Working with adult athlete survivors of sexual abuse

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The systematic documentation of sexual abuse of athletes within sport systems has begun to challenge the commonly accepted view of sport as an unproblematic site of youth empowerment and positive development (Leahy, 2010). Sport psychologists need to be equipped to be able to effectively help athletes through the recovery process without sacrificing their high-performance dreams and goals. Negotiating the complex dynamics of recovery work with profoundly traumatized athlete survivors of chronic sexual abuse poses a significant challenge to even the most skilled sport psychologist. Collaborative decisions about which path to take and which direction to turn, although crucial to an athlete’s recovery, may not always be easy to assess from the rapidly evolving knowledge base (Leahy, Pretty, & Tenenbaum, 2003). In this chapter I will focus on the current standard of care guidelines regarding the treatment of survivors of chronic sexual abuse struggling with complex, dissociative posttraumatic conditions, with a particular emphasis on the social context of high-performance athletes.

Sexual abuse and trauma

Researchers and clinicians have for some time been applying a trauma framework to understand the effects of chronic and repeated sexual abuse. Central to this theoretical framework are the concepts of posttraumatic stress disorder (PTSD) and dissociation as key responses to traumatizing events. Core posttraumatic symptoms include re-experiencing, avoidance, and hyperarousal (American Psychiatric Association [APA], 2000). Symptoms related to re-experiencing and hyperarousal can include intrusive thoughts, physiological arousal, reactivity to trauma cues, and hypervigilance. Avoidant symptoms can include avoidance of thoughts, feelings, places, or people associated with the trauma (APA).

Dissociation is “a disruption in the usually integrated functions of consciousness” (APA, 2000, p. 477). Dissociative symptomatology (e.g., amnesia, derealisation, depersonalisation) involves a splitting between the “observing self” and the “experiencing self.” During a traumatic experience, dissociation provides protective detachment from overwhelming affect.
and pain, but it can result in severe disruption within the usually integrated functions of consciousness, memory, identity, or perception of the environment.

Seven areas of functioning are affected through prolonged and repeated abuse, particularly that perpetrated by those in positions of trust, guardianship, or authority (Courtois, 2004). These areas include affect dysregulation (inability to regulate the intensity of affective responses); alterations in attention and consciousness leading to dissociative symptoms; self-perception embedded in a sense of guilt, shame, and responsibility for the abuse; traumatized attachment to the perpetrator, incorporating his (or her) belief system; relational difficulties with trust and intimacy; somatization and medical conditions; and attributions centering on hopelessness and despair (Briere, 2004). Recently, the concept of “complex trauma” has been developed in an attempt to explain these convoluted and intertwined posttraumatic, dissociative, and related symptom clusters (Courtois, 2004). To date, only one group of researchers has investigated the long-term effects on athlete survivors of child abuse using a trauma framework, and their research provided evidence supporting the applicability of the concept of complex trauma to understanding athletes’ needs for recovery (Leahy et al., 2003; Leahy, Pretty, & Tenenbaum, 2008).

Sport environment issues

Effective abuse-related therapy must address the sociocultural context of the survivor’s distress (Briere, 2004). Particularly evident from research reports across a number of countries is the manner in which certain aspects of the culture of competitive sport provide an environment that facilitates, rather than inhibits, the occurrence of sexual abuse in sport (Brackenridge, 2001). Two sport environment issues, perpetrator methodology and the bystander effect, require our understanding and attention if, as sport psychologists, we are to effectively engage in healing, therapeutic relationships with sexually abused athletes.

Perpetrator methodology

Leahy, Pretty, and Tenenbaum (2004) published qualitative data describing specific perpetrator methodologies sexually abused athletes have experienced within sport. Two key dimensions of perpetrator methodology included strategies designed to simultaneously engender feelings of complete powerlessness in the athlete, and conversely, to present the perpetrator as omnipotent. What seemed to characterize the perpetrator’s methodology, and was particularly obvious in cases where the abuse was prolonged and repeated, was the need to impose his version of reality on the athlete and to isolate the athlete within that reality. The perpetrator successfully maintained that reality by controlling the psychological environment, silencing, and isolating the athlete from potential sources of support. In addition to controlling the athlete’s outer life, her/his inner life was controlled through direct emotional manipulation, psychological abuse, and the creation of a highly volatile, psychologically abusive training environment. The perpetrator’s ability to successfully create and maintain such an environment may be related to the unique sociocultural context of competitive sport in some first-world countries. This context is one that has been criticized as being imbued with an intensely volatile ethos, and within which psychologically abusive coaching behaviors may be normalized as part of the winning strategy (Brackenridge, 2001; Leahy, 2010). This point brings us to the issue of the bystander effect.
The bystander effect

The bystander effect refers to the situation where the victim perceived that others, who knew about (or suspected) the sexual abuse, did not do anything about it (Leahy et al., 2003). For example:

He was in such a powerful position that no one interfered; I think no one questioned what he was doing. But now when I speak to people, they do say he stepped over the line with us, but … they didn’t say anything, they didn’t want to interfere with him, Yeah, I’m a bit angry about that.

(Leahy, 2010, p. 316)

Athletes’ experiences of the bystander effect point to the apparent lack of systemically sanctioned accountability in relation to the power of the coach-perpetrator that allowed the abuse to continue for many years unchallenged by other adults in the system. These bystanders included coaching, sport psychology, and other support staff or volunteers who were not as senior in the competitive sport hierarchy as the perpetrator. The bystander effect was especially notable in the elite sport context: “No one ever interfered with us because we were so elite, and no one ever questioned what we were doing.” (Leahy, 2010, p. 327).

For children, disclosure may be preempted if the child believes, or is aware that other adults know about the abuse (Palmer, Brown, Rae-Grant, and Loughlin, 1999). If observing adults take no action, the child may assume that the behavior is socially acceptable, or in the case of older children, as mentioned above, that the perpetrator’s message that he is omnipotent is really true and that they really are trapped: "it never entered my mind that others could possibly be experiencing the same thing [pause]. … This was something that was happening to me and it was between me and him and nobody else knew” (Leahy et al., 2003, p. 532).

Disruptions in attachment

Therapy is a trust-based relationship that requires not only authentic engagement but also vigilance in maintaining a healing dynamic within the therapeutic environment. One of the key difficulties in engaging in an effective therapeutic alliance with a chronically abused individual stems from alterations in the individual’s capacity to develop and maintain healthy relationships, including the relationship with the therapist (Pearlman & Courtois, 2005). To understand this complex posttraumatic adaptation to prolonged and repeated abuse, particularly that which started from early childhood, we need to draw on attachment theory, and two related coping mechanisms: the locus of control shift, and traumatic attachment to the perpetrator.

Locus of control shift

Attachment theory proposes a biological drive in humans to attach. If attachment does not occur, a child will fail to thrive. Prolonged and repeated abuse by a trusted caregiver presents the child with an overwhelming challenge to the biological need to attach. The child cannot physically escape the abusive situation (e.g., if it is within the family) and cannot choose not to attach. The only developmentally available way of coping is an internal process of dissociating. Amnesia, however, is rarely total, even though specific abusive episodes may be dissociated, so the child has to try to understand why caregivers are hurting him/her.
The meaning likely to be constructed at an early developmental stage, and arguably the only meaning capable of resolving the potential disruption of the attachment systems, is that it is the child who is causing the abuse (e.g., by being bad and, therefore, deserving of such treatment). This locus-of-control shift transfers responsibility for the abuse, or for inability to prevent it, onto the victim (Ross, 1997). This logic simultaneously preserves the idealized trusted caregiver (actively reinforced by the perpetrator methodology and the bystander effect) and allows the victim hope through the illusion of control. It also allows attachment systems to remain intact (Briere, 2004).

**Traumatic attachment to the perpetrator**

The outcome of the perpetrator methodology, described earlier, and the locus-of-control shift, is the development of a traumatized attachment to the perpetrator. This process has been repeatedly observed in not only chronically abused children but also in adolescents and adults in situations of prolonged traumatization (e.g., domestic violence, captivity; Herman, 1997; Ross, 1997). In these situations in which the victim is repeatedly rendered helpless and powerless, and the perpetrator is presented as omnipotent, with no alternative reference points, the victim becomes entrapped within the perpetrator’s viewpoint (Herman, 1997).

In Leahy et al.’s (2004) study, the athletes’ reports describe the perpetrator’s unpredictable and volatile emotional reward–punishment cycle that pervaded the sports environment. Within such an environment, the isolated victim is likely to become increasingly dependent on the perpetrator both for information and emotional support (Herman, 1997). The unpredictable cycling of fear and reprieve, punishment and reward, in the relatively closed context of an elite competitive sports team can result in a feeling of extreme, almost “worshipful,” dependence on the perceived omnipotent perpetrator (Herman, 1997). The more confused and frightened the victim becomes, the more need to cling to the one relationship that is permitted – the one with the perpetrator. A female athlete in the study said of the coach who sexually abused her over a number of years, “To us at that time, his word was like gospel” (Leahy et al., 2004, p. 536).

Traumatized attachment to the perpetrator can continue long after the abuse has stopped, as illustrated in the following comment from an athlete also abused by her coach for many years (Leahy et al., 2004, p. 536):

> I still remember I used to brag to my friends and my parents how great this guy was, how lucky I was, and how he was the best coach in the whole world, you know. I remember I used to say that to people, and he just made us believe that he was just absolutely brilliant and I did believe that. Yeah, and I still think he’s awesome … and I still feel guilty that I did blow the whistle, and I made him lose his job.

Where the locus-of-control shift and traumatized attachment are key coping strategies, disclosure simply does not happen, and common expectations of visible distress indicators may not be apparent. As the young person attempts to survive the toxic psychological environment, he or she may appear loving, needy, willing to please, and protective of the perpetrator. Silencing is an integral, not separate, part of the experience and is achieved through aspects of the perpetrator’s methodology, which keeps the athlete in the state of traumatized entrapment, as a female athlete sexually abused by her coach described: “I didn’t realize there was another way out [pause] or there was another option for me like [telling someone].” (Leahy et al., 2003, p. 661).
Some clinicians view the dissociation-facilitated locus-of-control shift and traumatic attachment to the perpetrator as the core therapeutic considerations in working with survivors of chronic childhood sexual abuse (Herman, 1997; Ross, 1997). Failure to recognize these complex dynamics is a potentially therapy-ending error:

I can’t say that I had any thoughts of saying, “No” [to the perpetrator], which is hard to justify to someone who says you’re old enough to say no … and like the [sport psychologist] couldn’t understand that, uhm at 17, or 16, I couldn’t say no … At the time it was crazy for me to try to explain how I felt, uhm, and so I actually said, “I can’t do it” … I just didn’t go back.

(Leahy et al., 2003, p. 662)

**Treatment principles**

Research on the efficacy of treatment for complex trauma is just emerging, much of it based on cognitive therapy approaches directed at stabilization of core PTSD and other symptoms (e.g., Reisick, Nishith, & Griffin, 2003). In general, however, there is insufficient evidence to categorically define the nature, longitudinal course, and relationship to PTSD treatment outcomes (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). Nevertheless, there is an evolving standard of care, and the current consensus model of treatment for chronic, complex traumatization is that a phase-oriented approach is necessary, in which treatment is clearly sequenced, tempered and task- and skill-focused (Courtois, 1999). Therapy must be empowering and collaborative and should normalize reactions to trauma. It is multimodal and transtheoretical, employing a variety of therapeutic techniques tailored to the individual needs and requiring a range of linked biopsychosocial treatment approaches (Courtois, 2004).

Within this model, the basic principles of good therapeutic practice remain valid, and it is important that from the outset these are communicated and monitored. These principles include issues of informed consent, confidentiality, clarity of professional role and boundaries, client empowerment and responsibility, issues of safety, emergency procedures, and adjunctive treatment options such as medication and hospitalization, as necessary. Throughout the process of the treatment, care should be taken to ensure that clients are developing the necessary self- and symptom-management competencies to maintain a level of functioning consistent with their lifestyles. For high-performance athletes, this approach will include maximizing the ability to maintain training and performance levels. Finally, vigilance must be maintained to ensure effective management of transferential and countertransferential issues (see Chapter 17). The therapist will need to consciously model self-regulatory skills to manage vicarious trauma reactions while maintaining a therapeutic focus on providing a safe, authentic emotional presence with clear therapeutic boundaries (Pearlman & Courtois, 2005).

The pathway to recovery for complex posttraumatic conditions is likely to require a relatively long time-frame, be intensive in terms of frequency of sessions, and vary in length of each session. Dissociation, avoidance, and motivated forgetting are likely to be extensively used as defense and coping mechanisms to keep painful material, or even the therapist, at a distance. It is important that the psychotherapeutic process proceed slowly and cautiously to avoid prematurely dealing with material that may retraumatize, and overwhelm the individual’s ability to cope and maintain daily functioning.
Phases of treatment

The prevailing consensus model of treatment follows a three-phased macro-cycle, within a treatment framework cued to the symptom clusters of complex trauma described earlier. Treatment usually proceeds in a back-and-forth manner, more often taking the form of a recursive spiral, rather than a linear path (Courtois, 1999). The issues addressed in each phase will reemerge repeatedly as treatment progresses, and as the key survival coping mechanisms (dissociation, locus-of-control shift, and traumatic attachment) drive trauma-centric meaning attributions.

The first phase

The first phase focuses on stabilization, the establishment of safety, the development of the therapeutic alliance, symptom management self-care, and skill building. Key tasks that have to be achieved include the development of personal safety strategies; education to demystify the psychotherapy process; education about the nature of trauma and its effects to normalize the often overwhelming trauma symptoms experienced by the client; self-management, and life stabilization skills; and building of social relationships and support systems. Affect regulation and modulation are key targets of skill building interventions, as are body awareness and self-care.

Sport psychology cognitive-behavioral mental skills interventions are applicable in this phase of building healthy coping strategies. For high-performance athletes, self-care will also include attending to the maintenance of proper nutrition, training recovery, and injury prevention. There can be severe physiological sequelae for athletes and their abilities to train and maintain the level of confidence necessary for elite performance. For example, an athlete violently sexually assaulted within her sport environment described how her attempts to cope with the overwhelming trauma psychologically and physically consumed all the energy she had previously directed towards training and competing:

I was tired, sick. … I had to really cut down my training because I’d break down [physically]. … I used to really enjoy training and loved competing [long pause] … like you know my sport has been the defining thing for me as a person [long pause, weeping].

(Leahy et al., 2003, p. 662)

The first phase also involves the establishment of the therapeutic alliance. Traumatic attachment processes may present significant challenges to this task. There may be recurrent testing of boundaries and the therapist’s trustworthiness, along with fears of future betrayal and violation. If not properly managed by the therapist, these relational dynamics can compound harm by replicating the perpetrator dynamics within the therapeutic relationship. It is crucial that the therapist projects and models and makes available to the client, a stable, secure, reliable, well-bounded treatment relationship framework. This secure environment is the foundation upon which therapeutic work will proceed.

With the focus of the first phase work on skill building and self-management, significant improvements in clients’ quality of life are likely to be experienced. For some clients at this juncture, termination or a break in therapy may be requested. Always ensure that an option to return to therapy at a later date remains open. For high-performance athletes, I have found it useful to try to use therapy “micro-cycles” to facilitate the athlete’s competition goals, with priority tasks in each micro-cycle geared towards ensuring sufficient self-regulatory...
skills are in place to allow the athlete to continue to compete at key events. This strategy is important because it is not uncommon that survivors struggle with feelings of being “contaminated” by their traumatic experiences, with a sense of hopelessness about themselves and their lives. Being able to access the parts of their identities (e.g., elite sport performers) that are experienced as being free from this contamination provide an important reparative experience and counter the internalized negative perpetrator messages.

The second phase

In this phase, the therapist and client undertake a gradual, sequenced exposure to traumatic material. The trauma experience or experiences are directly processed to resolve posttraumatic symptoms and to integrate the trauma experiences into the survivor's life in such a way as to allow a forward self-development that is not solely defined by past trauma. This process includes coming to terms with overwhelming affect, gaining control of symptoms, and reducing the need for dissociative defenses to allow a coherent meaning to be constructed that can be lived with. Detailed exploration of traumatic material is not for the purposes of abreaction (release of emotional tension achieved through recalling a traumatic experience), which is not healing, and may simply retraumatize. It is to promote posttraumatic growth (Courtois, 2004).

Before entering this phase, the basic issues of informed consent, clarification of expectations, and demystification of the process must be again revisited. Stabilization skills must be in place, and pacing and intensity has to be planned so that the client leaves therapy sessions in control. I have found that it is during this phase that sessions may require a longer time than the usual therapy hour: up to ninety minutes to ensure this stabilization happens. If pacing and intensity are not managed well, there is a risk of decompensation and the resurgence of maladaptive trauma-based coping behaviors (e.g., self-injury, suicidality).

During this phase, when working with high-performance athletes, I have found guided imagery a useful technique, because athletes are often already familiar with it. Narrative recording, through written or oral presentation, or art and other expressive media, have also worked well. It is important that the therapist is able to be authentically present to acknowledge and normalize responses, and to provide a containing environment for this work. The therapist must also be ready to assist the processing of extremely intense emotions, such as rage, shame, grief, and mourning. Therapist dissociation or withdrawal from the traumatized person's sometimes overwhelming anger and grief are potentially harmful countertransference responses. If a therapist is uncomfortable with anger or views anger or other negative affects as undesirable, then the practitioner may consciously or unconsciously encourage continued avoidance. Therapists also need to be knowledgeable about methods of safe expression and management of intense affect, to effectively facilitate the recovery of healthy affect regulation.

Common themes reoccurring during this phase will often center on the locus-of-control shift (i.e., the victim is responsible for the abuse) and traumatic attachment to the perpetrator, which can impede the expression and resolution of anger and grief and the development of empowered meaning attributions regarding the abuse. Acknowledging anger and grief is a major step to recovery, but it may be an intolerable step for the survivor unless traumatic attachment to the perpetrator is open for safe therapeutic exploration. Meaning attributions can reveal important underlying information about the locus of control shift and how traumatic attachment bonds are being maintained. The client, however, may perceive this information as unsafe to express if the superficial presentation (e.g., self-blaming attributions)
appears to be unacceptable to the therapist who too quickly jumps in with, “It’s not your fault” (Leahy et al., 2003). As one athlete succinctly expressed, “Sometimes that makes me angry (pause) because it sounds like it’s just a psychologist’s spiel rather than sincere, uhm, helping me to understand my confusion.” (p. 662). Rather than immediately challenging self-blaming attributions, and insisting that it is not the victim’s fault, it may be more productive to respectfully explore the multi-layered construction of the attribution.

The second phase proceeds until PTSD symptoms become manageable. When processing is complete and memory is deconditioned, symptoms often cease and anguish recedes as trauma is integrated with other aspects of life, and clients develop more complete narratives of their lives than they had before (Ford et al., 2005).

The third phase
The third phase involves reconnection with self and reintegration with social relationships and community networks. Therapeutic attention should still be maintained on issues of safety, self-care, and so forth. During this phase, issues related to the development of trusting relationships, intimacy, sexual functioning, vocational and career plans, and other life decisions are often the focus of ongoing work. This phase can also include the challenge of grieving for lost childhood. It may also involve decisions about ongoing relationships with abusive family members and perpetrators still within the client’s social environment.

During this phase it is important to continue to facilitate the development of relational skills by modeling healthy negotiation of boundaries and dealing effectively with relational errors or misunderstandings. No therapist is perfect, and inevitably will fail to live up to idealistic projections, miss salient client cues, or fail to perceive accurately the survivors’ needs. Modeling how healthy relationships can be preserved and repaired by good communication and emotional processing skills is an important therapist task through this phase to facilitate the development of present-day relationships that are not embedded in traumatized responses (Ford et al., 2005).

Effectively managing the termination process is a challenge when working with traumatized survivors because feelings of abandonment, loss, and grief may re-emerge. Sport psychologists working on an ongoing basis with residential teams may be at an advantage at this point, because both the athlete and the sport psychologist remain in the same environment, allowing a gradual and closely monitored transition. It is helpful to allow for the possibility of return to therapy because future challenges may trigger distress or crises. Therapists should, therefore, be particularly vigilant with this vulnerable group of athletes to not have dual relationships, or post-termination relationships outside the therapy structure, because such involvements would prevent the possibility of a return to a therapy (Pearlman & Courtois, 2005).

Conclusions

I spoke to the sport psychologist a couple of times but not once did [the sport psychologist] get it.

(female athlete sexually abused by her coach for many years; Leahy, 2010, p. 316)

Research and clinical evidence indicates that athlete survivors of sexual abuse, whether perpetrated within sport or outside of sport, form a significant percentage of the athlete
population with which sport psychologists will come into contact. Therefore, sport psychologists need to have the skills to be able to integrate effective treatment into the social context of the athlete's life. In this chapter I have described an introductory overview to the key treatment issues. This chapter is not enough to provide anyone with the competencies necessary to start engaging in an effective treatment relationship with traumatized athlete survivors of sexual abuse. Ongoing professional development training in this area should be undertaken before taking on the responsibility of facilitating recovery in this highly vulnerable group of athletes. Personal therapy may be useful to reveal therapist blind spots, and to protect from, or deal with, secondary traumatization. Finally, peer supervision is necessary to ensure the therapeutic process remains free of countertransferential errors that may be experienced by a traumatized athlete as harmful replications of perpetrator dynamics. See Box 32.1 for a summary of key points from this chapter.

Box 32.1

Key points on working with adult athlete survivors of sexual abuse

- Effective therapy must address the client's sociocultural context. Sport psychologists are well-positioned to be able to facilitate recovery, without sacrificing athletes' sporting goals, by integrating treatment into the social context of the athlete's life.
- Therapy is a trust-based relationship that requires authentic engagement, but also vigilance in maintaining a well-bounded, healing dynamic within the therapeutic environment.
- Establishing an effective therapeutic alliance with athlete survivors of long-term sexual abuse is only possible if the therapist is sensitive to the possible alterations in the athlete's capacity to develop and maintain healthy, trusting relationships in light of the confounding influence of ongoing traumatic attachment to the perpetrator.
- Current standard of care guidelines follow a three-phased macro-cycle within a treatment framework cued to the symptoms of complex trauma.
- Collaborative decisions about therapeutic micro-cycles can help ensure the athlete's performance at key competition events is maintained.
- Treatment may take longer than usual therapy, individual sessions may require longer duration, and treatment is unlikely to be linear. Issues may repeatedly re-emerge in different forms as treatment progresses.
- Therapists should be vigilant about having access to ongoing peer-supervision and personal therapy as necessary to ensure the treatment process remains free from harmful transferential and countertransferential contamination.

References


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