg.114).

Another vivid example of victim invisibility was observed in the study of rapists. "The decision to rape is so much an internal one, based on anger and power needs, that rapists frequently do not recognize their victims in court."(Salter, 1995, pg.67) The victim only serves as a de-personalized receptacle for the abusers' violence and his need to discharge anger. The abuser's distorted view of reality is projected onto the victim as if she is nothing; as if she is a blank screen that any "movie" or fantasy created and directed by the perpetrator can be played out upon. The screen is just a screen and has no personal qualities or value in and of itself except being there to reflect projected images.

When I demonstrate this situation in front of a live audience, I have an assistant hold up a white sheet in front of his or her body to show how the victim is effectively "blacked out" from the abuser's view. The perpetrator's own beliefs about the abuse are reflected back to him in how he "chooses" to see his victim as well as the starring role he plays in his own "movie".

### **Abuser's Thinking Errors and Lack of Responsibility:**

As I mentioned before, the non-sadistic abuser does not usually consciously acknowledge that his behavior is wrong and refuses to see that the victim is frightened or hurting physically or psychologically

During a taped interview, for example, a child molester of a 4-year-old described his view of his victim. "She was acting just like a little whore...She got out of the bathtub and ran around the house nude."

Another molester of a 2-year-old said, "She knew just what she wanted and how to get it."

A father who molested his three daughters exposed his perspective:

"I admit to incest, but I'm not a child molester. Incest was something we did as a family." (Salter, 1995, pg. 114)

Even if the perpetrator does become aware of his behavior as inappropriate, he often does not stop or often he feels that he cannot choose to stop.

### **Internalizing the Perpetrator's Projections:**

"The non-sadistic offender is not accurate in assessing the victim's reactions, and offers her an image of herself that has little authenticity. However, children's beliefs about who they are and what they feel are influenced dramatically by feedback from the environment, and eventually, the offender's projections onto the child are internalized by her, creating shame, confusion, and conflict. The voice of the perpetrator, as it surfaces in treatment, reflects the internalized false and extremely negative self image developed by the victim. The abuser's voice that lives in the adult survivor is consistently punishing and harshly self-critical toward the victim.

One of my clients, I'll call Teri, was assaulted as a teenager by Stanley, a long time friend and trusted co-worker at a restaurant when she stayed late to help out. She reports, "He said to me that I wanted the sex and that I enjoyed it because my body responded to his fingers touching me...there. I feel really bad because I had an ...my body felt good at some point. How could my body do that? I hated him. He said it was my fault anyway for being attractive. He said I'd flirted." He ignored her tears and terror and overpowered her attempts to escape while living out his own fantasy. "I couldn't tell anyone. He threatened to tell everyone at work that I was a slut. I thought he was my friend. My parents and the boss at the restaurant accused me of being lazy and irresponsible for not going back to work. They didn't even get how scared I was. I couldn't talk about it. I'd just start throwing up."

Teri never told a soul what had happened in this brutal assault. She fell quickly into social isolation and it was several years later that her story, hidden within several PTSD symptoms and connected to several other childhood traumatic events, surfaced in therapy. It took her a long time to feel safe and to find words to tell her story. It was of utmost importance that I compete with the perpetrator's voice and that I help this estranged young woman hear my voice defending her and placing the blame and shame where it belonged - on the abuser's violent and horrible acts.

Gradually she found a more objective perspective of the rape and wrongdoing that had really occurred and stopped blaming herself, her body's response and calling herself, "Stupid idiot", over and over again for having trusted this man. She began to feel safe enough to feel and express appropriate rage toward Stanley and her parents. Eventually self-acceptance, as well as an expanding social support system of slowly trusted friends, began to replace the shame and alienation Stanley had instilled in her. She went back to school and

became a director of a school specializing in helping abused teenage girls in California. She's tough and compassionate and "gets it".

The victim may identify with and internalize the perpetrator's projection and voice. This happened with Teri regarding taking in Stanley's distortions. The victim often buys into the abuser's projection because the abuse usually happens in isolation and there literally is no one else there to compete with the abuser's view and voice. There is no one available help the victim "reality test" the situation objectively or to help them disown the abuser's distorted perspective. In addition, due to the threatening or abusive situation, the client is in a highly charged and, therefore, a highly receptive state to suggestion and influence.

This receptivity is especially true with young children who rely on adults to teach them how to define normalcy and how to perceive a situation. An abuser might say, "All little girls do this with their Daddies. Isn't this nice?" Some non-sadistic offenders are so skilled at gradually grooming children for fondling and incest by manipulating their view of what's happening to them that victims don't even realize that they have been victimized.

### **Perpetrator's Empathetic Variability:**

Of note, the perpetrator may only have a lack of empathy in relation to the abusive acts and it is possible that he or she is protective of the victim in other circumstances, which makes the abuse even more confusing for the recipient. This capacity for empathy and kindness in other arenas that the abuser demonstrates to the community is also why many friends or family members cannot believe the victim.

If the non-sadistic perpetrator does finally "see" his victim and is able to have empathy related to the effects of the abuse, his arousal response is dampened and diminished as he recognizes the pain and suffering of his victim. When empathy occurs, it is possible that the perpetrator may stop the abuse, and he may even be sorry for his abusive actions, whether the acts consist of physical or psychological abuse.

### **Batterers and Cycles of Deviant Behavior:**

For example, a battered wife may become very confused when her husband apologizes after beating her or verbally abusing her, because he may follow the abusive episodes with loving, romantic moments. This often reflects a typical deviant cycle in domestic violence as described in The Verbally Abusive Relationship by Patricia Evans. In this kind of case, the perpetrator may be non-

sadistic, but often continues acting out the deviant cycle. If in fact, he is able to see his victim's "otherness" and respond with sincere attunement, he may see that his victim is a separate person who is in pain.

A great internal shift in his perspective is necessary and the need to misuse his power by overpowering must be addressed. Batterers enjoy a "power high" when they dominate; they report feeling nourished or fed by subjugating those around them within their control. Batterers live in a different worldview that defines success and good feelings by achieving dominance. They view fulfilling each other's needs in a relationship or supporting another's views as weakness. They do not attempt to please or empower another because they see that as losing power. Reciprocity in a relationship, or both partners achieving personal power, feels to them like they are losing their needed edge and leverage.

Sleeping with the Enemy is a film that clearly demonstrates the dynamics of battering behavior. The dominated partner often lives in the mutual empowerment world and believes that if she can give the batterer what he wants then he will reciprocate. He plays on that hope to make more and more outrageous demands and often tells her the beatings are her fault because "the towels weren't straight or the spices aren't alphabetized". These different worlds don't match and the partner needs to realize that the batterer is most likely uninterested in changing or unable to change. Something big like a traumatic event is often necessary to shift the dynamic.

In most battering situations however, the batterer must be motivated to heal himself and redefine his distorted sense of personal power. He needs to develop the enjoyment of and capacity for mutual shared power versus feeling "big and strong" *because* he feels dominant wielding power over the partner.

### **NON-SADISTIC ABUSE AND THE VICTIM'S PERSPECTIVE**

As I mentioned earlier, we develop our sense of self through reflection from significant others. Ideally, the mirroring and reflection is accurate, attuned and supportive. Then children can gradually build a strong identity and separate from their parents to become whole, autonomous beings, and as adults, they can feel more secure in their "otherness." A personal identity develops greatly influenced by mirroring and reflection from parents as a child grows up and is confirmed and validated by other people along the way. When there has been "good enough" positive mirroring, self-validation gradually is relied on more than measuring one's sense of value based on the external approval or disapproval of others.

#### **A Lost Sense of Self as well as Emotional Invisibility:**

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In non-sadistic abuse, the victim's self-esteem becomes practically non-existent because the perpetrator does not recognize her as a whole and separate person with individual needs and desires. She feels invisible as if she doesn't matter. This invisibility attacks a person's fundamental sense of existence. She needs to explore and lay her rightful claim to that unknown territory of self behind the screen the abuser placed in front of her to hide her own reactions and reality. She needs to become free of being a screen.

However, when a victim is merged with a perpetrator who does not see her at all, then she cannot see herself. Not only does the victim not trust other people, she does not trust or know herself. She has not developed a full capacity to trust or recognize herself because the perpetrator did not acknowledge, much less empathize with, her separate "personhood."

Another client, Tim, reports feeling as if he doesn't exist or that he is fundamentally bad. His teenage mother was soon left by her teenage husband and took out her pain and frustration by beating Tim and then often abandoning him to the care of relatives or foster care.

"I feel like she (mother) hated me. She always told me what a burden I was and she had such hateful eyes. She'd get crazy out of control and couldn't stop hitting me. Nobody cared enough to keep me. Sometimes I feel blank inside. I want to die. It's as if nothing is inside and my body stays really tense to hold some sort of identity together. If I relax I'm afraid I'll disintegrate into nothing...I get angry with my girlfriend who always seems to know what she wants and gets her way. I'm always sure of what she's feeling and she never pays enough attention to me. I have trouble standing up for myself or knowing what I want. So I just get angry. She thinks I'm a wimp. I'm scared she'll leave me again."

### **Challenging the Victim's Tendency for Co-dependency**

Although this client has lost the capacity, or has never gained the capacity, to "see" herself, the victim is often hyper-aware of others. In order predict behavior and to protect herself from her abuser, she has to become adept at recognizing the perpetrator's moods, desires and needs. As a result, the victim relates to the world in a distorted way, disregarding her own true feelings. The victim may become skilled at reading other's wishes, feelings and states, but she is unaware of her own. She becomes emotionally invisible and undefined. This often leads to co-dependent behavior and difficulty in identifying and expressing one's own needs, feelings and wishes.

### **Worthlessness to Worthiness:**

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Due to implied messages or outright accusations, the victim is likely to emerge from abuse with the belief that she is shameful, unimportant, worthless, and bad. She may feel self-recrimination and that, being “nothing”, she may decide she deserved what she got. The therapist can help the client to recognize, deactivate and gradually erase the impact of this internalized negative self-image.

The client will need to learn to develop her own reality to counteract and separate from the perpetrator’s damaging projections. This involves defining herself, finding the appropriate language for what happened to her, rediscovering her feelings regarding abusive events, and defining a sense of self so that she can know who she is and what she wants now.

## **NON-SADISTIC ABUSE AND TREATMENT IMPLICATIONS**

### **Being Attuned, “Seeing” the Client and Correcting Self-image:**

Because the victim in non-sadistic abuse is emotionally invisible, it is the task of the therapist to “see” the client accurately. Because the client was abused while being emotionally invisible, safety, for the victim of non-sadistic lies in emotional visibility. (Salter, 1995) The client usually finds relief in having her feelings, desires and states fully recognized and acknowledged during therapy. The client is afraid of not being fully recognized because, when the non-sadistic perpetrator did not see her as a separate being, that is when abuse occurred. The therapist needs to extricate the client from the self-image that was inaccurately mirrored to her, which has been “borrowed” or “introjected” from outside of her reality.

Being seen in an attuned way and with unconditional positive regard is a powerful corrective experience for the victim of non-sadistic abuse. The therapist might reflect the client’s feelings or insights back to her. For example: “I can see you are feeling sad about the losses you’ve experienced.” Or “You are very insightful about your own healing process and seem to understand what you want in your life now.” Sincere and supportive attunement to help the client experience being seen and understood accurately is a keystone for successful treatment and a huge relief for the client.

### **Aiding the Client’s Discovery Process of Needs, Feelings and Desires as well as Personal Identity and Internal Authority:**

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The client also needs to be encouraged to discover what her own feelings are rather than predominantly mirroring back the feelings, desires and states of others. In treatment, this client may over-focus on you as the therapist or on others' needs and emotional states while remaining unattuned to her own. The client needs to develop a sense of her identity and personal authority in her life. She needs to be consistently brought back to self-referencing questions such as "What do you want?" "What do you need for yourself in that situation?" because a primary therapeutic goal is to identify needs and desires that the abuser ignored and to help her reconstruct her awareness of her personal identity.

Clients will often ask for advice because they want you to tell them what to do. BEWARE. This can be a therapeutic trap. The client may feel drawn to asking you (and others) for direction but may rely on it to avoid making her own decisions. Also, she may seek advice and then reject it, feel belittled by it, or feel that you are taking control. This pattern reflects the original relationship with the self-absorbed perpetrator transferred onto the therapist and is an example of traumatic re-enactment. Sometimes we miss this tricky dynamic because in our efforts to be supportive and helpful, we may be prone toward giving well-intentioned advice.

### **Appropriate Language for Therapeutic Interventions:**

We can make suggestions and give information depending on the situation that sounds something like this: "Some people find it helpful to take a class on relationship skills. Others might want to rejuvenate their marriage by planning a fun getaway with their partner. Some people may feel that the difficulties are too great to overcome and want to explore finding a mediator or attorney to guide them through a divorce. What kind of options have you considered for yourself?"

We can however give effective interpretation of the situation as we see it - such as "It seems you are having a difficult time making that decision." Or "Sometimes it's hard to figure out what you want. It may take some time for you to determine what your needs, desires and feelings are." Or "It seems so easy to know what everyone else wants...But what about you?" Or "It sounds like you are finding some insights that are important and meaningful to you." The emphasis is helping the client to find that elusive "I". You need to avoid language that references you or your opinion and emphasizes theirs. Instead of saying, "Tell your family what you want." you might say, "Does your family know what you want? Why not?" or "Do you want to tell them? What might you tell them?" In this way you as a therapist need to avoid having an agenda other than to help the client do the difficult work of finding themselves. It will also be an enriching,

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exciting, and liberating discovery. As wounds heal, finding oneself is less and less painful and more like a joyful reunion with a treasured personal friend after many years of separation.

### **Disowning the Perpetrator's View, Dealing with Betrayal, and the Effects of Unpredictability**

The therapist also needs to help the client recognize that the perpetrator's point of view is skewed and distorted, abnormal and unacceptable and to help them separate from it. The client did not want or deserve the abuse. The victim of non-sadistic abuse has usually developed a severe and harsh "inner critic," which is the negative voice of the perpetrator that has been internalized by the victim. This inner critic has helped to bolster the perpetrator's ideas in the victim's mind. The internalized offender's voice typically embodies three core beliefs: that the child is worthless, enjoyed the abuse, and is responsible for it." (Salter. 1995. pg. 117)

In long-term chronic abuse the perpetrators of both sadistic and non-sadistic abuse manipulate the client through unpredictability and the client usually experiences alternating periods of trust and betrayal. The therapist must be aware that clients who have been victims fear betrayal and abandonment in all relationships including the therapeutic one. Trust can be easily disrupted.

### **SADISTIC ABUSE AND THE PERPETRATOR'S PERSPECTIVE**

#### **Sadism Defined:**

The sadistic perpetrator is cold and calculating as opposed to explosively violent rapists. The sadist may describe his act, pause until terror escalates, and then slowly torture his victim. Langevin defines sadism as "a sexual activity anomaly whereby as individual derives sexual gratification and control over his victim, from their fear, terror, humiliation, and degradation, as well as their injury and death. (Langevin, 1990, pg.106) One sadistic killer would tell his victims prior to his assaults:

"First I'm going to torture you in the most horrible and painful manner I can think of. Then I'm going to abuse you sexually in the most degrading way I possibly can think of. Then I'll kill you in the slowest and most painful way I can conceive...Do you have any questions?" (Heilbroner, 1993, pg. 147)

Surprisingly, in studies involving personal taped interviews with several sadistic serial killers, the men report an amazing absence of anger or rage directed at their victims. They are generally more aware of being detached. One serial

killer admitted he was “resentful of all girls”. (Salter, 1995.) While sadistic serial killers like Ted Bundy or the Hillside Stranglers who murder are the most famous, many sadists torture, but do not kill, their victims.

### **Perpetrator’s Empathetic Penetration of the Victim:**

Unlike the non-sadistic perpetrator, the sadistic perpetrator can “see” his victim completely. In fact, an accurate, albeit malevolent, empathetic connection with the victim exists for the sadistic perpetrator. He gets inside his victim: the victim is exposed and completely known versus invisible. The victim’s every reaction and any nuance of emotional and physical response to pain is carefully and expertly monitored.

An adult client reports part of her experience during a sadistic assault when she was 12:

“He locked his eyes on mine demanded that I keep my eyes open. I wasn’t allowed to look away or break eye contact in any way. If I did, he’d up the ante and do something even more painful. His eyes were vacant, black, evil and penetrating. I felt completely exposed and penetrated by those evil eyes. Looking back on my recovery process, the sexual and physical pain was easier to tolerate than the soul piercing violation I experienced from those haunting eyes. Every time I talk about it, or flash on that image which feels burned into me, I feel terrified again.”

She is trapped. There is nowhere to hide. Through his heightened attunement and skill in reading this victim he manipulates her and her responses. The victim is not allowed to dissociate and if she does, the perpetrator will attempt to “make” her stay in contact. One perpetrator, seeing that his victim was distracting herself by staring out the window, closed the curtains, others inflict greater pain and threaten the victim not to look away. These reactions show that the sadist is greatly attuned to the victim and his overt intention to evoke pain and terror. In contrast to the victim of non-sadistic abuse where the victim becomes invisible underneath the offender’s projections of his own internal distorted reality, the victim of sadistic abuse is seen and she is known, but in the most horrible way imaginable.

The sadist is an expert and highly skilled at his “job.” The sadistic abuser intentionally uses this knowledge gained from empathy against the victim to increase the victim’s terror, pain and degradation. The perpetrator feeds on the victim’s fear, terror and pain as if it is a nourishing meal. This feeding on another’s intensely painful reactions seems to produce intense sexual arousal and a “high” much like certain mind-altering drugs.

### **Violence and Arousal Patterns for the Sadistic Perpetrator:**

The sadistic perpetrator's arousal is heightened by the victim's suffering rather than dampened by it, and he will continue or increase the abuse if he sees that, indeed, his victim is truly suffering. Ted Bundy and the Hillside Stranglers were self-acclaimed masters at this manipulation and heartlessness.

Rapists who are non-sadistic often experience arousal to both consensual and forced sex, but not to depictions of physical violence without a sexual component. In contrast, studies have determined that sadists are often not aroused at all by consenting sex, but may be particularly aroused by non-sexual assaults and violence. (Abel, 1977) This could be taken to mean that sex is used more as a method or tool to inflict pain, humiliation and degradation rather than for sexual satisfaction for the sadist.

The sadistic perpetrator does not need to deny his victim's suffering; he or she wants to intentionally increase it. Sadistic abusers crave the fear and helplessness of their prey; they enjoy it and are greatly aroused by it. This craving is intense and the intervals between "feedings" often grow shorter and intensity of injuries inflicted on victims often escalates over time.

### **SADISTIC ABUSE AND THE VICTIM'S PERSPECTIVE**

#### **Deception Develops as a Safety Device to Defend against the Sadist:**

In sadistic abuse, the victim feels painfully exposed and highly visible because the sadistic perpetrator knows her so completely and uses this knowledge specifically to hurt and threaten her. Any expression of caring or interest in anything was dangerous because it could be taken away or attacked to hurt the victim. Wanting, needing, desiring, and reacting all provided obvious ammunition for the abuser. As a result, the victim in sadistic abuse often needs to hide her feelings to avoid being known as much as possible. Hiding her real experience from the torturer, and later from others as a symptom of the abuse, is the only tactic that preserves for her any shred of self and safety. The victim finds vulnerability and exposure nearly intolerable, and she has learned that she needs to deceive the outside world about her real feelings because, in that way, she believes she can avoid abuse.

Trusting someone, even she believes that they are safe, feels extremely risky. After revealing herself to someone she considers safe she may feel a need to disconnect or to end the relationship. Even as trust develops in the safety of effective therapy, she may continually need to test the therapist whenever she begins to reveal more of herself. I feel that this happens within the survivor for several reasons. She believes self-exposure will lead to painful attacks. She feels that the other will see her as damaged or evil like the perpetrator, and she may feel anxious that the person she told will be harmed or destroyed by the perpetrator because of his threats to her about breaking silence.

### **Sadistic Perpetrator's Projection of Evil and Victim's Introjection of It:**

The sadistic perpetrator often projects his own sense of being sick, perverted, dirty and evil onto his victim – which unfortunately, in his case, is true. This creates an extremely negative self-image. Taking in the perpetrator's projection, the victim can feel that she is just as evil, horrible and slimy as the perpetrator. Fusion between the perpetrator and victim in sadistic abuse is intense because, in a sense, they shared the same psychic space during the torture and abuse. This can also happen in non-sadistic abuse but is much less intense.

While the sadistic perpetrator is predominantly detached and feels through his victim, the victim has tremendous difficulty disconnecting from the abuser because she feels as if he resides deep inside her body and experience. One person described the difference in an unusual but insightful way. Referring to the non-sadistic abuse she had endured at the hands of a parent she felt she could put the abuse "in the dishwasher" in contrast to the sadistic abuse she'd received at the hands of a practiced sadist - she felt he inhabited "the whole house."

## **SADISTIC ABUSE AND TREATMENT IMPLICATIONS**

### **Being Seen Holds Initially No Solace for the Victim of a Sadist**

Unlike the victim of non-sadistic abuse, the client who has been the victim of sadistic abuse is *afraid* to be "seen." The therapist must use caution in using empathy with a victim of sadistic abuse because that is what the sadistic perpetrator used as a weapon against her as a tool for pain and suffering. The client will often be very clever at hiding her feelings because there was danger in revealing them to the sadistic perpetrator. It can take quite some time for a therapist to get a complete history from a victim of sadistic abuse because she is in the habit of hiding rather than revealing feelings, events, etc.

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Even though being seen and remaining safe is a relief on one level for the client, the client may suffer intense anxiety over revealing her feelings as she becomes better “known” by her therapist. The client may go through periods when she appears to be healing, but at other times she may also seem to be losing ground in her healing process. “High levels of de-compensating anxiety may be generated by the ‘being known’ quality of therapy that is all the more debilitating for the client because of the confusion for both the client and the therapist that accompanies the deterioration.” (Salter, 1995, pg.122)

(NOTE: Victims of sadistic abuse usually have high anxiety reactions when they encounter situations where they are required to wait. Waiting was often a part of the torture process used by the perpetrator to increase suffering and build terror in the anticipation of the next painful event. Therapists are well-advised to be sensitive to a client’s understandable reactivity about waiting and to inform other professionals involved in the treatment to be particularly conscious of being on time for sessions or appointments with clients dealing with this element of abuse. Also, many medical procedures are often intense triggers due to the sense of bodily invasion and the use of tools that often result in pain or discomfort that may feel too close to the original tactics used during sadistic abuse.

As a clinical illustration of this point, a political refugee was sent alone to the hospital because it was determined that he needed an MRI for treatment of an injury. He was strapped to a narrow table and was about to be sent into the narrow tube for the MRI procedure when he ripped off the straps and ran wildly out of the hospital. His caseworker at the Torture Victim Rehabilitation Center could not locate him for three days afterward because he literally went into hiding in response to this unfortunate experience of trauma re-enactment. He needed someone to be there with him to support him through the experience and help him distinguish between safe medical care and previous similar circumstances that had trapped him while being tortured.)

### **Helping Clients Find Safety Outside of Deception**

The client needs to realize that safety no longer lies in deception and that she will receive compassion rather than torture when she becomes vulnerable. As usual, the therapist must provide a safe, benevolent environment in order for this to take place. The therapist needs to be aware that the use of empathy is a double-edged sword for the client. The victim feels gradually better being supported in her real self “coming out” to find the comfort of safety with the therapist and selected others but cannot avoid lapses into recalling the dangerous and self-destroying empathy and malevolent connection used by the torturer.

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The ongoing fear of being known makes therapy and any other sort of intimacy a rough and perilous ride. Therapy for survivors of sadistic abuse which, of course, includes tortured political refugee survivors as well, needs to proceed slowly with constant attention to the client's reactions to self-exposure, exposing details of the abuse and becoming known to the therapist and others. **WARNING:** As a therapist, don't take the client's show of trust for granted and superficial reassurances from the client need to be disregarded when accompanied by decompensation. The client may not, in fact, distrust the therapist but may be more under the influence of her reactions to the sadistic abuser. When overt actions or symptoms and words expressed by the client differ, "the therapist is well-advised to shut her ears." (Salter, 1995, pg. 122)

### **CLIENT EXTREMES CONCERNING ISSUES OF TRUST**

Often it is difficult for a client, whether she is a victim of non-sadistic or sadistic abuse, to build a "realistic" trust with a therapist or anyone else. Because the wound to basic trust is extreme, clients may be extreme about trust. Clients may react to this wound by "throwing their trust" onto everyone unrealistically, naively, and indiscriminately perhaps, in part, because the need to be rescued from abuse and life-threatening events is so strong. She needed a protector, but no one was there to protect her from the perpetrator, so now she may be constantly seeking a rescuer and trusting people she doesn't know well enough for them to deserve it. She will naively trust anyone.

Or she may over-generalize the wound in trust to mean that it is too dangerous to trust anyone, no matter how trustworthy they actually are. It is also possible for a client to revert from one extreme to the other; she may trust everyone and then no one. This kind of split originates from her wounds. Of course, either of these extremes is limiting or potentially dangerous to the client.

The therapist needs to help the client develop discriminating awareness in order to help her recognize who can be trusted and who cannot be trusted. She needs to reconnect with her body boundaries and trust her own "gut reactions" in all situations. Trust in relationships takes time. It develops and is earned over time. No one is completely immune to unanticipated disappointment or betrayals that injure or destroy trust but we can help the client develop concrete skills separate from her over-reactivity to her abuse history that can enable her to better assess trustworthiness.

### **Working Radar Without Safe Responses**

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Picking up the information isn't enough for the client to increase her "relative safety" in the world. She needs to learn about active responses to enhance her chances for safety. She must be free enough from the perpetrator's controlling influence from the past or in the present to feel empowered enough and to feel entitled enough to act on new choices regarding her own best self-interest instead of following abuse-induced patterned compliance.

A forty-year-old client shared her experience upon leaving my office after discussing trusting her boundaries and how she felt in her body when she picked up "bad vibes" from someone:

"I walked out of your office into the hallway in front of the elevators and there was this man standing there waiting for an elevator. Something about him made me really uncomfortable. I got on the elevator with him and felt panicky until I could get out of there. All the safety I felt during the session went out the window..." (Or perhaps down the elevator shaft.)

She told this story to me the next session. I could see that she was picking up the signals so her radar was working but her reaction remained compliant. I found out that she still didn't feel she had any other choice but to submit to contact she found aversive or unsafe. I brainstormed several feasible safer choices with her and she was amazed that not only had none of them entered her mind; she realized that even if they had, she would not have considered them as real possibilities.

"I didn't even consider that I could take the stairs, or walk the few steps back inside the safety of your office or the waiting room, or that I could come and tell you or your receptionist. I could've gone to the bathroom down the hall, I suppose, too. I felt that I had to get on that elevator or he would've known something was wrong. I really did feel I had no choice."

### **DIFFERENTIATING FUSED EXPERIENCE**

Because the victim in sadistic abuse becomes fused with the perpetrator rather than being emotionally invisible, the victim of sadistic abuse projects an array of intensely ugly emotions but they can be an entangled mixture of hers and his.

### **Working with the Client's Projection or the Perpetrator**

The therapist must also be aware that, during a therapy session, he may be treating a "third person"—the perpetrator who is carried inside of the client. Because the victim and perpetrator "fuse," the client may act out the role of the

perpetrator or project the role of the perpetrator onto the therapist or many other people or situations.

Not long ago, I treated a client that had been stalked, abducted and sadistically abused by an ex-husband. She changed her name and moved away while he was in prison before he would reach parole. She sought treatment because she was still highly symptomatic. She had conquered alcoholism eight years earlier and still attended AA meetings. She told me a relevant story about what happened to her over a series of several meetings:

"I always go early enough to find a seat where I feel safe because I can watch the door so I can see everyone as they come in. The problem is that there is this one guy that looks just like my husband, Frank. Exactly like him. He has the same wavy dark hair and that dark Italian skin. He just oozes Frank. He even wears jogging suits like Frank liked to wear. I sit there when he's there and I feel terrified; I try not to look at him but the hairs on the back of my neck stand up the whole time I'm at the meeting. I often have to fight the impulse to run out of there. My palms get sweaty and sometimes I can't focus on the meeting very well. I try to latch onto my sponsor or any of my friends there."

We used this Franklike person in treatment and had her practice feeling in her body what it would be like to say or do anything she felt she needed to in relation to him including feeling the possibility of running out of there, etc. Feeling she could run and escape to a safe place was an important corrective experience for her since in reality she'd been tortured and trapped by her ex-husband. It was also very empowering that she had taken such strong actions on her own behalf by moving away and changing her name. When she realized her resourceful reaction to his upcoming parole, she felt powerful and strong.

She felt her charged trauma reactions to the Franklike man at AA, and in her mind, he was fused with her and her experiences with the real "sadistic Frank". We used her weekly reactions to him to act as a barometer to gauge where she was in her healing process. The symptoms that seeing him at meetings evoked gave us important clues to what was still unresolved. She knew cognitively that he wasn't really Frank but her body reacted as if he was. The projection of her perpetrator husband onto this stranger was very strong.

### **Differentiating from the Fused Experience with the Perpetrator**

Of course, she could have simply changed meetings but her sponsor and several new friends went there so she was reluctant to do so. And fortunately for

her, in this particular situation, she didn't change because what she learned was so significant to her healing process. A few sessions later she reported the following:

"Remember last week when you had me defend against Frank as if I was pushing him away physically and I felt stronger and could actually feel having strong boundaries like the "shields up" on Star Trek...? And then we did that piece on how I could feel separate from Frank in my body and I could find 'me' apart from 'him'? I could eventually distinguish what are 'me' and 'not me' over and over again.

Well, I went to AA this week as usual and took my safety seat braced for that guy to come in. Well, he came in and I couldn't believe it! He wasn't even Italian. He was still wearing the sweats but he doesn't look at all like Frank now! I even felt that maybe sometime I could even go up and talk to him. He looks sort of nice. I'm not ready yet. I'm still too freaked out about how I 'made' him Frank...But I realize that I feel so much safer now."

Frank used to literally follow her around and she thought she was successful in ditching him because he was imprisoned as well as her actions taken to move and to change her name. But psychologically, she still carried him alive and well within her and projected his image and presence onto others and then reacted with panic and terror. She'd found herself and differentiated from the fusion with him that had been a part of the sadistic abuse. She'd broken and disowned the projection belonging to the perpetration, a significant signal of healing and resolution.

Usually there is important information to glean from a client's projections of the perpetrator. The therapist may learn information from the client's behavior about the details of an assault or a long-term abusive relationship. The skilled therapist can then use these clues to help the client resolve remaining negative influences and to alleviate PTSD symptoms related to the traumatic event.

### **Digesting Experience of Trauma as Victim and as Internalized Perpetrator**

Because the fusion of experience between the victim and the perpetrator can be so intense, especially in sadistic abuse and torture, the client may need to work through, not only her role as victim, but also her experience of the perpetrator's thoughts and feelings. Even if uninvited, the voice, feelings, and thoughts of the perpetrator may become available to her as if she is experiencing the incident she went through with him *from his perspective*.

One of the reasons I suspect this may happen is that there is no boundary left between victim and torturer in sadistic abuse. There is at least a slight boundary provided by the screen overlaid on top of the victim's experience in the non-sadistic abuse even though it is a false one. Physical and energetic boundaries are injured and broken by definition in acts of violence. Boundary repair is always necessary but this fusion experience goes beyond injured boundaries and the therapist needs to facilitate skillful differentiation.

### **Stabilization and Memory**

Often it is recommended *not* to go into the specifics of torture memories with political refugees, war trauma veterans, survivors of the Holocaust or with other survivors of other extreme forms of sexual assault and violence such as cult ritual abuse. Stabilization is paramount and helping the survivor find a foundation of safety and functioning is the priority. However as people feel safer, or because they are triggered by major life events, we often need to work directly with memories.

### **Defusing Fusion and Integrating the Perpetrator's Experience**

Clients surviving such extreme life events may encounter fusion experiences and it is helpful for therapist to at least be aware of the possibility and consider some ways to help a client understand and integrate this terrifying type of experience. The therapist must learn to "keep his or her seat" as they practice in the Buddhist meditation tradition. The environment must be safe for the client to access the perpetrator's state. The therapist must hold the container so that the client can move through this difficult passage safely without inflicting any harm on the therapist or on herself or others.

One of my clients I'll call Sue, came in for treatment with more PTSD symptoms than I'd ever seen before and absolutely no concrete memory of what had happened to her. It was the first time I had the experience of the client "becoming the perpetrator" in my office in such an overt way and it was unsettling the first time it happened.

She was highly dissociative but I don't believe she was dealing with a Dissociative Identity Disorder formerly referred to as MPD or Multiple Personality Disorder. I have had a few clients that I have felt fall under that diagnosis as described in the DSM IV. My view in her case was that she had an encapsulated experience of the perpetrator in her that was breaking through when she finally found someone that she felt understood her trauma experience.

Without warning she leapt towards me and came partially out of her chair after exploring a dissociated state which we called 'gap'. She reached her hands toward me as if to strangle my neck but she didn't touch me. Her face was twisted in intense rage and she was spitting her words at me in a deep husky male voice:

"You little bitch...I'm going to strangle you. I hate you little bitches."

She was almost immediately aware of what she'd said and apologetic. I relaxed and told her that I felt something very useful and significant was happening. I felt she was feeling safe enough to let the rage come through, as frightening as it was, and that we may learn more about her situation as a result. It happened a few more times when this voice issued other threats seemingly to me in the session but she could gradually see that these messages were spit at her during a brutal assault she'd barely survived at age seven in the woods on her way to school:

"I'll come find you if you tell. I'll kill you and your whole family if you tell."

She said she felt really relieved that she hadn't scared me away. We'd passed a test together. I didn't overreact and she began to see that she could be safe with this highly charged perpetrator energy. She never lost consciousness after these experiences and her ability for co-consciousness grew as this continued to happen. She "gapped out" less and less and memories surfaced that were more concrete and eventually they felt more manageable to her.

Another client's experience of the perpetrator lasted much longer. While working on recovering from sadistic torture, she reported:

"All of a sudden after my last session, I felt this incredible force as if a speeding train was rushing through my brain at 400 miles per hour and my perspective changed drastically. I could still observe the process but I felt like I was inside the perpetrator versus his energy being inside me. I felt turned inside out in a way and "being him" was terrifying. I was mostly "him" for about four days and then it happened less and less often but I feel I know what it's like to "be a murderer" and I also know that I am not. He is. I am not and never will be."

Later she wrote up a more detailed description of being the victim at first and then her awareness switching to the perpetrator's experience at a point in the attack where she felt she'd experienced dying. An excerpt of her story of her sadistic assault at age twelve follows:

The victim's view:

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"The single hand that grabbed me was as cold as a reptile claw. With an iron grip, he effortlessly dragged me up those stairs like a useless and offensive bag of garbage, purposely banging my head on every step on the way up. At the top, still dizzy, I gained some footing and attempted to struggle free. Used to wrestling matches with my older brother, I broke his wrist-hold and swung at him. He went even crazier and threw me on the ground as if I had no weight at all and landed his heavy hulk right down on top of me knocking the air out of me and crushing my ribs.

He began screaming ugly words and spit about an inch from my face and told me he'd kill me for fighting him. "No one fights me and lives, you worthless little whore!" He had both my wrists in one hand held behind my back. It felt like I had no arms. He used his other hand to grip my small neck in a strangle hold; I could barely breathe and began gasping for any shred of air. I wanted to bite his face off. He sensed the attempt to bite, told me I was going to die, and put his entire wide-open mouth over my face to lock out all the air.

Not only was it gross and disgusting, it was effective in suffocating me. It was like being swallowed alive and having all the life and breathe literally sucked and suctioned out of me. To say I was terrified is such an understatement. I can't describe the intensity of these few moments or in the moments that followed. My body began to jerk and spasm wildly as if I was receiving strong electric shocks. I could feel a high voltage charge running through his body too in the excitement of the kill. He was killing me! I was dying! It was so fast and intense and alone. I couldn't quite grasp it; I was going to die. There was absolutely nothing I could do about it. God, the helplessness was overwhelming. What happened next was truly amazing and I don't really understand what actually occurred.

The switch to the sadistic perpetrator's view:

There must be something that keeps our awareness local to our own bodies so that we perceive and experience from our own center. NOW, I realize that that sounds kind of obvious and we usually take that fact for granted. What I discovered is that, under extreme stress, the center of awareness can move completely into another person. (I suppose some people can do this at will without the stress.) I don't mean an exaggerated empathy for another person's feeling state; I mean actually perceiving as if you were really them. In the flash before I "died", my consciousness entered Carl. I "became him". As him, I felt my hands strangling this young girl. As him, I looked at her terrified face through these rimless black eyeballs, and enjoyed drinking in the fear. As him, I needed the intensity that only came from fear or killing. Like a strong drug, it satisfied a deep craving. As him, I hated the innocence; I fed on the fear; I was completely turned on. Hurting this brat made me feel ecstatic and powerful and enough. As him, I felt my mouth smothering the life out of her and she deserved it. They all deserved it. I hated them all. I felt forcefully evil and very, very focused.

A near death perspective:

Just as suddenly, my awareness left both of "us" and went out into this calm, quiet place. I felt a momentary experience of relief from popping out of the body and really didn't seem to be missing anything important now out of form. I assumed this was death, but it's not really accurate to say "I was thinking" since I didn't particularly feel like an "I" and the awareness perceiving seemed non-conceptual. It didn't appear to matter much which of the roles I had actually played; I didn't seem overly interested. I felt a sense of movement farther and farther away – or it may be more accurate to say that it was like being absorbed into something larger and less separate or defined. I did still have some sense of location and individuality but by far the most striking, was the absolute certainty of well-being. Given the circumstances I'd just experienced, that deep knowing that everything was just fine, was remarkable. Even now I have a confidence in death that enables me to live with less fear. I realize this a strange way to find inner peace and security. Well, in any case, this reverie was short-lived.

A return to the victim's experience:

All of a sudden, I felt like I'd been hit by a runaway train and abruptly and aggressively yanked back into my physical body and into excruciating pain. Time had passed because I was now unclothed in Todd's room lying on a shower curtain on top of his bed with the cowboy bedspread. Strange what details I remember. I looked up and there was Carl wounding my body in ways I prefer not to describe in too much detail. He was viciously violent and sexually violating. I am trying to write about this torture delicately, but there was nothing "delicate" about it. He seemed a skilled and practiced terrorist who knew how to use the sharp objects to induce bleeding inside without severe physical damage. He obviously found the blood tremendously exciting. He reveled in it and smeared it all over himself and me.

She was able to integrate all of the intense states in her healing process and feels that she has gained valuable understanding. These experiences helped her understand why it had been so difficult for her to express anger or hatred. She had unconsciously been afraid of going crazy or later, when the memories had surfaced, she was afraid of becoming like the perpetrator. It also explained why she'd felt so contaminated at times. Integrating her experiences of being the victim and integrating being the perpetrator as well as her near death experiences have given her a strong sense of resolution. She says, "I feel like I've been to hell *and* heaven and back."

When people have been victims of abuse and torture, they usually experience social isolation, psychological fragmentation and physical dissociation. It is the task of the therapist to help clients reintegrate themselves into whole, embodied functioning people. When victims are experiencing social isolation, their fear of betrayal and abandonment can be so severe that they lose trust in people altogether. Often they cannot recognize people as resources for healing because

often the perpetrator has been such an influential, negative model for human interaction.

### **The Split Self: The Traumatized Self and the Functioning Self:**

Not only do victims feel isolated from relationships with other people, their genuine selves can become split off and disconnected inside of themselves. This represents a kind of psychological fragmentation that is always exhausting. Much of the victim's energy may be expended, consciously or unconsciously, in trying to maintain the part of herself that is still managing to function on a daily basis and to keep it separated from the wounded self, which gets allocated all of the overwhelming and disintegrating feelings.

### **Building Bridges of Awareness Between Selves**

The traumatic experience of the abuse can become encapsulated and split off. The more intense the experience the more likely it is to be walled off to the extent that the client may not be able to access memories. Statistically, many survivors of torture, trauma, or abuse recall memories between the ages of thirty-five and fifty if the memories had been suppressed. Major life events such as moves, promotions, marriage, birth of children, or divorce may trigger recall. Death of the perpetrator(s) often acts as a strong condition for a return of disconnected memory.

All of the victim's survival mechanisms are being used just to make it through the day, but then wounded feelings and flashbacks often interrupt this hard-earned capacity to function. The therapeutic task here is to build a bridge between a client's functioning and the memories surfacing from the wounded self or selves very slowly. When the protective and defensive wall between selves starts to come down it is usually a highly charged experience for the client. The client fears that the painful and out of control feelings will take over and that functioning will be lost or compromised. This dilemma that can occur when trauma symptoms take over is well articulated in the following testimony of a Vietnam vet:

"After a certain moment you just keep running the hundred yard dash: you are always ready for it to come back. I have to isolate myself to keep myself from exploding. It all comes back, all the time. The nightmares come two, three, times a week for a while. Then they let up a bit. You can never get angry, because there is no way of controlling it. You can never feel just a little bit: it is all or nothing. I am constantly and totally preoccupied with not getting out of control."

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(van der Kolk, 1987, pg. 8)

## **Use of Illicit and Psychoactive Drugs**

Without being able to regulate response to stimulus it's easy to imagine why victims of traumatic events resort to drug and alcohol use. Victims are often attempting to regulate arousal in order to defuse feelings of being out of control or to dim painful memories. Use of illicit drugs can be seen as the client's attempt to self-medicate their PTSD symptoms. While they are trying to manage their anxiety and depression, using these kinds of drugs can exacerbate depression and anxiety, as well as contribute to all kinds of secondary problems. On the other hand, use of psychoactive drugs under the supervision of a psychiatrist that are designed to facilitate re-regulation or to treat specific symptoms such as anxiety and depression can be helpful in the recovery process.

## **FALSE MEMORY SYNDROME**

Many clients come to treatment with memory of events intact: others do not. Fortunately we can usually alleviate symptoms without the content of memory, but in most cases, as the client's body awareness is utilized and the client accesses a sense of safety and support, memories begin to resurface and can be integrated versus dissociated. When the material is high in intensity it is recommended that the process be at a slow pace, alternating between elements that were highly activating and resources a client chooses to focus on that facilitate a relaxation response. Memories retrieved this way usually become clearer and clearer and lack confusion or the need for speculation.

The therapeutic goal is not to dredge up memories but to maintain stabilization for the client as memories surface. Often memories are explicit and accurate and the client feels confident in their accuracy. Because trauma memories are stored in the body implicitly, we need to have access to body awareness and not only cognitive ideas or speculation about what has happened during the traumatic event.

When treating victims of abuse and torture, it is extremely important to be aware of the False Memory Phenomenon. It is imperative for a therapist not to jump to conclusions about what they think happened when clients start describing unclear, patchy memories or listing significant symptoms. Symptoms can't tell the story until we have more recovered information. We want to truly support our clients and it is important that we are all on the right track for healing to be available and efficient. It is useful to maintain the stance of open curiosity and to follow the client's experience through the practice of body awareness versus

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cognitive speculation. Speculating about or making allusions to what an image or sensation might mean without any evidence can be very detrimental. There are a few reasons that this can be problematic.

### **Need for Memory Retrieval due to Thwarted Threat Response**

When human beings confront threat, part of the natural response is the need to locate and identify threat in order to know how best to respond. We evaluate whether to fight, to flee or to freeze. When the traumatic event happened too fast for us to locate threat or the experience is so intense that memories are not available, the client will still be searching to identify where the threat came from in order to continue to complete the threat response sequence. This situation may be likened to doing a search on the Internet. The victim's body is on "search," but stuck trying to scan to locate the threat. Once the threat is identified and the sequence can be completed, the client can return to a relaxation state.

When completion is thwarted, the client cannot finish the sequence and remains agitated and instinctually mobilized to respond to the threat. In this hyper-aroused physiological state, the client is primed to take in any suggestion or speculation from the outside to "fill in the blanks" in order to attempt to complete the sequence. Clients can experience a tremendous urgency about memory retrieval for this reason. (Levine, Peter Lectures 1990)

For example, a therapist or friend may make statements to a client such as: "With your symptoms it's possible that incest occurred in your family," or "Your father seemed to have the opportunity to do this to you". As therapy progresses, these original statements may turn out to be inaccurate and cause even greater pain and confusion for the client. Unfortunately, ritual abuse, torture, physical and sexual violence do occur as I've described earlier in the discussion of sadistic and non-sadistic abuse. In many cases an experienced therapist may be correct but, by stating speculations, therapists or caregivers may be unwittingly contributing to a client taking as truth a falsehood that serves a biological need to identify threat. This can cause all kinds of unnecessary complications for the client in her family or lead her to believe possible inaccuracies that she was sexually or ritually abused when, perhaps, in fact, she survived invasive medical trauma in early childhood.

For example, a male client who was very upset at his family, reported:

"I was convinced that I had been sexually abused and had surmised that it was probably my father which didn't help my relationship with him any. Since I seemed unclear about parts of it, my therapist encouraged me to stay with my process as it unfolded in my body awareness instead of

getting too caught up in my mind's efforts to try to figure it all out. I was amazed when I discovered that what I was really dealing with was an early childhood surgery that I had no way of understanding as a little kid. It felt violating and occurred near my genitals. It had "felt like" sexual abuse.

Surgeries *are* invasive and violating to the body even when we know they are necessary and ultimately good for us. To the body, it still feels like getting ripped open by a wild animal.

The instinctive reptilian brain uses images and very simple vocabulary to communicate with us. This is the part of the brain that has specialized in self-preservation for centuries and it knows how to help us when we are threatened. It often sends us "feels like" messages or images when we are processing trauma memory. A client began processing what she assumed was a trauma related to her psychotic mother's abuses. Eventually near the end of the session we discovered the symptoms were related to a surgery on her face and neck that she knew had happened eight years earlier. Interestingly, she hadn't associated the symptoms she wanted to work through with me in the session with the surgery until we followed her body awareness. By using body-tracking methods and the understanding of completing physiological sequences as taught by Peter Levine in his trauma recovery model, Somatic Experiencing®, the situation eventually became clear. In a condensed paraphrased version of the working, she said:

"I feel disconnected. It must be how I felt around my mother when she was psychotic. (mental idea) Now the whole left side of my face is numb. (Beginning to track body awareness) I get the image of the left side of my face being only bone with no flesh on it and the right side feels normal and fleshy."

We gave time for her awareness of the healthy side to alternate with the bony exposed injured side and to discharge the frozenness remaining there. The bony side gradually became re-associated and fleshy also. She continued:

"This is so strange....I don't know what this is about. I feel as if a bear tore my face off.... (There was no bear. It is a "feels like" message) Oh, Oh I get it... It's the surgery I had a few years ago. I've never had feeling on the left side of my face since because they had to cut some nerves when they removed the lymph nodes. They peeled my face back from my neck to my nose and then had to stitch it up behind my ear."

It makes sense that having one's face peeled back surgically "feels like" having a bear rip the face off. The point is that the body will reveal the truth whatever it is and we don't have to play Sherlock Holmes and try to solve mysteries. We need to respect the body's innate wisdom in allowing memories to

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surface when the circumstances are right and to get comfortable with “not knowing” until the truth comes through. (Interestingly, she was also able to regain sensation in the left side of her face that had been completely numb before the working. She had been told previously by the surgeon that nerves had been cut and she would never regain feeling in her face on the left side. Nerve damage may have healed in the eight years since surgery and, in this session, we focused mostly on resolving the facial dissociation.)

Again, because the false memory phenomenon can cause problems for clients and also their family, it is important for the therapist to encourage the client to stay open and curious and to explore a memory with the body until they *know* rather than trying to pin down the particulars through speculation. As clients go through the process of therapy, they will eventually discern the truth, but only as the body is ready and willing to give them the memory pieces, one at a time. The body may reveal stored memory gradually because, if something is exposed all at once to a client, then it may be too overwhelming for the client to handle, and re-traumatization could occur.

In another case of “false memory,” a young woman’s previous therapist actually suggested that she had been sexually abused by her father. This is the same client that I mentioned earlier and called Sue. She became convinced that this incest had to be true because she always felt anxious and upset around her family, especially her father. She ended up having dreams about her father coming to her room in the middle of the night which she interpreted as incestuous visits even though she couldn’t remember him doing anything to her.

When she came to me for trauma recovery work, she was confused and determined to divorce her family. She had already ended most contact by refusing visits, sending back unopened mail, and refusing most phone calls. I kept encouraging her to stay open and curious. I suggested that we give it some time and that we would probably find out the truth soon enough. I reassured her that she could heal many of her symptoms without explicit memories anyway. She decided to stay curious and keep exploring possibilities but not to have contact with her family yet. We decided that before she cut them off forever to plan a family conference six months away to give us time to decipher her symptoms and to allow memories to surface so she’d feel better equipped to address her concerns with her family specifically. Eventually the truth became clearer.

Eventually, Sue discovered she had been assaulted by two adult male strangers on the way to school when she was seven years old. She suffered a terrible assault, but she never told anyone because, as I mentioned previously, the perpetrators’ threatened her life and the lives of her family if she said anything.

“So every time I saw my family, I can see now that I had this urgent need to tell them, but I couldn’t. I didn’t even have words for what happened to me. Even if someone had realized something was terribly wrong with me and asked about it, I wouldn’t have been able to talk back then. I just forgot what happened. I couldn’t eat or sleep hardly at all. I got obsessed with sports and never sat still. I couldn’t, I was way too wired. So I can see why I got so upset seeing anyone in my family—especially my father because it was my father that I needed to protect me the most. It was like anytime I saw or heard from my family, I felt all the terror and pain from the trauma, but they hadn’t done anything to me.”

When she could finally tell her family what happened, she was very angry that they hadn’t protected her, which was the real source of her anger towards them all along. They didn’t know she had been assaulted or why she had been so hostile to them for 15 years. Finally, she was reconciled with her family. It is clear, as this example attests, that false memories can be, in some cases, as potentially devastating to people’s lives as the actual trauma because it can rob the client of much needed support and caring when they need it the most.

### **CONCLUSION AND SUMMARY:**

In this paper, I have woven threads through the tapestry of many related and sometimes divergent topics on various forms of atrocities acted out upon humanity within and between it’s own membership. These topics have been examined from a clinical perspective I’ve gained from working with several violently assaulted clients over the past fourteen years in private practice as well as in my extensive travels as a teacher of Trauma Resolution Strategies for professionals. These clients have had experiences such as war trauma, torture, incest, physical and emotional abuse or have survived as displaced political refugees. These experiences of relational traumas have also been explored from a social perspective gained through the eyes of the media, its’ viewers, and relevant research studies, as well as a personal viewpoint that includes many insights and observations.

Two core issues are presented here. First, the disturbing devastation to individuals and societies as a result of man’s intentional inhumanity to man referred to as Relational Trauma, and second, the elucidation of some useful insights and healing strategies to enhance the effective treatment of this particularly disillusioning type of traumatic experience.

This paper explores the hard-core reality of the disintegrating and sometimes silencing or amnesia inducing impact this type of traumatic experience can bring in

its wake to us as individuals and collectively as a society. Sometimes trauma and its' victims are considered contaminating as if the symptoms or the powerlessness they experience could be contagious or damaging by association. A strong conclusion I have drawn is the deep need for social support as a foundation for healing for the individual or the community at large versus the isolation so many survivors experience when they face trauma alone.

The significance of group support struck me a few years back when the news reporters made an important observation about healing after a major earthquake in Los Angeles. They said that the Hispanic communities that gathered together *outside* the treatment facilities provided by the Red Cross, etc. fared much better than their mostly Anglo counterparts that sought out private counseling alone.

In examining the media's portrayal of violent acts from cartoon-like, action-packed thrillers as entertainment to the more realistic depictions of the intense damage inflicted upon victims in the aftermath of traumatic events, we are asked to evaluate our own attraction as well as aversion to trauma and its fearful effects. On one hand it is common for us to deny or minimize the reality of trauma, and on the other, we, as a society, eagerly await the around the clock exposure of the gory details of devastating world events with a callused "if it bleeds, it leads" mentality. Sometimes we want to blame the victims – possibly to reassert our own sense of safety or invincibility. Or we may ask them, through our unrealistic attitude, to get on with their life a few short weeks after the difficult incident.

As caregivers or even as concerned citizens, we face the challenge of dealing with compassion fatigue or dehumanizing detachment that can, and *sometimes must*, shield us from the continual onslaught of atrocity coverage. How do we stay open-hearted and appropriately socially active and avoid burn out? This question is not easily answered and bears further inquiry.

One of the most valuable contributions of the material presented here involves what I feel represents a more precise understanding about the implications of the distinction between sadistic and non-sadistic abuse. Effective treatment can be aided greatly through understanding the specific ways the perpetrators' perspective and intentions are internalized by the abused client.

The role of empathetic attunement is particularly highlighted – the total lack of it that occurs during non-sadistic abuse where the victim is used as a "projection screen" and denied her own reality contrasted to the highly refined art of attunement occurring during sadistic abuse but that is used in an evil way to the client's considerable detriment. This discovery is also important to comprehend

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the somewhat predictable symptoms that can result for a specific client depending on what type of abuse they have suffered. It also gives the therapist important insights into at least two areas: the type of trauma transference that may occur in treatment and the danger of inappropriate use of empathy for the survivors of sadistic abuse.

Another significant issue discussed here concerns the possibility of fusion that may occur between victim and perpetrator during violent and invasive acts. I am postulating that the occurrence of fusion may result from severe boundary rupture and identity disintegration the client may experience under aggressive attack. As a result, the client may have access to the violent act on the painful receiving end as the terrified victim and, perhaps what may be even more frightening, they may also have access to the perpetrator's internal evil state of mind and being. This access may mean that they feel what the perpetrator felt and may experience *his* desire to act out and mistakenly fear it as their own. The therapist must help the client to differentiate these difficult states to regain an individualized identity.

Upon further reflection, I feel the fusion experience I'm describing is fundamentally different from the Dissociative Identity Disorder diagnosis delineated in the Psychological Diagnostic Guide referred to as the DSM – IV even though some of the initial appearance of behavior may be somewhat similar. Once the often encapsulated perpetrator experience is expressed, it seems more easily integrated than the more highly structured or rigidly defined alters within the DID diagnosis. Building bridges of awareness between split selves as well as between the victim's perspective and that of the perpetrator's seems ultimately useful. I enthusiastically invite discussion with others regarding these formulating concepts. In general, I feel treatment strategies for many brave survivors seem to be in the process of becoming clearer and more discernible. However, these cases are usually incredibly complex and not to be under-estimated.

On the other hand, questions that remain largely unanswered for me concern the effective rehabilitation of perpetrators. Success is sadly lacking. Recidivism reigns in the ninetieth percentile. Without significantly better results in this important treatment area, we have advanced only slightly toward resolution of violence or in mitigating the influence of the seemingly uncontrollable impulses leading to it.

Lastly I feel that an open-minded stance is strongly recommended concerning the complexities of the False Memory Phenomenon for both clients and therapists. I feel that there is significant evidence that traumatic memories are largely stored in the body and cannot be fully reached or ascertained only

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cognitively. Just as many people who have experienced trauma consider it healed from a mental perspective even when symptoms persist, tracking the incident through the body can give the definitive answer regarding true resolution as well as clues for more complete healing if needed. Body awareness as a treatment strategy also serves us in discerning true from possible inaccurate memory when dealing with the intensity of a traumatic event.

When people have healed trauma they also return to having a sense of connection to others and to the greater web of life. When someone has been abused, they have lost, or may have never developed, a sense of connection to the world. They are disconnected in the most fundamental way. It is the task of the therapist, and society in general, to help victims of abuse and torture to reintegrate themselves and to reconnect. Mr. Roberts, the famous "horse whisperer", calls this necessary reconnection "rejoining the herd".

Only by speaking the unspeakable, by looking torture and abuse in the face and finding an individual or collective voice to express our outrage against it can we help create the foundation necessary to begin to heal these ongoing tragedies. We cannot afford to view unspeakable trauma from a distance as impersonal entertainment or with uninterrupted detachment. Trauma is deeply personal - to all of us. We need to involve ourselves as intimately as we may be able. Developing an understanding of trauma or having the capacity to maintain an open heart can be a huge contribution on its own. When victims have access to the help that they need and start to heal from Relational Trauma including violence, war, abuse or torture, they may eventually begin to feel connected to themselves, to society, to the community, and to life again. The risk feels immense and this act of trust takes great courage.

Discovering the deep resources within oneself that enable true healing may become the hidden gift in trauma. Successfully surviving severe trauma can lead to transformation that only a true initiate can imagine. One often has the experience of foregoing previous pettiness and self-absorption. Many survivors develop a more mature, compassionate understanding and concern for all of humanity and often create ways to engage in relevant pro-social activity.

Witnessing transformation in the making as a client's triumphant spirit finds its hold is truly one of the great awe-inspiring benefits of being a therapist invited along any individual's healing journey and I feel this intimate participation is one of life's greatest privileges. As Albert Einstein commented, "A human being is a part of the whole we call universe, a part limited in time and space. He experiences himself, his thoughts and feelings, as something separated from the rest – a kind of optical illusion of his consciousness. This illusion is a prison for us, restricting us

to our personal desires and to the affection for only the few people nearest us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living beings and all of nature."

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## ***SADISTIC ABUSE***

**STYLE:** Cold & Calculating. May describe act, then slowly torture.

**MIRRORING OF VICTIM:**

Accurate, empathetic connection and offender uses information against the victim to increase terror and pain. Victim is deeply known, visible, seen.

**AROUSAL RESPONSE:** Abuser's arousal is increased by victim's suffering and is intentional @ inflicting pain and inducing terror.

**THINKING ERRORS:** Do not include denial of victim's suffering. May project onto client their own sense of being sick, perverted, dirty and evil.

**IMPACT OF FUSION:** Offender prone to enmeshment with victim. Victim may introject extreme forms of negative self-image; i.e., sense of being horrible, slime, evil.

**VICTIM PRESPECTIVE:** Deeply known by abuser, feels overly exposed. Genuine feelings and responses seen, acknowledged and used to hurt. Vulnerability becomes intolerable and need to deceive imperative. Hides out.

**THERAPEUTIC TASK:** Caution in use of empathy because was abuser's tool for pain and suffering. Intense anxiety and decompensation possible as client becomes better "known" in therapy. May get better and worse. Client needs to realize safety no longer lies in deception. There can be benevolence in face of vulnerability. Therapist must provide compassionate field.

## ***NON-SADISTIC ABUSE***

**STYLE:** Rapists angry and explosively violent. Molesters groom victims through seduction, manipulation, and cycles of trust and betrayal.

**MIRRORING OF VICTIM:** Distorts victims, reality to believe victim wants contact. Projects own desires on victim.

**AROUSAL RESPONSE:** Turned off by pain. Decreased arousal if suffering seen or acknowledged.

**THINKING ERRORS:** Rationalize own behavior. Will not see child's aversiveness. Believe victim wants or deserves contact & violation.

**IMPACT OF FUSION:** Less fusion. Incongruence, isolation & separateness felt as well as difficulty in knowing self.

**VICTIM PERSPECTIVE:** Victim experiences emotional invisibility. The victim's true feelings are disregarded and he or she functions as merely a screen for the offender's desires. The victim may become skilled at reading other's wishes, feelings, and states but is unaware of his or her own. Co-dependency issues.

**THERAPEUTIC TASK:** The unseen client usually finds safety in being seen in therapy because the danger was in being unseen during abuse. Need to extricate client from their "borrowed or introjected" self-image. Need to compete with perpetrator's perspective and deactivate inner critic. Client fears betrayal and trust easily disrupted.

Reference: TRANSFORMING TRAUMA by Anna Salter

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