

Violence, Sex, And Therapeutic Healing

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The young woman looked younger than her 18 years as she sat looking at me, eyes wide, hands trembling in lap, trying to maintain a placid expression. Her face of anxiety about being in this place at this time betrayed her youthful attempts at engaging humour. Mary, diagnosed as having schizophrenia, her primary nurse, and I were alone in a quiet room to talk about what Mary had, for six years, believed to be unspeakable: the fact that she had been sexually assaulted at the age of 12.

I was called to the Unit to see this young patient when on this, the most recent of her many admissions to hospital, she decompensated just prior to discharge. According to staff reports, Mary had been doing well during her hospital stay; recovering from the schizophreniform symptomatology with the aid of medication and milieu therapy. However, just as she was about to be placed outside the hospital Mary began to show symptoms of extreme anxiety, agitation, avoidance of interaction, and breakthrough anger. During one outburst, she apparently stated in anger that no one had ever asked her about her sexual history. If staff had they would know that she had been raped at the age of 12. The staff quickly inquired into this and as Mary began to settle with their support, interest, and changed medication regime, a tragic story unfolded.

At the age of 12, Mary and a similarly aged girlfriend, were walking across a city park on their way home when a man stopped them to ask them for directions. As they tried to explain to him the directions he was requesting, he pulled both off into the shrubbery and under threat of death, sexually assaulted each in turn. The girls, both pre-pubertal, were obviously terrorized and humiliated. Mary spoke of going home hoping to have some understanding and support from her parents. On blurting out the story, her parents responded to their shock and dismay by saying that she had no right to be in the park at that time of day, and that she knew better than to talk to strangers. Apparently Mary's girlfriend experienced a similar reaction from her parents. The event was hushed up and Mary was not permitted to go to the authorities. The girls were mostly left to their own devices as both families seemed best able to deal with the event through silence and secrecy. This, of course, invited Mary and her girlfriend into a special and unique friendship which blossomed over the next year or so. When Mary was 13, during a sleep over that she and her best friend arrange, the friend began to explore Mary's body sexually when she believed Mary to be asleep. This brought forth feelings for Mary that were similar to those she experienced when the man used her body without her consent. She became very frightened and broke off the relationship with her friend. A year and a half of personal isolation followed. At the age of 14 1/2, Mary fell in love with a teacher at school and began to write her love letters. The teacher, rather than dissuading Mary from experiencing these kinds of feelings at all, acknowledged Mary's feelings for her and gently helped her understand that these feelings could not be returned because of the teacher/student relationship. Mary remembers being very hurt by this, however, she came to accept it and subsequently, at about the age of 15, fell in love with one of her best girlfriends. After Mary realized that her love also had a sexual component, she experienced her first psychotic break and was diagnosed as having schizophrenia. Since that time she has been in and out of hospital on five occasions with average stays of three months. During this process she was also removed from her family and placed in a series of foster homes. After her current hospitalization, she was expected to move into an independent living situation.

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During my first meeting with Mary, I chose rather than to repeat all the details of the history, to confirm that I had read the chart and understood her distress at having to talk with me. I then spent time personally engaging her. I found her, although sedated, to be highly forthright, easily able to follow questions and conversation, and more often than not direct in her response. She would, at times, show affective upset particularly when approaching the subject of the early sexual assault. Eventually, I experienced our conversation to be sufficiently genuine and engaged to ask her the following questions.

“I am curious,” I said, “after the events in the park where that man took advantage of your body for his own purposes, how do you think others saw what happened when you told them of it? Did they see it more as a sexual event, or more as an event of violence?”

“Sex.” said Mary without hesitation.

I next asked, “How about the professionals that you have seen, such as here at the hospital? Do you think that now that they know these things happened to you, that they think of what went on in the park more as an event of unwanted sex, or more as an event of violence?”

Mary looked around the room, eventually her eyes landed on her primary nurse, who she had already admitted was a special strength for her recently, and then looked back at me with doleful eyes and said, “Sex. Didn’t they ask you, the ‘*Sexpert*’ to come and talk to me?”

Then I asked her, “Mary, how about yourself? When you look at what happened those six years ago, do you now see it as more a sexual thing that was unwanted and wrong, or more as an experience of violence?”

She looked at me with confusion on her face, obvious distress in her reflection and said “I have always thought of it as sex, but it never seemed to be something that I wanted.”

Mary’s story is familiar to many of us. Hers may be dramatic due to her youth, the severe symptomatology following the event, and what appeared to be a primarily lesbian sexual orientation. However, what struck me most about her experience was its chronicity. I wondered how she was able to continue carrying such a great burden of upset, despite what appeared to be many attempts on her part to heal from the assault.

The intent of this presentation is to provide clinicians with a potentially useful way of helping clients make experientially useful distinctions between sex and violence that can therefore enable them to begin their healing processes. What I intend to offer here is not a panacea for all sexual assault or sexual abuse, nor it is something that will fit for all persons. However, I have found the distinctions that are offered through this way of working to be helpful to clients and significant others alike.

In talking with Mary it appeared to me that despite what must have been an exceptionally violent experience at the age of 12 she had for many years internalized the experience as somehow being sexual in nature. Further, she believed that others in life – friends, family, and professionals – also saw what occurred as some form of abhorrent sexual activity. It was my hypothesis that this internalized conversation of believing what occurred in that park was sexual rather than violent had added significant disability to Mary’s experience. Perhaps sufficient burden was added to direct her to the clinical state that she showed at the moment. This hypothesis was generated not only from Mary’s story of her own experience, but from that of other clients I have seen. For instance, husbands of women who have been sexually assaulted often feel that somehow their wives have been sexually interfered with, or the women

themselves may feel that their sexual lives are ruined.

In part, such attitudes and beliefs make sense when the social context of our understanding of sexuality and violence is taken into consideration. For instance, if one looks at Webster's Dictionary (1983) for a definition of **sex** it is as follows:

'The sum of the structural, functional, and behavioural characteristics of living beings that subserve reproduction by two interacting parents and that differentiates males from females.'

While this may technically be a correct definition of sex as it relates to assigned gender, it is not by any means what most people think of when they speak of sex. If one were to then look up the definition of **sexual relations** in Webster's, there is a single word: '**coitus**'. Using this definition, the fact that Mary was penetrated at the age of 12 by a man's penis, puts the act into the category of sexual relations. However, it has always appeared to me that such a perfunctory definition of sexual relations (i.e., one based on penis penetrating a person), has significant short-comings. My impression has been reinforced during the years of my clinical practice through talking with patients about their disturbed sexual experiences and what it is they have actually been hoping to experience instead. One way I have found helpful to orient people to their intended experience is to ask them to reflect on other positive experiences. On many occasions I have asked people to close their eyes and bring forth in their minds (without acting on the recollection or saying anything aloud about it at that moment) one of their better sexual experiences of life. Without fail in Western culture people's best sexual experiences include the following (Sanders 1989, 1988):

- 1) Each person involved in the sexual activity experienced themselves being there *volitionally*, and that each experienced self and other as having access to emotional and physical *sexual arousal*.
- 2) This volitional arousal occurred in an interpersonal context of *intimacy*: simply meaning *mutual* emotional/physical *vulnerability* in a larger context of *trust* that the vulnerability would not be taken advantage of.

When I then ask people to open their eyes and compare the play back of this *experiential definition* of sexuality to their inner reflections, I invariably receive agreement between the two. Occasionally, however, someone may say, 'Well, I remembered an anonymous sexual experience where I didn't know the other person involved. The sex itself was quick and intense – in fact, it was one of the best!' Yet even for that brief instance, both participants knew each other to be there for sexual reasons. They knew the events were mutually arousing and both experienced the activities as volitional. It also occurred in a context of brief, but very intense intimacy: mutual vulnerability with trust that the vulnerability would not be taken advantage of.

The difference between this experiential definition of sexual relations and the simple behavioural definition of coitus as sexual relations is profound. Using a behavioural definition - coitus - one can either inadvertently or purposely ignore the experience of either or both of the participants in the activity. By using an experiential definition, one is not limited to a single form of behaviour in order to bring forth that experience.

Sometimes I have wondered how it came about that sex is defined as intercourse or coitus alone. I think perhaps two things have contributed to this definition. The first is the nature of reproduction and its dependence on coitus for effective species procreation. This may invite people to see the sexually reproductive act as *the act* of sexual relations. However, it has been known for three decades that women and men have differential physical opportunities from intercourse simply by the nature of their genital structures. Whereas men have the most intense feeling in their penis plus use it for intercourse, women have the most intense sexual feeling from their clitoral area while using their vaginas for intercourse. Although many women find intercourse pleasurable and even sexually exciting to the point of orgasm, it is known that men need to learn to slow down to match the timing of sexual excitement with their female partners. It is also known that many women are not able to regularly count on orgasm during intercourse

simply because intercourse itself is not sufficiently physically effective, although its intimacy value is reported as intense.

The second factor that I think may have been important in defining sex behaviourally and not experientially has to do with the tradition in our culture of patriarchy. Here I am interested in patriarchy as being a society organized according to the principles of male experience having relatively more importance than female's experience. One can see that within such a social understanding, if a man is gaining personal pleasure from penetrating a woman, no matter what that woman's experience may be, the activity is seen as sexual relations.

It is my hypothesis, therefore, that these two factors (intercourse as necessary for sexual reproduction, and the prioritization of males' arousal experience over that of females) have defined sexual relations as the fact of intercourse. Such a definition only helps to blind us to what most appear to be seeking – the personally felt experience of mutual sexuality.

However, when we look at Mary's story, I think for almost all of us it would be clear that what she experienced during the event in the park was violence. Humberto Maturana's (Maturana 1986) definition of violence is:

'The holding of an opinion by one person or group to be true such that another person's or group's opinion is untrue and must change'²

Using this definition, it becomes unavoidably clear that what occurred in the park that night was, indeed, primarily violent. However, Maturana's definition is a broad one and would include many actions that we in society might not usually consider as violence, such as, sending children to school against their wishes, or incarcerating criminals.

The observation that some violence appears to be acceptable and some unacceptable can be understood using the notions of social responsibility and acceptability. The social acceptability of violence changes from one time to another and from one culture to another. For instance, it is currently illegal for parents in Sweden to physically spank their children. It has become increasingly unacceptable in Canada, although it is not illegal. This is a far cry from just two generations ago when the phrase *'spare the cane and spoil the child'* expressed a common and accepted idea. Similarly, at times of war the actions of "raping and pillaging" seem to be accepted as something that conquering armies are apt to do. Unfortunately, our social tradition of patriarchy and the subsequent emphasis on patriarchal values (i.e., property and ownership), tend to promote violence as something that is simply a damaging physical interaction between a non-owner and the owner's 'property' no matter what the individuals' experience of that interaction. If, as with some sexual abuse or sexual assault, no damage was done to the 'property' (the victim), the tradition of patriarchal values does not see the transaction as violent. For the last two decades feminist writers have been inviting us to understand that violence has as its primary and most fundamental meaning, the experience of those who are subjected to it.

There are three basic distinctions that I have found to be useful in helping patients begin the process of therapeutic healing from events such as sexual assault and sexual abuse:

1. **Sex** - defined experientially and based on mutuality;
2. **Violence** - defined as the imposing of one's will over another; and
3. **Personal responsibility** for one's actions within a context of social acceptability.

However, the challenge has been to introduce these notions to clients in a way that they can readily understand them. Additionally, if they are able to carry the ideas with them over time and apply them to their own experience, a meaningful internal conversation can develop that

² This can be functionally shortened to: 'the imposition of one's opinion over the opinion of another'

permits the option of a higher quality experience of life.

My goal in talking with Mary was to introduce these distinctions in a manner that may help her discriminate the elements of her experience more clearly and benevolently. Such clarity would then offer her opportunities to develop greater health and personal validity. It is my intent in therapy to purposefully offer these increased socially responsible opportunities to those clients and persons experiencing constraint or restraint³. In my work with Mary, I wanted to offer this to her rather than require she take my help.

I decided to introduce what I have come to call “the baseball metaphor ” after Mary told me of her belief that important others in her life thought of what occurred in the park as sex and that now, despite her own experience of it being unwanted and imposed, she also thought of it as being somehow sexual. It has been my experience that this metaphor can be useful to both men and women who have experienced sexual assault and/or unwanted, inappropriate sexual activity such as sexual abuse. However, in order for it to be helpful, I believe it must be introduced in a caring and considerate manner and while the client and professional are well engaged.

I looked at Mary and I asked, “Do you play baseball?”

She looked back obviously perplexed and perhaps even thinking, ‘He’s the one showing bizarre thinking and I’m the one diagnosed as schizophrenic.’ “Yes,” she replied.

“Well, please bear with me for a short while. Let’s pretend for a moment that you are in a baseball game. You’re the catcher and it’s the last inning of the game with the last batter up. The batter has one more strike before being out and if this batter goes out, your team wins. Let’s pretend that this is a fun game between two teams on a Sunday afternoon. Both teams have been enjoying themselves and are looking forward to the end of the game so they can move on to celebrate. As the pitcher throws the ball, the batter swings with great effort, misses the ball, and you, as catcher, catch it. You now know that the game is over, your team has won, and the follow-up parties await. However, before you can fully recover your balance from the catch, the batter turns and with full and mighty strength, swings the bat hard across your head. If this were to occur, would we call this baseball?”

Mary looked at me, eyes wide, obviously thinking and said “No.”

I said, “I’m curious, why should it be that if a man uses his genitals *against* a woman, we would call it sex?”

It was Mary’s response to this question that has prompted my talking about this in professional circles. She looked at me, silence in the room. Initially I could not read her expression but slowly tears began to roll down her cheeks, softening her stony look.

On many occasions since this session, I have asked professionals what they believe Mary was emotionally experiencing at the moment of her tears. Many women say, perhaps relief. Many men state, perhaps sadness at the time lost. But, in fact, when I asked Mary to tell me of her tears, she looked at me, and angrily said, “You mean I had to wait all these years to learn this?”

It was this anguished cry of a youth who had spent six years of personal turmoil and torment following an act (that was clearly experientially violent) with confusion as to its sexual

³ Constraint can be thought of as an internalized experience of external restraints. For instance, many of us can remember a small child walking toward an object that s/he has been told not to touch while saying aloud “No! No! No!” The external no has become an internalized no, whether or not the child succumbs to the constraint or not.

implications. I have found the fact that the implications had taken on a larger influence for her own personal development to be especially poignant.

Once I validated her anger and her right to be upset that this had taken so long, I then began to inquire of her ability to work with this concept over time, particularly with her primary nurse. I asked, "If the professionals also thought this way, would you find it helpful in coming to experience yourself as more healed around the events that occurred those six years ago or would it make little difference?" "A big difference!" was her response.

The issues of violence, sex and social appropriateness were not all that Mary was struggling with. Her many years of hospitalization, family disruption, and difficulty accepting her lesbian orientation and its meaning, when taken together were significant and powerful invitations to disruptive behaviour and experience. Nevertheless, this simple *baseball metaphor* permitted Mary to both cognitively and experientially recognize and begin to internalize more useful distinctions of the sexual assault than that which society had offered her. The intervention also became available for professionals - those who would read the consult, who would talk with the primary nurse in attendance, and who would talk with Mary herself.

Although I saw Mary on one or two more occasions and her clinical status improved dramatically and remarkably over a short time, I am not sure exactly what happened to her later. I did see her in a store a year or so after our first meeting. I do not think she saw me, however, from across the store, I saw her interacting like any other shopper - buying a Walkman from a salesperson. I do know that for other women and men and their spouses the baseball metaphor has served as a concrete and identifiable foundation from which to start meaningful healing after the traumas of sexual assault and sexual abuse.

References

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