THE QUADRUPLE TABOO

Sexual abuse of women by women in the Jewish Orthodox community

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I dedicated this to my mother, Dvorah Kieffer, who is a different type of survivor.

She taught me always to be grateful for the blessings in my life, and with her support, I have many.

The committee for this doctoral dissertation consisted of:

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SECTION ONE: THE PROPOSAL OVERVIEW

This study will examine the phenomenon of sexual abuse of women by women within the Orthodox Jewish community. This study aims to understand the therapeutic process, the cultural and religious sensitivities of Orthodox Jewish women, the complexity of the victims' sexual identity, and the strategies necessary to provide relief and healing for current victims while guiding future practice.

The importance of this study is grounded in the reality that this phenomenon of sexual abuse is unique due to the communal sensitivities and personal and communal ramifications that the abuse creates. These ramifications are a central component in the driving purpose of this study, which is to bring awareness, understanding, and therapeutic solutions to the Quadruple Taboo. The Quadruple Taboo is comprised of four components: 1) sexual abuse, 2) the Orthodox Jewish community as a closed community and the ramifications of having a lack of discourse around sexuality, 3) the common perception that women are victims, not predators, and 4) the religion's prohibition of same-sex relationships. Independently, each one of these components is worthy of study, but together, they create a phenomenon that has yet to be explored. To provide a complete set of recommendations on the therapeutic process, the scope of this study needs to be set. The defined aspects of sexual abuse set the content, the characteristics of the Orthodox Jewish community, sexuality and the cultural and religious sensitivities of the Orthodox Jewish community, same-sex relationships, stigma, taboos and secrets, trauma, women victims, and the outlook on women perpetrators.

SECTION TWO: THE STUDY PROBLEM

The study problem is an exploration of the phenomenon of sexual abuse of women by women within the Orthodox Jewish community. To understand the complexities of this problem, it is necessary to examine the larger context in which it exists. The characteristics of the problem are multifaceted, but a foundational component is sexual abuse.

Characteristics of the Problem:

SEXUAL ABUSE

Sexual abuse is a global issue affecting individuals ranging from children and teenagers to adults (Underwood et al., 2007). Part of the intensity of this problem is the staggering number of acts of abuse committed each year. According to the National Sex Offender Public Website NSOPW (United States Department of Justice, n.d.), about 20 million out of 112 million women (18.0%) in the United States have been raped. About 35% of women who were raped as minors also were raped as adults, compared to 14% of women without an early rape history. The data regarding children is equally terrifying. The Center for Disease Control (CDC) estimates that approximately 1 in 6 boys and 1 in 4 girls are sexually abused before age 18 (*Preventing Child Sexual Abuse, Violence Prevention Injury Center CDC*, n.d.). For this proposal, when discussing sexual abuse, the population is victims under 18 as defined by the 2003 World Health Organization “Guidelines for medico-legal care for victims of sexual violence." This definition stipulates that child sexual abuse or sexual violence committed toward an individual under the age of 18 years includes various actions and activities, such as "rape/forced sex, indecent assault, and sexually obsessive behavior" (World et al. 2003, p.5).

Many actions constitute sexual abuse; however, for this paper, the specific act or acts are not the focus but rather the creation of a traumatic effect. Such as non-consensual intercourse attempts to obtain sexual acts (World Health Organization et al., 2003, pp.5-7) and “involvement of a child in sexual activity it cannot fully comprehend or consent to (Halvorsen et al., 2020). This includes (1) being touched uncomfortably, (2) being made to touch another person's private parts involuntarily, (3) having one's private parts (breasts or genitals) touched involuntarily, and (4) being subjected to forced vaginal, oral, or anal sex(Rosmarin et al., 2018). Trauma experiences also come from sexual activities not limited to classic penetration. Still, they expand to various situations, such as touching and kissing in the genital area, verbal humiliation with vulgar vocabulary, and coercion into watching sexual activities or exhibitionism (Tardif et al., 2005). For example, exposing a child to sexual acts and pornography or having a child masturbate while the perpetrator is watching also falls under the category of sexual abuse. Finally, oral-genital sex on the victim or from the victim to the perpetrator, finger or object penetration in the anus of the victim is considered sexual abuse as well (Tsopelas et al., 2012, p. 307). The scope of these behaviors is all included in sexual abuse; however, the intensity of the trauma varies depending on the context and frequency of the acts.

Sexual abuse is a critical component of the Quadruple Taboo. Still, it is vital to recognize the context of sexual abuse, for this research will focus on the Orthodox Jewish Community. Therefore, it is crucial to understand the Orthodox Jewish community and the unique characteristics of this ethnic group as it operates as a closed community and the impact this research will have on social work.

Scope of the Problem:

THE ORTHODOX COMMUNITY

Orthodoxy is a relatively new term that describes a variety of Jewish groups who share a common denominator of dedication to Torah and Halacha, known as the oral and written commandments (Jewish Virtual Library, n.d.). Authors Rosen, Greenberg, Schmeidler, and Shefer (2008) describe the Orthodox community and its origins:

> Three main Jewish ethnic groups are Ashkenazim (descendants of Yiddish-speaking European Jews), Sephardim (descendants of Spanish and Portuguese or North African Jews), and Oriental Jews (descendants of Jews from the Middle East and Central Asia). The level of religious observance among the Jewish patients in the catchment area of northern Jerusalem ranges from secular, Reform, and traditional, through Orthodox, to non-Hasidic and Hasidic Ultra-Orthodox. Hasidic Jews belong to a movement of Jewish mystics founded in Poland by Rabbi Israel Baal Shem Tov (1700–1760) (Rosen et al., 2008)

These groups and subgroups of religious Jews believe in Torah observance, Mitzvot (the commandments), and commitment to Halacha (Freund & Band-Winterstein, 2013). Jewish Orthodoxy is not a religion you practice only in the synagogue; it is a religion, an ethnicity, and a culture (Abes, 2011). The religious aspect is guided by laws or halacha. These laws are the blueprint that drives daily life. For example, there are rules for waking up according to the timing of prayer, how to function when you wake up (wash your hands, thank the Lord for waking up), and dress and eat (dietary laws). These rules govern beyond the mundane activities of daily life. For example, there are rules for when to have sexual intercourse, when to work, on what days to cease work, and when and how to celebrate holidays. Therefore, "most ultra-Orthodox Jews rely on the authority of rabbis in matters relating to religious law and in managing their everyday affairs, including, among others, issues of sexual abuse and how to cope with them" (Zalcberg, 2015, p. 110).

For Orthodox Jews, following halacha comes from different motivations. One motivation is the belief that the world is a hallway into the world to come and that all actions and thoughts are recorded and used to secure a place in the eternal world to come (Akerman, 2019). Another motivating belief is that halacha trains us, as human beings and as a

community, to be better people and create a better world by being better. One way halacha acts as a training manual is to design boundaries around daily actions to train the person for self-control and respect for others (Rosenthal, 2005). One example is the elevation of daily actions with religious intent and ceremony that imbues an action with meaning and divinity. For example, before one eats, they bless the food. This action of blessing 1) creates intent and thought of what one is eating, 2) metaphysically elevates the action by blessing it, and 3) trains the person to appreciate their food.

These boundaries and restrictions make the communities physically separate from the broader population. The Orthodox community can be "characterized as collectivist, traditionalist, patriarchal, and insular". It is also highly hierarchic, with members expected to be loyal to it, obey its leaders, and comply with strict behavioral codes beyond strictly observing the Jewish commandments" (Nadan et al., 2021, p.1). Therefore, it is common for Orthodox Jews to live in separate towns or neighborhoods. They keep themselves segregated from non-Jews as well as secular Jews, reject Western and modernist values, and study in a separate semi-private education system (Coleman-Brueckheimer et al., 2009), (Shoham & Timor, 2014), (Weiss et al., 2013; Zalcberg, 2017) (Nadan et al., 2021). The more insular subgroups tend to fear outside systems, particularly the government and secular legal authorities (Schnall, 2006). Their rabbis are the ultimate authority and will determine how they relate to outside authorities (Katzenstein & Fontes, 2017).

Within these segregated communities, marriage and family life are central to the personal and communal life of Orthodox Jews (Ackerman, 2019). One of the first commandments is to procreate, and marriage is viewed as a holy union between a man and a woman. The high regard for family influences many aspects of life, and gender roles are derived and encouraged to protect family values and the family unit. For example,

> Orthodox Jewish boys and girls are usually educated separately from an early age. In more insular Orthodox communities, conversing socially with someone of the other gender is considered inappropriate, leading to a high degree of gender segregation outside the home. In addition, in these communities, sex is a taboo subject and not discussed (Zalcberg, 2015, p.124).

When children of the community reach adulthood, their parents will want to assist them in making a match that can become a strong marriage partnership (Holman & Holman, 2002). (Ackerman, 2019). This structure guides male and female relationships, even marriage partners, and has specific gender roles. Men are often viewed as the ultimate authority, particularly regarding religious matters, while women are seen as the home's caretakers and the family's material needs (Katzenstein & Fontes, 2017). Within this structure, there are consequences for not following the rules and particularly dire effects for those who break the rules. For example, those who do not keep the commandments suffer the consequences of being perceived as a sinner worthy of self-recrimination, discipline, chastisement, and ethical education. This perception of reputation and behavior is why it is pivotal to clarify the Orthodox community's attitude towards sexuality, as it directly influences how sexual abuse is seen and treated.

Orthodox Jews rely on the authority of rabbis and Halacha to regulate their sexual lives. By Jewish law, sexual relationships should be restricted to married couples. The rules of family purity (Nida) prohibit sexual relations at certain times during a woman’s menstrual cycle. There are prohibitions against incest, homosexual relations, and "spilling the seed in vain," which is why homosexual relations are unequivocally censured and viewed as a sin. Control mechanisms to prevent the transgression of these prohibitions include strict separation of the sexes, numerous restrictions and prohibitions concerning the body, stringent norms of modesty, and early marriage arranged through matchmakers. When these rules and regulations are broken, there is a compounding effect on the individual's life. This parsing of the Orthodox Jewish community's different cultural and religious aspects is essential for

understanding the second component of the Quadruple Taboo. The Orthodox Jewish community as a closed community lends to the ramifications of having a lack of discourse around sexuality, which is revealed by the stigma attached to violating the rules within the closed structure.

Violating these rules creates a stigma; therefore, sexual topics are kept a secret to avoid the stigma. The Orthodox society handles issues relating to sexuality by avoiding their discussion, especially among young people. Sexuality is considered a taboo topic and is surrounded by a strong "conspiracy of silence" (Zalcberg, 2015). Orthodox society tends to cover up behaviors viewed as deviant and avoid "washing its dirty laundry in public" to maintain social cohesion and preserve its good name and image as a morally superior society (Zalcberg, 2015, p.111). Since sexual abuse is a transgression of a perpetrator's rules, the stigma can often extend to the victim. For example, being a victim of sexual abuse can cause a person's reputation to be degraded and affect their marriage prospects. One would prefer to choose a match that has not dealt with trauma and its effect than choose someone who might need special care due to the impact of her being abused. Protecting a person's good name and reputation is highly significant in the face of the consequences that can come about. Therefore, any indication of professional help that expresses a need for treatment creates a stigma. To further understand the role of stigma and the complexity of the taboo it creates, it is essential to provide the defining characteristics of this population.

Grittner and Walsh (2020) explored the role of stigma in the lives of female-identified sex workers. They researched the definition of stigma:

> Gofman (1963) originally defined social stigma as “an attribute that is deeply discrediting,” reducing the possessor of the stigmatized attribute “from a whole and usual person to a tainted, discounted one’’ (3). Link and Phelan (2001) further theorize that social stigma becomes embedded within the individual, and one’s status becomes the totalizing lens through which society views them. This totalizing

> identity results in stigmatized persons experiencing negative external perceptions and social rejection (Phelan et al., 1997**).** Corrigan (2004) identified two forms of stigma: public stigma and self-stigma. Public stigma, he proposes, blocks stigmatized individuals from social opportunities, both directly through discrimination and also from self-censorship, such as when the stigmatized individual stops pursuing opportunities or seeking services such as healthcare due to prior negative experiences. Self-stigma involves the internal process within an individual who internalizes negative social perceptions, creating shame and negatively impacting self-esteem and self-worth (Corrigan, 2004). (Grittner et al., 2020, pp. 1654-1655)

Stigma creates a tainted perception of the individual within the environment. Whether it be by the perception of the people within the environment or a self-perception of the individual. The outcome is that the stigmatized individual is reluctant to approach or utilize resources that would be beneficial. For example, there are Orthodox Jews who claim that their community attaches a stigma to those receiving psychological help (Feinberg & Feinberg, 1979) (Becher, 2024). Individuals receiving treatment fear that anyone who learns of their situation will consider them "crazy" or "insane" (Wikler, 1989, p. 117). This stigma is compounded by the importance Orthodox Jews place on the family background when considering a partner for marriage, which is often wholly or partially arranged after careful investigation (Rockman, 1994). As such, Orthodox Jews often fear that by seeking therapy, they are ruining their siblings' or children's chances of finding a suitable match or their own match *Shidduch anxiety* (Greenberg, 1991; Margolese, 1998; Sublette & Trappler, 2000; Wikler, 1989) (Schnall et al., 2014). Furthermore, the intimate nature of their communities makes it difficult to keep such things a secret (Schnall, 2006). The ramifications of the closed community creating stigma extend beyond the individual's platform for discussing sexuality; it also impacts how parents interact and educate children. For example, parents' attitudes toward efforts to discuss child sexual abuse prevention with their children are beliefs in socialized shame. The social stigma towards sexuality makes parents feel awkward discussing sexual topics with children. Parents shared how social stigma makes sexuality

topics uncomfortable and scary (Prikhidko & Kenny, 2021). This is correlated with a more prominent theme that sexual abuse facilitates shame, self-blame, and stigma.

Another layer of the intensity of this problem is that shame and fear of reprisals keep children from telling someone they were sexually abused (Crisma et al., 2004), (Paine & Hansen, 2002), with cultural factors reinforcing such feelings (Reitsema & Grietens, 2016), (Halvorsen et al., 2020). Corrigan (2004) notes that stigma can be public stigma and self-stigma. In the case of sexual abuse, there is both public and societal stigma toward sexual abuse and sexual matters (Prikhidko & Kenny, 2021). Moreover, self-stigma is when the victim feels shame and a sense of being damaged due to the sexual abuse (Daniels, 2016). Both stigma (Deitz et al., 2015) and shame (Zalcberg, 2015) are common causes of the nonreporting of sexual abuse in various cultures. This is evident within the Orthodox community due to the importance of the family name, history, and reputation within community circles as nonreporting increases (Featherman, 1995). Another area where reputation impacts an individual's or family's desire to report sexual abuse is in the arena of marriage.

Many marriages are arranged in Orthodox communities, and the question of a family's reputation takes great practical significance. A family's reputation is important when considering a match. The slightest "strike" against a family can tarnish their reputation and severely impact the chances of prospective matches. This would be true even if a family member is a victim of sexual abuse. As Schnall (2006) concurs, there is a natural and palpable fear that reporting sexual abuse will adversely affect family standing in the community and marital prospects for family members (Katzenstein & Fontes, 2017).

As a minority culture with a long history of persecution, Jews have learned not to draw attention to their differences or take actions that might bring shame or notoriety to their

families, including reporting child sexual abuse to secular authorities (Featherman, 1995) (Katzenstein & Fontes, 2017). This historical and social development also embeds the fear of stigma in an ethical realm. Within the Orthodox Jewish community, the complexity of sexual abuse, the stigma it carries, and the taboo it creates can only be fully understood by delving into the intricacies of taboos and the culture of secrets.

TABOO AND SECRETS

According to the American Psychological Association, a Taboo is considered a religious, moral, or social convention prohibiting a particular behavior, object, or person. Therefore, the discourse regarding sexuality is perceived as prohibited within the Orthodox community. The issue becomes taboo and is not to be talked about publicly. This taboo generates consequences and a hushed atmosphere when sexual feelings arise or if sexual assault or abuse occurs.

The idea of Taboo and secrets is another dimension to the stigma and shame that we discussed above, contributing to the lack of discourse regarding sexual abuse. Empirical evidence supports that the most common reason for keeping secrets is being concerned about the social consequences (Afifi & Burgoon, 1998; Roesler & Wind, 1994) and the finding that perceived social disapproval significantly predicts secrecy (Major & Gramzow, 1999); (Vrij et al., 2003), (Itzhaky & Kissil, 2015). This evidence correlates with the ramifications of one being an outcast from the Orthodox community when a transgression of Jewish laws occurs. Additionally, secrecy requires secret keepers to intentionally and actively engage in strategic behavior that prevents others from being aware of the secret (Lane & Wegner, 1995). This type of behavior includes both active and inhibitory efforts. Diligent efforts are directed toward the social environment and can consist of activities such as hiding clues that might suggest a secret exists or changing the conversation topic. Inhibitory efforts are internal

strategies that can include suppressing secret-related thoughts or feelings and keeping the natural desire to disclose personal information in check (Lane & Wegner, 1995). (Itzhaky & Kissil, 2015). Lane and Wegner (1995) suggested that secrecy can activate a set of cognitive processes, resulting in an obsessive preoccupation with the secret. Their model suggests that secrecy starts with intentional thought suppression. This suppression of secret-related thoughts then leads to intrusive thoughts about the secret material, and these intrusive thoughts lead to renewed efforts of thought suppression. As a result, thought suppression and intrusive thoughts occur cyclically in response to each other, leading to a negative cycle that can lead to an obsessive and disturbing preoccupation with the secret material (Lane & Wegner, 1995; Mass et al., 2012; Wegner & Lane, 1995).

Most prior research on the consequences of secrecy has associated secrecy with a variety of adverse outcomes, such as health problems, obsessive thoughts, and emotional distress (Finkenauer et al., 2002; Finkenauer & Rime, 1998; Kelly & Achter, 1995; Major & Gramzow, 1999; Masuda et al., 2011; Wismeijer, 2011; Itzhaky & Kissil, 2015). The emotional energy a person keeps and lives with a secret that needs to be conjured is tremendous. Sexual identity and sexual orientation are common secrets individuals tend to keep. Yet most theories of sexual development tend to view disclosure of this secret as an essential first step toward healthy sexual development. (Itzhaky & Kissil, 2015). To best understand the ramifications of this closed community and the necessity for therapy, it is imperative to know the historical context in which these elements regarding same-sex relationships and abuse against women and children are situated.

History of the Problem

The study problem is an exploration of the phenomenon of sexual abuse of women by women within the Orthodox community. This problem exists in the larger context of sexual abuse. Historically, the social policy and social work support systems focused predominantly on interpersonal violence against women. The policies, guidelines, development, acceptance, and legitimacy of the LGBT community evolved from the existing context for same-sex relationship violence. Simultaneously and on a global scale, closed communities began to address the ramifications of sexual abuse and same-sex relationships within their communities. Within the Orthodox community, there is a stark contrast to how controversial psychological-cultural issues related to mental health have been handled. This is most notable about homosexuality and the concept of sexual orientation (Slomowitz & Feit, 2015). Whereas in other medical aspects, such as medical ethics, Orthodox Rabbinics are usually rooted in the most contemporary findings in science and research. As to what is and is not permitted, Jewish law takes on a technical/legalistic nature and application once scientific authority and clinical best practices are established. This is true of many medical and ethical decisions, such as end-of-life decisions surrounding brain death and organ donations, where Orthodox Jewish law must be integrated with the latest medical knowledge (Tendler, 1990). This is not the case regarding sexuality, sexual orientation, and same-sex relationships since it is against Jewish law, and therefore, there is no opportunity to compromise.

Same-sex relationships and the LGBTQ community:

Most historians agree that there is evidence of homosexual activity and same-sex love in every documented culture, whether such relationships were accepted or persecuted. We know that homosexuality existed in ancient Israel because it was prohibited in the Bible, whereas other sources reveal it flourished for both men and women in Ancient Greece. Despite different responses to homosexuality, the global ethos was one of the centuries of

persecution by church, state, and medical authorities. For example, homosexual activity or deviance from established gender roles or dress was banned by law or traditional custom; such condemnation might be communicated through sensational public trials, exile, medical warnings, and language from the pulpit.

Over time the response to this persecution was social movements and organizing around the acceptance and rights of persons who might today identify as LGBT or queer. Gradually, the growth of public media and ideals of human rights drew together activists from all walks of life, who drew courage from sympathetic medical studies, banned literature, emerging sex research, and a climate of greater democracy. By the 20th century, a movement in recognition of gays and lesbians was underway, abetted by the social climate of feminism and new anthropologies of difference.

In Western history, before the 19th century, there was little formal study of what was later called homosexuality. Early efforts to understand the range of human sexual behavior came from European doctors and scientists, including Carl von Westphal (1869), Richard von Krafft-Ebing (1882), and Havelock Ellis (1897). With the rise of Hitler's Third Reich, the former tolerance demonstrated by Germany's Scientific Humanitarian Committee vanished, and research, including the great library, was destroyed.

In the U.S., The Mattachine Society, founded in 1950 by Harry Hay and Chuck Rowland, was the primary organization for gay men as an oppressed cultural minority. Other important homophile organizations on the west coast included One, Inc., founded in 1952, and the first lesbian support network, Daughters of Bilitis, founded in 1955 by Phyllis Lyon and Del Martin. Through meetings and publications, these groups offered information and outreach to thousands. These first organizations soon found support from prominent sociologists and psychologists. Finally, in 1973, the American Psychiatric Association

removed homosexuality as an “illness” classification in its diagnostic manual. Before this, throughout the 1950s and 60s, when courts and clinics defined gay love as sick, criminal, or immoral, gay men and lesbians continued to be at risk for psychiatric lockup and jail, losing jobs and/or child custody. In 1965, as the civil rights movement won new legislation outlawing racial discrimination, the first gay rights demonstrations took place in Philadelphia and Washington, D.C. Expanding religious acceptance for gay men and women of faith, the first out gay minister was ordained by the United Church of Christ in 1972. Other gay and lesbian churches and synagogue congregations soon followed. As a result of hard work by countless organizations and individuals, helped by the internet and direct-mail campaign networking, the 21st century heralded new legal gains for gay and lesbian couples. Same-sex civil unions were recognized under Vermont law in 2000. Massachusetts became the first state to perform same-sex marriages in 2004 (*History of Lesbian, Gay, Bisexual, and Transgender Social Movements*, n.d.) This legislative change resulted from many actions throughout history, as same-sex relationships have not always been accepted by society.

Only in the past 20 years have laws been passed to legitimize same-sex relationships, marriages, and rights. One example is the changes to the Diagnostic and Statistical Manual of Mental Disorders. Silverstein, in his article The Implications of Removing Homosexuality from the DSM as a Mental Disorder (2009), gives an overview of the progression of homosexuality in the DSM:

> On December 15, 1973, the Board of Directors of the APA declassified homosexuality per se as a mental disorder from the DSM-II… By DSM-III (American Psychiatric Association,1980), homosexuals were classified as either ego-syntonic toward their sexual orientation and not in need of treatment or ego-alien, and therefore, suffering from a mental disorder... In the DSM-III-R (American Psychiatric Association, 1987), the diagnosis of ego-dystonic homosexuality was removed. Left was the residual diagnosis, Sexual Disorder Not Otherwise Specified (e.g., ‘‘persistent and marked distress about one’s sexual orientation’’), but this could apply to ‘‘any’’ sexual orientation (Silverstein, 2009, p. 161).

Silverstein (2009) argued at the Nomenclature Committee that psychiatric diagnosis was the child of morality and that Judeo-Christian values controlled psychiatric practice. For example, “in 1973, when the APA finally responded to decades of activism by removing homosexuality from the DSM. Unfortunately, however, that vote did not signal the absolute end of the psychiatric stigmatization of homosexuality; shortly afterward, during the height of feminists' critiques of traditional gender roles, APA agreed to introduce gender identity disorder into the psychiatric nosology” (Ault & Brzuzy, 2009, p.188).

It is noteworthy that, since 1980, transsexuality has been classified as a mental disorder and, consequently, is currently included within the international manuals of mental disorders of broader scope, such as The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research of the World Health Organization (WHO) and with the term ‘‘Gender identity disorder’’ was reflected in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R) produced by the American Psychiatric Association, even if it has been partially removed from the fifth edition (DSM-V et al. Association 2013b) (Atienza-Macías, 2015), All in all, this new edition does not meet the expectations of the various associations and groups of transgender individuals who expressed the hope that transsexuality would be removed from diagnostic classifications, similarly to how homosexuality was removed in the 1970s (Atienza-Macías, 2015).

The literature demonstrates social changes and movements regarding the acceptance and legitimacy of same-sex relationships, different sexual identities, and orientations (Silverstein, 2009). However, there is a gap between the progress and development of society's attitudes towards same-sex relationships, as demonstrated in the article and in the processes throughout the different publications of the DSM, and the strict rigidity within the Orthodox community to prevent any social change, attitude, and laws.

The dominant view within Orthodox Judaism, one of the more traditional and religiously observant movements, does not accept gay and lesbian relationships (Powers, n.d.). (Abes, 2011). While the more modern Orthodox groups attempt to be more inclusive and grapple with the issue of homosexuality, for the more traditional Orthodox Jews, there is no room for compromise since the Torah is clear and immovable in its forbiddance of homosexuality (Beck, 2010). For Orthodox Jews who follow the text as it is written, which does not allow for any contextual considerations, the Torah clearly prohibits any sexual activity between two men and, by extension, homosexuality. For example, Leviticus 18:22 says, "You shall not lie with a man as one lies with a woman; it is an abomination." It continues with, "A man who lies with a man as one lies with a woman, they have both done an abomination they shall be put to death, their blood is upon themselves" (Leviticus 20:13). In recent years, other interpretations have been made that represent these and other injunctions in the Talmud (central text and the primary source of Jewish law and theology) as irrelevant to the modern construction of gay sexuality (Greenberg, 2004; Mariner, 1995). While some modern Orthodox groups argue for more contextualized and culturally relevant interpretations regarding homosexuality, this particular issue is off-limits for the Orthodox communities, and they are only willing to accept the literal interpretation (Itzhaky & Kissil, 2015). For Orthodox Jews, homosexuality is a sin that carries a severe punishment. Therefore, Orthodox Jewish gay men, due to the strict rules against homosexuality, choose to conceal their sexual orientation (Itzhaky & Kissil, 2015). Often, a son who comes out is shunned by the Orthodox community, and his parents sit shiva for him (the Jewish mourning ritual on the death of a family member; Mark, 2008). Further, Orthodox Jewish gay men know that if they come out, their sexuality may reflect negatively on their families. For example, an openly gay individual may tarnish a sibling's potential for an arranged marriage (Mark, 2008). The enormous pressure to conform and to avoid shaming the family or losing

the only world they know significantly adds to the difficulties facing Orthodox gay men as they try to accept themselves in this religious community. Regarding their sexual orientations, many gay men in the general population struggle with isolation from family and friends. This process is much harder for Orthodox Jewish gay men because they are raised to remain separate from the secular world and, therefore, have more difficulty seeking out secular support and resources. Additionally, they tend to avoid seeking help from within their communities because of the difficulty of maintaining anonymity. Understandably, many Orthodox Jewish gay men choose to conceal their sexual orientation. (Itzhaky & Kissil, 2015). In a qualitative study that researched 22 Orthodox gay men by Itzhak & Kissil (2015), they discovered that participants tried to resist their homosexual identity by denying they were gay, marrying, or seeking help and counseling to see if they could change how they felt. None of them tried to change the discourse in the community, accepting that homosexuality is a sin that they need to hide. Participants often talked about the importance of the Orthodox community in their lives, on the one hand, acknowledging the strict rules and norms that make being gay so difficult, but on the other hand, emphasizing that this community is what they know; it is familiar and comfortable for them and where they still want to live. Growing up in this religious community and being isolated from the outside world, many of them could not think of any other alternative. They reported relying on the community to provide for all their needs and felt there was no other place to live (Itzhaky & Kissil, 2015). Participants wanted to stay in their community and felt that this was their only home. They knew the possible grave consequences of homosexuality and could not afford to lose the only home they had ever known; therefore, they were willing to make every effort to ensure their sexual orientation remained concealed. (Itzhaky & Kissil, 2015). This study exemplifies the perception and outlook of the Orthodox community regarding same-sex relationships and the grave ramifications of being gay within the Orthodox Community.

Female sexuality in Orthodox Judaism is complex, and the primary principle is obedience to the law, governed by the Talmud, as well as interpretations of the law by Rabbinic scholars. Those texts are referred to by modern-day scholars who interpret the correct behavioral act. Feelings are generally not prohibited unless resulting in an act. Much of what is written about female sexuality is not from actual experiences but what is observable by men or assumed by them regarding genital intercourse. Female sexuality is seen as passive, not active. Limitations are placed on sexual expression; it is to be within a heterosexual marriage, and both behaviors and frequency are regulated. Sexual pleasure is acknowledged in women, which is important, but depending on the interpreter, subject to regulations and limitations (Biale, 1984). For both men and women, modesty laws are related to sexuality and define sexuality as purely based on the body (Glassgold, 2008).

Lesbian sexuality is not envisioned, thus not proscribed in Hebrew versions of Leviticus (unlike certain male sexual behaviors with another man (Leviticus18:22). The debate in Rabbinic texts is whether lesbian acts are actually sex, as what is traditionally defined as sex (male-female genital intercourse) does not occur (Biale, 1984). Suppose certain erotic acts between women are not defined as sex, and their legal status changes. These behaviors are deemed licentious and have fewer sanctions. However, these behaviors are interpreted by the Orthodox community in the same view as same-sex relationships with men. And, thus, punished as such. However, not defining lesbian sexual behaviors as sex moves it to another area of discourse. Ironically, this invisibility of women in the Talmud and the definition of lesbian “non”-sexuality presents certain Halachic (Jewish law) leniency (Glassgold, 2008). However, the social and communal perception regarding sexuality in general and women’s sexuality, in particular, is not discussed. It contributes to the social norm within the Orthodox community that this is a taboo issue, leaving no place for discourse around sexuality. A stark example of this gap comes from the professional field of Social

Work. Social Work moved from seeing different sexual identities as disorders to legitimizing sexual identities and accepting one's inclination and choice regarding one's own sexual identity.

Within the Orthodox community, these changes have not evolved. The Orthodox community, as noted above, has stringent rules regarding sexuality and gender roles. This gap creates shame, distress, and secrecy and harms an individual within the Orthodox community with a different sexual orientation than what is allowed. The lack of legitimacy does not allow sexuality or sexual identity exploration, even in thought. When another woman sexually abuses a woman within the Orthodox community, there is an extreme dissonance between her known social norms and her experience, which is what this research aims to explore. Understanding an Orthodox woman’s viewpoint also requires an explanation of the historical context.

Until 100 years ago, women and children were viewed as inferior to men. Children were used and abused for labor, and they were not viewed as equal or an entity that had rights or needed to be considered. Women did not have equal rights; they were considered men's property and benefited only by being one’s wife or daughter. Therefore, abuse, sexual abuse, or violence were prevalent. It depended on the nature of the men in their lives. Violence was part of their education, and their purpose was to satisfy men sexually. With different social global events, the feminist revolution started, and women’s rights were established in the law, rectifying policies, laws, and work opportunities to create equality between the genders. Parallel to this process, the social and legal views of children started to change, and laws against child abuse and sexual abuse were passed. These cultural changes reflect a positive social change in the status of women, a change in employment opportunities, the level of wages, and various characteristics that were once considered feminine and are now treated

more objectively. Unfortunately, in our society today, there are still gaps between the genders, which affects the view of a woman as an object and allows for situations of control and abuse. There is a gap between the victim's and criminal processes, which conflict with each other instead of complementing each other. Women or children who have experienced abuse usually describe guilt, shame, confusion, anger, and helplessness. Unfortunately, these feelings lead to the silencing of the event out of shame and fear of judgment. This silence creates difficulty and anger in society and the legal systems that want to pursue the law, seeking evidence and detailed exposure of the crime.

According to the World Health Organization, 1 in 3 women globally experience violence. They are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner – a number that has remained unchanged over the past decade (*Devastatingly Pervasive*, n.d.) Additionally, 6% of women globally report being sexually assaulted by someone other than their husband or partner. Given the high levels of stigma and under-reporting of sexual abuse, the actual figure is likely to be significantly higher (*Devastatingly et al.*). The World Health Organization continues to explain that violence – in all its forms – can impact a woman's health and well-being throughout the rest of her life – even long after the violence may have ended. It is associated with an increased risk of injuries, depression, anxiety disorders, unplanned pregnancies, sexually transmitted infections, HIV, and many other health problems. It impacts society and comes with tremendous costs, impacting national budgets and overall development (*Devastatingly et al.*). According to RAINN (Rape, Abuse & Incest National Network), every 73 seconds, another American is sexually assaulted. 1 out of every 6 American women has been the victim of an attempted or completed rape in her lifetime (14.8% completed, 2.8% attempted). About 3% of American men—or 1 in 33—have experienced an attempted or completed rape.

From 2009-2013, Child Protective Services agencies substantiated or found strong evidence to indicate that 63,000 children a year were victims of sexual abuse. Most child victims are 12-17 or victims under the age of 18. 34% of victims of sexual assault and rape are under age 12, and 66% of victims of sexual assault and rape are aged 12-17 (RAINN). These statistics demonstrate the prevalence of sexual abuse, the need for culturally sensitive approaches when treating these cases, and the understating of the traumatic effects presented in these situations.

TRAUMA

Judith Herman, in her book *Trauma and Recovery* (1992), explains that trauma is a person's reaction to an event that overwhelms their system. She notes:

> "Psychological trauma is an affiliation of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. . . Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe." (Herman, 1992. P.33)

Different people react differently to events they encounter. However, Van der Kolk reports on the most common causes of Post-Traumatic Stress Disorder (PTSD). He found that in men, the most common reasons are combat and being a witness of death or severe injury, while sexual molestation and rape are the most common causes of PTSD in women. (Van der Kolk, 2000). When people are faced with life-threatening or other traumatic experiences, they primarily focus on survival and self-protection. Their behaviors are a direct result of their way of coping, "they experience a mixture of numbness, withdrawal, confusion, shock, and

speechless terror...The longer the traumatic experience lasts, the more likely the victim is to react with dissociation" (Van der Kolk, 2000, p.8).

When the traumatic event results from an attack by a family member on whom the victim also depends for economic and other forms of security, as occurs in victims of intrafamilial abuse, victims are prone to respond to assaults with increased dependence and paralysis in their decision-making processes. The cultural and religious boundaries within the Orthodox Jewish community act as familial experiences; therefore, the trauma of sexual abuse often presents according to these parameters. Other known reactions to trauma are flight, flight, and fright. These reactions differ according to the amount of adrenaline and cortisol the body creates. Usually, in cases of sexual abuse, the body is overloaded by adrenaline and cortisol; therefore, the victim often freezes or is in a state of fright. Victims often continue to dissociate in the face of threat, suffer from profound feelings of helplessness, and have difficulty planning effective action (Van der Kolk, 2000).

Social norms, such as the modesty beliefs (described above) within the Orthodox Jewish community, heighten these feelings. The women then feel helpless and have difficulty planning effective action, leading the victim to self-blame. When the victims try to make sense of what happened to them, they often reflect and ask themselves, 'Why didn't I do something?' 'Why didn't I yell/hit/run away?' 'What did I do to make this happen to me? These questions perpetuate the allusion that the victim had control or did something to make the trauma happen.

When the environment reacts in a way that reinforces the feelings of the blame of the victim, it denotes the legitimacy to discuss what happened openly. The behavior seems abnormal to someone who does not know what happened to the victim, and the individual feels judged. If the environment does not accept these behaviors, for women to survive, they

need to hide their feelings and behaviors and act according to community standards. This hiding of one's feelings is partly because of how gender and women's roles in society developed throughout history.

PERCEPTION OF WOMEN'S ROLES AND WOMEN PERPETRATORS

Common gender stereotypes regarding women and a woman's role in society include mothering, being a nurturer, loving, and being empathic. Women are perceived as gentle, pretty, and delicate (Haines et al., 2016). The traditional social roles of women and men have remained unchanged for many years (Barska, 2005; Diekman & Goodfriend, 2006). The traditional social role of women is that of the lady of the house, taking care of the family and being focused on children and their happiness. Traditional occupational roles attributed to women are related to caring for others (e.g., homekeeper, nurse) and require communal characteristics (e.g., kind, sensitive) (Eagly et al., 2000). In most countries, attributes such as affection or sensitivity are considered more typical of women, whereas characteristics such as aggressiveness or courage are considered more typical of men (Dragomir, 2020).

The delineating of specific characteristics or character traits for women is prominently held within the Orthodox community. As noted in the discussion above regarding community practices, men are often viewed as the ultimate authority, particularly regarding religious matters. At the same time, women are seen as the caretakers of the home and the family's material needs. As caretakers, the notion that women would act abusively or cause harm is foreign. Therefore, any female-perpetrated sexual abuse that is acknowledged is viewed as an extremely rare occurrence (Peter, 2009). Despite its taboo status, the unfortunate reality is that some women sexually abuse children. Female-perpetrated sexual abuse is a relatively rare phenomenon compared to male violence. Researchers estimate a prevalence range between 1% and 20%, depending on whether the data is collected from official criminal

justice sources or self-report surveys (Peter, 2009). Despite the data suggesting that female-perpetrated sexual abuse is less frequent than male-perpetrated violence, denying women's capacity to harm children only succeeds in silencing the victim's experiences of female abuse (Peter, 2009). This is even more so for an Orthodox woman who is sexually touched or abused by another woman.

This research suggests that recognizing sexual abuse by another woman within the Orthodox community is extremely difficult. Not only do women not have the appropriate words to describe what has happened, but the lack of discourse regarding sexuality and the lack of differentiation between a supportive touch and a sexual touch also create a blurred understanding of what might happen when one woman touches another inappropriately.

The different definitions discussed above show the many broad elements and ramifications that come into play when another woman sexually abuses a woman. It shows the various dimensions of the Quadruple Taboo and how each aspect amplifies the difficulty of relating on a cognitive, emotional, practical, and physical level to what occurs when a woman sexually abuses an Orthodox woman or girl.

How the problem is within/connected to social work and the connection to social work values

Orthodox women whom other women have sexually abused are vulnerable on many levels. First, they are vulnerable as a sexual abuse victim. Second, due to their Orthodox structure and livelihood, which does not encourage talking openly about sexual feelings, sexuality, or sexual abuse, there are limited means to legitimize the experience and begin to heal from the abuse. Finally, the fact that other women have abused them confuses them and

makes them think their sexual identity might be questioned. All these factors create vulnerabilities and struggles, and social work's ultimate objective is to foster an equal society that considers each individual's struggles and strengths (Gelman & González, 2016). Furthermore, this research connects to specific Social Work values within the Code of Ethics. The first is to serve people in need: **"**Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and address social problems" The National Association of Social Workers (NASW) Code of Ethics" (Hartocollis, n.d.). Another apparent value refers to the dignity and worth of a person.

Women whom other women have abused feel devalued and are not acknowledged for their hardship. They often feel damaged and do not have a conscious comprehension of what has happened to them. Religious culture creates challenges that require a culturally sensitive approach that aligns with another value in the code of ethics: Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunities to change and address their needs. Social workers are cognizant of their dual responsibility to clients and the broader society. They seek to resolve conflicts between clients' interests and the wider society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession. Hartocollis, "The National Association of Social Workers (NASW) Code of Ethics (Hartocollis, n.d.). These values come into play as this study examines what information therapists who work with Jewish Orthodox women regarding sexual assault and abuse know about same-sex victims. An important ethical principle of social work practice is the concentration on increasing clinical knowledge and skills to aid clients better (NASW, 2008). One of the main directives of this study is to develop further the

clinical knowledge base of mental health practitioners working with Orthodox women struggling with sexual abuse by other women, thus better-informing assessment and treatment techniques that improve service to clientele. The social worker's requirement to serve clients' well-being is consistent with the core components of the social work value system. The NASW code of ethics states: "The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people…. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living" (NASW, 2008, para.3). Another important criterion of the social work value system that is relevant to this study is the principle of the importance of clinical competence and the significance of continual professional self-improvement. The NASW code mentions the ethical principle that "Social workers practice within their areas of competence and develop and enhance their professional expertise" (NASW, 2008). Additionally, "Graduate education serves multiple goals, including providing practical training, exposure to theory and research, and, at the doctoral level, an opportunity to learn the tools and attitudes of research and to expand the frontiers of knowledge" (Gelman & González, 2016, p.4)**.** Hopefully, this research will provide insight that will enhance the knowledge regarding the experience of orthodox women whom other women abuse.

Throughout this section, there was an attempt to demonstrate the complexities and intricacies that influence the thought process and mental space of a religious woman another woman abused. However, an added value of this research is the relationship and the effect between the therapist and the client when the therapist has to confront these issues as an Orthodox woman herself. There is growing literature on religious countertransference describing common types of negative countertransference (Griffith, 2006) (Moukaddam et

al., 2019) and nuanced relationships between the patient's religious transference and the therapist's countertransference (Abernathy & Lancia, 1998; Kehoe & Gutheil, 1984; Peteet, 1981; Spero, 1995) (Peteet, 2009). Additionally, Foster, 1998, notes that one must recognize the contributing role of the therapist's subjectivity in psychodynamically oriented practice, which cannot be more vital than in treating patients whose culture, race, or class markedly differ from that of the therapist. Foster explains that "cultural countertransference is viewed as a matrix of intersecting cognitive and affect-laden beliefs/experiences that exist within the therapist at varying levels of consciousness. Within this matrix lie the clinician's American life value system; theoretical beliefs and practice orientation; subjective biases about ethnic groups; and subjective biases about their own ethnicity" (Foster, 1998, p.253). Using qualitative methods to interview therapists regarding their personal experience from the therapist's stance and what they understand and come upon from the client's perspective will give added value regarding countertransference, transference, and the therapist-client relationship.

Conclusion

The phenomenon of Orthodox women whom other women have sexually abused has yet to be explored. This research attempts to look at this phenomenon and understand the different complexities from different angles to provide knowledge and awareness regarding the mental state of an Orthodox victim of sexual abuse by another woman.

This study can potentially aid victims, therapists, and clinicians by providing the knowledge and awareness with a culturally sensitive approach required to obtain legitimacy and practical information for their well-being. The following chapter will further expand and clarify the literature on critical concepts mentioned in the dissertation overview.

SECTION THREE: LITERATURE REVIEW

This research explores the phenomenon of Orthodox females whom other Orthodox women have sexually abused. The premise of this research is based on the intersection of four taboos and that an Orthodox woman whom another woman sexually abuses is affected by these four taboo notions. First is the taboo of sexual abuse, which creates shame and guilt. Second, the Orthodox community is a closed community that embeds the taboo to discussing anything sexual and the social ramifications of a closed community. The third is the taboo regarding same-sex relationships within the Orthodox community, and the fourth is a broader taboo regarding the perception of women and gender roles, which exclude the notion of women as perpetrators. The literature was examined through these four aspects.

The First Taboo: Sexual Abuse and Trauma

As established in the previous chapter, sexual abuse is a common phenomenon that can cause trauma and severely impact the victim throughout their life. There is extensive and well-documented research on the physical, emotional, and psychological effects of sexual abuse and the trauma victims suffer. Some studies cover many different population groups and settings, from males and females to children and adolescents, from veterans to inmates. All this research clarifies the issue's depth and intensity.

Research conducted by Rosmarin et al. in 2018 highlights that a history of childhood sexual abuse is a strong risk factor for many mental health problems (Beitchman et al., 1992; Kendall-Tackett et al., 1993; Mullen et al., 1996; Pérez-Fuentes et al., 2013). A key finding in this research is the prevalence of childhood sexual abuse, with worldwide rates ranging from 8-31% for females and 3–17% for males (Barth et al., 2013; Finkelhor et al., 2014; MacMillan et al., 2013) (Rosmarin et al., 2018). Earlier research conducted by Underwood et al., 2007 established that survivors of sexual abuse may experience single or multiple incidents impacting physical, behavioral, cognitive, or emotional functioning. In general,

adolescents experience higher rates of victimization than adult victims (Menard, 2002), and subsequently, after a traumatic experience, females are more likely to develop psychological disorders (Foa & Rothbaum, 1998; Rowan et al., 1994).

This is not the only study where sexual and trauma for women presents insight into how important it is to understand this taboo. Different studies continue the evidence that females differ from men regarding sexual abuse and trauma. For example, research studies from 1994 conclude that females who are sexually abused have a heightened risk of developing posttraumatic stress disorder (McLeer et al., 1994), but this disorder does not encompass all symptoms experienced in sexually traumatized survivors (Rowan & Foy, 1993). Additional symptoms can include low self-esteem, feelings of guilt, and depression. The risk of developing chronic disorders such as borderline personality and dissociative identity disorder also increases after being sexually traumatized (Murray, 1993). (Underwood et al., 2007). Ulman (2002) notes that despite the high prevalence and severe effects of Child Sexual Abuse (CSA), victims often do one of two things: (1) fail to disclose the abuse or (2) delay telling others for years (Smith et al., 2000) (Ullman, 2002).

Disclosing CSA is a complex and challenging process, and there are often discrepancies between detected and experienced incidents (Hillis et al., 2016; Mills et al., 2016; Stoltenborgh et al., 2015). On average, it takes between 17.2 and 21.4 years before survivors of CSA tell someone about their experiences, and the longer the delay before disclosure, the more serious the symptoms are (Steine et al., 2016; Easton, 2013). Around 60–70% of CSA survivors do not disclose until they are adults (Lemaigre et al., 2017), and 27.8% of CSA survivors have not told anyone (Ruggiero et al., 2004; Smith et al., 2000; Priebe & Svedin, 2008) (Halvorsen et al., 2020). Shame and fear of reprisals are two significant reasons that keep children from telling someone (Crisma et al., 2004; Paine & Hansen, 2002), with cultural factors reinforcing such feelings (Reitsema & Grietens, 2015).

Additionally, many children comply with the abuser's demand for silence because of secrecy pacts, violence, and threats (Schaeffer et al., 2011); Krähenbühl, 2011) (Halvorsen et al., 2020).

All this literature on the first taboo illuminates the depth of trauma that sexual abuse creates. The research establishes that beyond the act of abuse, the compounding trauma often leads to victims keeping the abuse to themselves. The proven traumatic ramifications of this act of self-preservation include ahame, guilt, and anger. When discussing this phenomenon, the cultural context of the orthodox victim magnifies the fear and ramifications of disclosure, which will be elaborated on further in the following section.

The Second Taboo: (a) Closed Communities and Orthodox Jews

Understanding the ramifications of a closed community is extremely important for this study since one of the pillars of the "Quadruple Taboo" is the orthodox community as a closed community and how that influences one who belongs to the community whom a perpetrator of the same sex sexually abused. Additionally, it is important to understand these facets as they affect how programs and other therapeutic responses are implemented. Living within a closed community includes different norms, rules, and behaviors. Usually, to belong to a community, there are threshold conditions that each Individual strives to meet. Failure to comply with these conditions, laws, or regulations has social consequences that could lead to exclusion.

In the Orthodox community, the threshold condition is to be a Jew who defines himself as Orthodox and abides by Jewish law (Halacha). The benefits of belonging to a community are expressed in a great sense of belonging and having a community that has a great deal of concern for each other. Many of the various laws are related to interpersonal relationships. This is implied in many of the religious rituals. For example, there are three

prayers a day that can be prayed privately, but community prayer in the synagogue is preferable. The minimum number of people for a communal prayer is ten men. This is also the case when birth and circumcision need to be performed when a wedding is held or to differentiate when the dead are buried. The recent research by Suskin and Al-Yagon (2020), which examined the effectiveness of a culturally sensitive short-term dance/movement therapy (DMT) group intervention, highlights how women's bodies and societal roles are highly intertwined within this closed community—examining 47 self-defined Orthodox Hebrew-speaking women who volunteered to participate in one of three non-clinical DMT groups held within 15 months. These groups were facilitated in non-clinical settings requiring neither psychological nor mental health affiliations nor referrals. There was no required baseline profile regarding any of the current study's dependent variables; therefore, apart from defining themselves as being affiliated with the Orthodox community, no other criterion was necessary nor checked. The women were ages 23–55 years (M = 33.32, SD = 7.75), married (except one participant), with 13–20 years of education (M = 15.32, SD = 1.60) and an average of 5.20 children (SD = 3.11). Data analysis from all demographic characteristics and all pretest study variables showed no statistically significant differences between Groups A, B, and C; therefore, the three groups were combined for all further analyses. Participants completed five self-reports at the pretest and post-test and reported their demographics. These self-reports included the body appreciation scale, Body investment scale, Rosenberg self-esteem scale, Mental health inventory, and the "Big Five" inventory, which are measures of constellations defined by the Five Factor Theory of Personality.

Suskin and Al-Yagon found that "at their essence, women differ fundamentally from men and must therefore assume distinct gender roles. Women's role is designated as primary caregiver, homemaker, and supporter to enable the husband's religious study and prayer. Specifically, the biblical commandment to "be fruitful and multiply" (Genesis 1:28)

irrefutably dominates these women's lives, leading to an abundance of children to raise" (Suskin & Al-Yagon, 2020). As a study investigating dance and movement, this research furthers the conversation about the physical role of women's bodies. As a closed community, numerous micro laws, rules, and regulations configure the most intimate aspects of Orthodox women's personal, physical, sexual, and reproductive lives.

Intertwined in all areas of bodily practice are the themes of modesty and concealment (Tzniut) and restraint regarding inner drives and outward behavior (Taragin-Zeller, 2014; Yafeh, 2007), characterized by abstinence from touching the opposite gender (Negia). All Ultra-Orthodox women ideologically adhere to these renunciation and concealment practices, designed to make the body and its material needs "fade away" or disappear. The findings from the study lend realization as to the uniqueness of how to provide interventions for this population. Results showed a significant increase in body appreciation on-body care and comfort in touch. In addition, participants reported a significant increase in psychological well-being and a significant reduction in perceived conscientiousness following the intervention. This study supports the idea of a culture-sensitive response that would benefit the Orthodox community, which is reluctant to accept and seek help from the secular world. In addition, this study indicates the great need for programs and educational workshops addressing the woman's body, touch, and self-image.

Another facet that is imperative to understanding how taboos are created within a closed community is the influence that being part of a closed community has on one's feeling of well-being. 2020 research published by Russo-Netzer and Bergman found that in highly close-knit community-oriented societies, a strong sense of belonging to a community enables individuals to prioritize more hedonic aspects of their lives to promote their life satisfaction. Of the 407 Ultra-Orthodox Jewish individuals interviewed (mean age ¼ 33.58, SD ¼ 8.89), 55.5% of whom were women. The results demonstrated that prioritizing meaning and a sense

of community were positively associated with life satisfaction. However, the beneficial aspects of belonging to such a community may come with a price; while having a strong sense of community may enhance life satisfaction, the often strict adherence to the norms and regulations of the community may hinder the ability to pursue one's own needs or a lifestyle choice that is counter to the community. For example, an individual in the process of questioning one's sexual orientation may ignore certain feelings to maintain life satisfaction.

Freund & Band-Winterstein, 2013, examined Social work-related change processes in the Jewish ultra-orthodox society in Israel. Due to the understanding that the Orthodox community, as a closed community, was reluctant to use secular services, they explored the experience of the encounter between the cultural, western, secular, and professional characteristics of social work and those of a closed and isolated group, such as the Jewish ultra-orthodox society, from the social worker's point of view. The study was conducted using the qualitative-phenomenological method. They interviewed 33 social workers with different religious identities in daily contact with ultra-orthodox Jewish clients across the country. Participants included six men and 27 women. A total of 9 defined themselves as ultra-orthodox; 13 were national religious, and 11 were secular, with 1–20 years of experience. Participants worked in mental health, child abuse, divorce, miscarriage, and distressed adolescent girls within the public, private, and third sectors, in hospitals, social service offices, and fellowships. The data analysis related to three major themes dealing with change processes in the ultra-orthodox society, namely closed-mindedness and openness. The first theme refers to community and social changes such as help-seeking and legitimacy awareness, community openness toward change, and the treatment of certain groups in the ultra-orthodox society. The second theme focuses on treatment contents such as what to talk about, what is still considered taboo, and the legitimacy of personality issues. The last theme relates to the role of social work in the ultra-orthodox society and addresses issues such as the

professional training of ultra-orthodox society members and the legitimacy of social work, together with rabbinic authority.

The research notes that the ultra-orthodox population is guided by an introspective dialog based on a closed-minded approach toward issues that contradict Halacha (religious law) and Torah views. These themes are often rejected out of modesty and, therefore, are not part of the ultra-orthodox discourse, despite the clients' desire and need to address them during treatment. In the article, they give sex as an example. However, the article lacks specific details regarding the nuances of this topic. The authors provide helpful insight within the discussion on the ramifications of Shame and stigma as a preventive factor in discussing taboo issues. They note that the Orthodox community is going through changes regarding receiving help from social workers. However, the process is gradual, and the need for Rabbinic approval and legitimacy to discuss one's issues in private still needs to develop.

Similarly, Keidar, Regev, and Snir. (2021) examined the perceptions of non-Orthodox arts therapists regarding work with children from the Orthodox community. Art therapy is defined as cross-cultural therapy, a term that points to the significant influence that the cultural difference between the different parties has on the process (Fung & Lo, 2017). Clients from different cultures may have different ways of expressing distress or understanding the source of their misery and how it might be alleviated (Fung & Lo, 2017). Likewise, cultural beliefs regarding mental illness and health sometimes lead to the development of a stigma, which presents an obstacle and amplifies the feelings of shame attached to experiencing mental distress and seeking treatment (Cross & Bloomer, 2010; Gopalkrishnan, 2018). A client's traditionalist-collectivist cultural background may present significant challenges in therapy since the Western system of cultural values underlying the practice of psychotherapy fundamentally differs from the traditionalist system of cultural values (Qureshi & Collazos, 2011). Studies examining psychotherapy in the Orthodox

community show that despite the progress in terms of openness to psychotherapy and the legitimacy of receiving aid from outside the Orthodox world (Freund & Band-Winterstein, 2013), there is still apparent ambivalence, suspicion, and hostility toward external sources of mental health support (Popovsky, 2010; Freund & Band-Winterstein, 2017). These attitudes are sometimes reflected in a limited ability to cope with doubts, a hard time engaging in introspection (Hess & Pitariu, 2011)), and an expectation that the client will be provided with practical recommendations (Hess, 2018). Furthermore, the fact that the community occupies such a central position in the life of the individual may undermine the very legitimacy of focusing on one's individual identity (Freund & Band-Winterstein, 2017; Schlesinger & Russo; Netzer, 2017). The community presence may also lead a client to be unwilling to expose hardships or cooperate during therapy due to fears of harming their own or their family's social status within the community (Greenberg & Witztum, 2013; Barth & Ben-Ari, 2014). On the other hand, other studies suggest that the therapist's provenance from outside the community may increase the client's sense of trust and engagement due to the decreased possibility of exposure within the community (Stolovy et al., 2012; Freund & Band-Winterstein, 2013). In the case of child psychotherapy, the parents may experience significant distress stemming from their sense of responsibility for the child's spiritual and religious upbringing (Schnitzer et al., 2011). The research questions were as follows: (a) How do non-Orthodox art therapists experience art therapy with ultra-Orthodox children? (b) What defines the specificity of the therapeutic relationship, if any, when the encounter is intercultural?

The sample consisted of 17 art therapists between the ages of 31 and 62 (M = 43.52) who are presently working or have previously worked with children from the Orthodox community. In addition to treating children from the Orthodox community, all the therapists had experience in art therapy with secular children. All the therapists were non-Orthodox women, most secular, except for three participants who identified as Religious Zionists.

Semi-structured interviews were conducted with the practitioners of art therapists. There were no previous personal or professional interactions with any of the study's participants. The interview guideline consisted of open-ended questions regarding therapists' general perceptions of practicing art therapy with Orthodox children.

One main objective from some of the interviews focused on bolstering the child's self-expression. This objective revolves around the ability to express the self, including encouraging flexibility and broadening the child's range of reactions to include ones that do not stem from cultural norms or ones that may even oppose them, such as refusal: "to allow another kind of expression, to allow me to connect to what it is I'm feeling." Some therapists expounded that children from the Orthodox community often find it challenging to be authentic and express thoughts and feelings as individuals in the context of strict cultural norms(Keidar et al., 2021). The inability to express one's feelings might also accrue due to the strict laws (Halacha) regarding one's conduct. The individual is not encouraged to discuss how they feel about the law but is encouraged to observe it despite the daily difficulty in performing it. Thus, suppressing any feelings of hardship.

Another objective that came up in the statements of some therapists touched on the need to develop and evolve the children's emotional vocabulary. Children, especially those of primary school age, tend to express themselves through their behavior rather than talk about their feelings, a blockage that manifests itself in behavioral problems. According to a few therapists, one reason for this may have to do with the Halachic ordinance against defamatory speech, which prevents the clients and their parents from speaking about the evil deeds committed by others. Furthermore, a few therapists mentioned that in some more complicated cases, such as sexual assault or fear of the client leaving the religion, the community put an end to the therapy, and the client was transferred for treatment by a therapist within the Orthodox community.

Some therapists talked about parents and children sharing experiences and dreams during therapy sessions, including forbidden or frowned upon in the Orthodox community. These therapists explained that the revelation of such content could occur because the therapist does not belong to the ultra-Orthodox community. Thus, there is little risk of her exposing the secret. Similarly, some therapists added that clients could be candid because of the therapist's lack of judgment toward the revealed content since she does not espouse the Orthodox community's ethical standards and value system. As a result, the clients and their parents are more willing to share and reveal traumatic experiences, such as multi-generational sexual abuse.

Language seemed to be a significant theme in this study. Some therapists explained that they use expressions taken from the religious world to describe and mediate therapeutic terms. They likewise adjust their language to resemble the Orthodox way of speaking, which is more proper and less casual. This way of speaking forgoes the use of slang, on the one hand, but on the other hand, it also sometimes lacks words and expressions of a higher register. Moreover, certain words, such as words describing bodily functions and secretions, are forbidden or frowned upon, and the therapists must adapt their speech accordingly. (Keidar et al., 2021).

The lack of language and words to express sexual abuse can create extra hardship and difficulty in discussing and disclosing what has happened. Inevitably, it enhances the taboo regarding discussing abuse. This leads to exploring the issue of sexual abuse within the orthodox community and the ramifications in a closed community.

The Second Taboo: (b) Closed communities, Orthodox Jews, and Sexual Abuse

By now, it is clear that sexual abuse leaves victims traumatized, leading to potential feelings of Shame, guilt, anger, confusion, and a host of other emotional and physical

detrimental side effects. In addition to this stark reality is the compounding impact an individual may experience as part of a closed community, such as found within Orthodox Judaism. Due to the unique aspects of Orthodox Jewish communities' reliance on Jewish Law (Halacha) and beliefs in modesty, the element of this closed community that requires further explanation is the taboo within the community of not having an open and healthy avenue for sexual discourse. This section explores the consequence of this taboo through the lens of Sexual abuse and child sexual abuse within the orthodox community and the further research that has been presented on this issue.

Rosmarin, Pirutinsky, Appel, Kaplan, and Pelcovits (2018) examined sexual abuse, mental health, and religion in a religiously diverse sample of male and female Jewish adults from North America. They found childhood sexual abuse to occur across the spectrum of Jewish religious affiliation and greater prevalence among formerly Orthodox individuals. Furthermore, a history of childhood sexual abuse was associated with a greater risk for psychiatric distress and less religious involvement. However, spiritual/religious engagement and belief appeared to facilitate resilience in the context of abuse. The authors Note that when sexual abuse is experienced in a religious context, effects can be particularly severe and may include changes in subsequent spiritual/religious development alongside the development of mental distress (McLaughlin, 1994).

The sample size was 372 participants, Jewish adult men and women from the United States and Canada, ranging in age from 18 to 83 years (m = 37.54, SD = 15.34). Participants completed a structured diagnostic interview for DSM-IV disorders. A series of self-report survey instruments were administered in six waves, each six months apart, over three years. Inclusion criteria for the study were as follows: (1) self-identity as Jewish (any affiliation), (2) 18 years of age or older, (3) current residence in the United States or Canada, (4) fluency in the English language, (5) access to a telephone, and a computer. This comprehensive

recruited a religiously diverse sample across four religious groups: (1) 100 individuals who were raised Orthodox and remain Orthodox (Always Orthodox), (2) 98 individuals who were raised non-Orthodox and later became Orthodox (Formerly Nonorthodox), (3) 138 individuals who were raised non-Orthodox and remain non-Orthodox (Never Orthodox), and (4) 36 individuals who were raised Orthodox but no longer affiliate with Orthodoxy (Formerly Orthodox).

The research found that sexual abuse was associated with significantly higher levels of depression and anxiety, lower levels of well-being, and a 34% greater likelihood of having a diagnosable psychiatric disorder. While healthcare professionals may hesitate to engage in frank and open discussions about sexual abuse when treating patients from isolated religious communities, these results highlight the importance of screening for sexual abuse among Jews. They also highlight a need for continued Jewish community-based prevention and education programs, such as those provided by Amudim, Jewish Community Watch, Takanot, and other organizations.

Within each of the groups mentioned above, a history of sexual abuse was associated with significantly lower levels of intrinsic religiosity (viewing faith as a master motive) and lower levels of religious observance. This latter finding is consistent with theoretical and empirical reports in the literature suggesting that sexual abuse may have particularly deleterious effects on spiritual/ religious development (Ganje-Fling & McCarthy, 1996; Rossetti, 1995). It is possible that known psychological sequelae of sexual abuse, such as worthlessness, lack of purpose, and hopelessness, may undermine the maintenance of spiritual faith and practice. Further, sentiments of disillusionment, betrayal, and mistrust of others may engender spiritual struggles and anxious or avoidant attachment to God, particularly in cases where ostensibly religious individuals perpetrated abuse.

This latter result is particularly notable considering the above discussion; despite the potential for religious victims of childhood sexual abuse to develop spiritual struggles, the domain of spirituality/religion can remain a helpful resource. In this regard, spiritual/religious engagement and belief hold promise for facilitating resilience in the context of sexual abuse. Notably, recent years have seen the development of spiritually integrated interventions for survivors of sexual abuse (e.g., Murray-Swank & Pargament, 2005), and initial findings are promising.

This relationship between religious/spiritual belief and sexual abuse is explored further by Korbman, Pirutinsky, Feindler, and Rosmarin (2021), who examined CSA (Child Sexual Abuse), anxiety, depression, and positive/negative religious coping among 372 Jewish community members with and without CSA histories.

Childhood sexual abuse (CSA) is a pervasive problem affecting between 1% and 17% of men and 10% and 30% of women in the United States, and 3% and 29% of men and 7% and 36% of women worldwide (Finkelhor et al., 2014; Pereda et al., 2009; Stoltenborgh et al., 2011). It is, therefore, of utmost importance to study CSA within a cultural framework to understand factors that may underlie prevalence, disclosure, and effects on physical health and psychological well-being for survivors of abuse.

In a study of 1,005 Israeli adults, 25% (31% of females and 16% of males) endorsed a history of CSA (Schein et al., 2000). Most recently, a longitudinal study of 372 Jewish men and women in the United States and Canada found that 18% of men and 27% of women endorsed a history of any child sexual abuse (Rosmarin et al., 2018) in addition to prevalence rates, which don't seem to differ across secular and religious groups. It is also important to understand the impact of CSA within a cultural context. CSA is associated with many long-term problems and adverse mental and physical health outcomes, including anxiety,

depression, substance use, sexual problems, self-injury, eating disorders, increased risk for revictimization or perpetration of abuse, and other interpersonal problems (Briere & Elliott, 1994; Finkelhor, 1990; Garnefski & Diekstra, 1996; Hornor, 2010; Maniglio, 2009; Polusny & Follette, 1995). Existing research suggests that CSA occurs at similar rates among Jewish individuals as in the rest of society in both Orthodox and non-Orthodox sects (Blau, 2017; Mansbach-Kleinfeld et al., 2015; Rosmarin et al., 2018; Schein et al., 2000; Yehuda et al., 2007). In the Orthodox Jewish community, as well as among other religious minority populations with strict laws governing sexual behavior, prevalence rates are still high and comparable to secular groups (Resnicoff, 2012; Rosmarin et al., 2018; Spröber et al., 2014; Yehuda et al., 2007).

CSA is largely underreported in the Orthodox Jewish community because of the stigma related to sexual behavior and because of Jewish laws about reporting misdeeds within the community (Brofsky, 2017; Katzenstein & Fontes, 2017; Resnicoff, 2012). Due to the sensitive nature of the topic and the impact of stigma on its exploration, research examining the impact of CSA in religious minority populations, such as the Jewish community, is, therefore, particularly important. Such research is also fundamental to understanding CSA in a cultural and religious context.

The present study by Korbman, Pirutinsky, Feindler, and Rosmarin (2021) examined data from a community sample of 372 Jewish men and women who participated in the Harvard Medical School Study on Judaism and Mental Health (Rosmarin et al., 2018). The parent study utilized anonymous, self-report survey instruments and assessments administered to adult participants. CSA was just one of many variables examined throughout the study. Depression, anxiety, and religious coping data were also measured. As such, the data for the present study was derived from the same time point, and all analyses were cross-sectional. As expected, CSA victims reported higher levels of anxiety, depression, and

negative religious coping than those without a history of CSA. As well spiritual struggles, as measured by negative religious coping, were significantly positively associated with CSA, anxiety, and depression, and mediated relationships between CSA and these aspects of mental health. These findings underscore the potential clinical relevance of spiritual struggles among religious individuals with CSA and the importance of addressing Spirituality and Religion as factors in treatment.

Ben-Ezra, Palgi, Sternberg, Berkley, Eldar, Glidai, Moshe, and Shrira (2010) explored the impact of sexual trauma on changes in religious perception, subjective health, and mental health among sexual assault victims. The author's population choice to focus on religious Jewish women, who suffered from one of the most horrible traumas women can go through, provides insight into how integral it is to provide culturally sensitive intervention for this population. The author's research revealed that, because of cultural and societal reasons, mainly stigma and blame from close circles (e.g., family members, neighbors, etc.), these women did not seek professional help and decided to use an indirect approach and gain help and support from internet forums. If a stronger secularization is found after trauma among these women and in case this secularization is found as detrimental to their mental health, first aid centers and professionals better understand how to help them. A total of 111 Jewish women participated in the study, including 51 sexual assault victims and 60 comparisons matched on age, religion, and marital status. The study was of a retrospective, cross-sectional design. Approximately half of the women (47.5%) who suffered sexual assault changed their religious perception and belief in the direction of secularization. In addition, these women exhibited elevated psychiatric symptoms and lower well-being relative to the comparison group. Generally, the sexual assault victims reported being more stigmatized, having lower subjective health, poorer mental health, lower coping ability, and lower well-being relative to the comparison group. These results support previous studies that found similar results

(Falsetti et al., 2003; Fontana & Rosenheck, 2004; Frazier et al., 2001; Littleton et al., 2008). One conclusion that is apparent from this research is that the individual's belief system was altered and disrupted due to sexual trauma. The effect of sexual assault was significant and led to intensive secularization. This loss of faith demonstrates that the trauma shatters the core beliefs of a benevolent, controlled, and just world (Janoff-Bulman, 1992; Lerner & Miller, 1978), all of which are important aspects of spirituality. This is in line with theories that ascertain that trauma not only obstructs world views but also leads to drastic intrinsic and extrinsic behavioral and motivational changes (Foa & Rothbaum, 1998; Janoff-Bulman, 1992; Lerner & Miller, 1978)

The research found that a small number of sexual assault victims experienced a heightened religiousness (high sense of spirituality), which is one of the components of posttraumatic growth (Calhoun & Tedeschi, 1998). This heterogeneous change pattern reflects the complex relationship between trauma, faith, and belief system change that is moderated by other personal, interpersonal, and environmental factors. As seen in the result of the logistic regression, being stigmatized was found to be an important factor in exacerbating the change in faith. This can be explained by the lack of acceptance and blame that is bestowed on women who have suffered sexual trauma. Blameful comments such as "she was asking for it" or "she did not dress modestly enough" can have a deadly effect on the victim, especially when coming from close family members and friends (Littleton et al., 2008). At times, such blameful comments may undermine the victim's ability to cope. The loss of interpersonal trust and belief in times of peril can take its mental toll and lead to changes in faith. This may explain why, among religious women, most changes in faith were toward secularization and not vice versa. Secular society tends to be less denouncing toward sexual trauma victims in comparison with more conservative societies that tend to cover up these issues. The results of the preliminary study revealed changes in belief patterns due to

psychological trauma. Mental health professionals should take these aspects into consideration when treating women who suffered sexual trauma.

Ben-Ezra, Palgi, Sternberg, Berkley, Eldar, Glidai, Moshe, and Shrira (2010) show evidence of the depth of impact the trauma from sexual abuse causes within a closed community. It demonstrates that there is a change in one's relationship with one's belief system and the community when a person is sexually abused. It also supports the understanding of stigma and blame, which are stronger in the orthodox community when a victim is sexually abused. The community and trauma work in tandem, influencing the ability of a victim to come forth and talk about what has happened to them. This is reflected in different attempts for intervention within the Orthodox community.

Over the years, there have been successful interventions working on providing support within the Orthodox Community. For example, in their article "Addressing Childhood Sexual Abuse Jewish Communal Obligation and Response" (2014), Gerson, Rosenthal, and Hoffman give insight into the challenges of the Orthodox community when discussing child sexual abuse and also describe the implementation of a specific educational intervention. This article describes an evidence-based education/prevention program for New York City and Long Island gatekeepers (rabbis, administrators, Jewish educators, social workers, psychologists, lay leaders, and volunteers) in the Jewish and broader community. A collaboration of the New York Board of Rabbis (NYBR) and FEGS Health & Human Services is designed to give these gatekeepers the knowledge and tools to identify and responsibly report cases of child abuse. Rabbi Reiss (2012) speaks of the critical importance of establishing a safe atmosphere in which concerns can be raised by those who suspect abuse and of educating professionals so that they "understand how and when to make a report to the governmental authorities." Creating a safe atmosphere and space to discuss sexual issues correlates with this research in exploring the taboo regarding sexual discourse in the orthodox

community. In the summer of 2007, the team at the NYBR met the founder of "Darkness to Light," a national non-profit organization based out of Charleston, South Carolina, and learned about its Stewards of Children initiative (see www.d21.org). A 2.5-hour training program for professional leadership, staff at various organizational levels, and volunteers based on the principles of choice, consciousness, and personal power that educates and motivates them to prevent, recognize, and react responsibly to child sexual abuse. The program of Stewards of Children has been tested through different research designs and has been found effective in keeping the community safer. This research has also found that, for every trained adult, up to ten children in the community were safer. Individuals who completed the training indicated that the program had reframed how they approached child safety as parents, grandparents, neighbors, and professionals.

The NYBR did not anticipate the resistance it soon encountered to its outreach effort. Although many congregations and rabbis thought the work was very important and they were proud to be part of an organization that was tackling this critical issue, they hesitated to bring it into their congregations. It was still too difficult for many in the Jewish community to discuss the issues of child abuse and molestation. Thanks to some courageous community leaders, key organizational partners, and government and foundation funding, Stewards of Children began to gain traction in the New York area. When implementing this program, they introduce the Stewards curriculum with some Jewish content. Over the last few years, another 2500 community leaders were trained in this program in an attempt to make the community safer. The community needs to be aware that child abuse, child sexual abuse, and family violence of all sorts occur in the Jewish community as much as they do in the general community. Community leaders need to learn about the issue, act on that knowledge, and ultimately have an impact on this epidemic and its devastating effects. This article demonstrates the ambivalence regarding sexuality within the Orthodox community. On the

one hand, there is a fear of discussing sexuality, child sexual abuse, etc. And on the other hand, there is a real need. The article also emphasizes the importance of using Jewish content to enable discourse and create collaboration. This demonstrates the challenge and ambivalence within the orthodox community regarding sexuality. There is a great difference between the personal and the communal. On the personal level, in a one-on-one relationship or conversation, people from the orthodox community may be willing to admit, discuss, and relate to sexual issues. However, when it comes to the communal realm, there is a reluctance to address the issue without having a dominant Rabbi or Rabbinical authority to lead the way. This is also reinforced in the next article, which examined sexual education in Israeli Orthodox schools.

Hartman and Samet (2007) attempt to understand what happens when religious traditionalism is brought explicitly into the conversation about sexuality education. Cultural ideologies defining sexuality as a "problem" are not only overtly stated but formulated as a prescriptive set of norms. The researchers interviewed teachers in Israeli religious high schools about their attempts to negotiate among (1) the cultural ideology of a religious establishment that prohibits all adolescent sexual behavior, (2) their own role as agents of socialization within that establishment, (3) their concurrent (and increasingly conflictual) role as caretakers committed to the healthy development and emotional well-being of students, many of whom have, in body if not in mind, rejected or simply rendered irrelevant the tradition's governing ideologies and norms; and (4) their own internal morass of unresolved emotions, deeply held values, and axiomatic beliefs. They used a qualitative design since this topic has not been previously researched to understand in depth what happens in religious Orthodox schools as far as sexual discourse is concerned from the educator's point of view. The researchers conducted one-to-one, in-depth personal interviews with 13 female and nine male teachers about their thoughts and experiences connected to sex education in Modern

Orthodox Israeli high schools. Informants' teaching experiences varied; all had a strong background in the study of biblical and rabbinic writings. The male teachers were all graduates of upper-level rabbinical seminaries, and the female teachers were graduates of Judaic Studies programs in teachers' colleges or universities. It is important to note the significant differences between the boys' and girls' schools. The latter, for example, in grades 11 and 12, offered special weekly classes, sometimes more and sometimes less formal, that dealt with issues of marriage and family life as an extension of classes in the Bible and other religious literature addressing marriage and family life. Boys' schools, by contrast, offer no such courses. The questions guiding the interviews were as follows: Do the teachers teach sex education? If so, what material or curricula do they draw upon? What sources of knowledge/authority do they look to for guidance in making these decisions? How do they define what their students need? How do religious teachers negotiate the tension between traditional norms and ideals and the realities of their students' lives? How do they understand and make space for the developmental needs of the adolescents in their classrooms while adhering to a traditional point of view? How do they relate to the differing and often conflicting sources of knowledge concerning what is "good" for the adolescent? How do they make sense of their roles as agents of their pupils' socialization into healthy religious adulthood? They found that teachers use one-on-one conversations to emphasize that while the religious law itself is indisputable and beyond question, human weakness can undermine one's ability to live up to its standards. Acting upon sexual desire neither invalidates his/her religious identity nor commits him/her to exile from the religious community. The findings demonstrate the failure of Orthodox Israeli high school teachers to generate an alternative, "unofficial" discourse of sexual education that adequately addresses students' lives and needs. In this case, the consequences of attempting to do so compromised teachers and put students at risk. The non-language they constructed to speak about sexuality in the classroom turned

out, at best, to be no language at all and, at worst, a language of obfuscation and intimidation whose inadequacies gave rise to its diametrical converse: a perverse confessional mode all the more frightening for its unmediated, unsupervised directness. The researchers concluded that sexuality must not simply be addressed within the educational setting but needs to be addressed directly. Unfortunately, the article demonstrates as well the hardship an educator has when trying to discuss sexuality within the orthodox community. The taboo regarding sexual discourse is so severe that educators struggle with addressing sexuality. In this atmosphere, one can just conclude how difficult it would be for a victim of sexual abuse to reveal or disclose any sexual act or abuse that was committed against them. Understanding the cultural atmosphere and taboos is monumental to working with the orthodox religious community.

Third Taboo: Same-sex relationships in the Orthodox Community

Being part of the Orthodox community has many advantages in terms of feelings of purpose, community, and belonging. However, as mentioned, there are also ramifications when one goes against the rules, guidelines, and expectations of the community. As noted in the study problem, same-sex relationships, especially homosexuality, are considered a sin that is not acceptable within the Orthodox community.

In a qualitative study that researched 22 Orthodox gay men by Itzhak & Kissil (2015), Individual in-depth interviews were conducted to better understand their experiences living with a concealed gay identity in their community. The participants lived in the northeastern part of North America and ranged in age from 18 to 48 years old. The inclusion criteria were being an Orthodox Jewish gay man, 18 years old and older. All participants but one reported being married, and 19 reported having children. Participants were recruited through a

snowball sampling approach. Four dominant themes emerged from participants' responses: Emotional turmoil, ways of coping, impact on family relationships, and importance of the context. All participants in this study described a range of negative emotions related to realizing they were gay and knowing that homosexuality is considered a sin in their religious community. Participants described tremendous Shame, guilt, disgust, and self-hatred. Several participants talked about suffering so much that they thought about killing themselves. A few tried to commit suicide. All participants reported no doubts about the need to hide their homosexuality because it was a quality in them they could not tolerate or accept and, therefore, believed that nobody else in their religious community would accept. The need to hide their sexual identities, even from people who are close to them, added another layer to their negative feelings. Thus, not only did the participants feel shame and guilt about being gay, but they also reported feeling bad about having to live dishonest lives and lie to their loved ones on a daily basis. The researchers discovered that participants tried to resist their homosexual identity by denying they were gay, marrying, or seeking help and counseling to see if they could change how they felt. None of them tried to change the discourse in the community, accepting that homosexuality is a sin that they need to hide. Participants often talked about the importance of the Orthodox community in their lives, on the one hand acknowledging the strict rules and norms that make being gay so difficult, but on the other hand, emphasizing that this community is what they know, it is familiar and comfortable for them and where they still want to live. Growing up in this religious community and being isolated from the outside world, many of them could not think of any other alternative. They reported relying on the community to provide for all their needs and felt there was no other place to live (Itzhaky & Kissil, 2015). Participants wanted to stay in their community and felt that this was their only home. They knew the possible grave consequences of homosexuality and could not afford to lose the only home they had ever known; therefore, they were willing

to make every effort to make sure their sexual orientation remained concealed. (Itzhaky & Kissil, 2015). This study exemplifies the perception and outlook of the Orthodox community regarding same-sex relationships and the grave ramifications of being gay within the Orthodox Community. Especially the difficulty it creates with feelings of shame and guilt and as a taboo subject within the Orthodox world.

Shilo, Yossef, and Savaya, in 2014, studied the effect of religion on Jewish male homosexuals. The research aims to understand how being part of a religious community adds stressors to the experience of homosexuality within a minority religious group, how the lack of support from the community affects the stress symptoms on the Individual, and how religious people who often turn to their internalized religious emotions for support, may or may not have that tool available when dealing with this cause of stress. The article also examines how internalized homophobia as a result of growing up and living in a mainly homophobic society affects the religious male homosexual. Although being a part of a religious community has been known to have a positive effect on mental health, as the community gives a sense of identity and belonging, the homosexual experience is an identity conflict as the community lacks supporting homosexual activities and is considered to be forbidden according to religious law. Additionally, there is an expectation that members of the community marry, have children, and value traditional family life. Sexual orientation is a part of identity formation within an individual. The importance of acceptance of one's identity by the individual's immediate support system is an important factor in the individual's mental health during identity formation. This can also be said of religious identity. If there is a conflict between these and a lack of support, there may be an increase in feelings of guilt, shame, depression, suicide ideation, and behavioral attempts at increasing prayers and expressing anger with God (Schuck & Liddle, 2001; Subhi & Geelan, 2012).

Shilo, Yossef, and Savaya (2014) studied a group of 113 Jewish homosexual males, examining internalized homophobia and how the level of social acceptance affected the stress and, therefore, the mental health of the group. Variables included levels of religious affiliation and level of "outness" – i.e., the stage in the "coming out" process. The study showed a strong positive correlation between social acceptance and positive mental health. It also showed a correlation between high levels of internalized homophobia and negative mental health. Additionally, positive religious coping was not shown to have a positive correlation with mental health. The authors used a demographic sample of 113 Jewish homosexual males with independent variables such as age, religious affiliation (very to not at all), sexual orientation, education, and family status. Linkert scales were used for questionnaires regarding the variable's studies (Coping strategies, mental health, internalized homophobia, and social support). Regression coefficients, mean, and deviations were run to create a correlation table of coefficients between the variables. This research touches on a very fundamental part of the Quadruple Taboo. When discussing the victims of same-sex abuse, understanding the Jewish-orthodox attitude toward same-sex relationships is key to understanding the issues that the victim is experiencing. A religious female who has been brought up to turn to her internalized religious emotions as a support system for coping with stress and negative emotions, often turning to God and prayers for assistance, may find that these sources of support can no longer be used in the case of sexual emotions and possible lesbian feelings. With this support system unavailable, stress will increase, and negative mental health can result. Additionally, internalized homophobia may further increase stress, as will the fear that her human external support system – family and friends – will not be there for her in times of need.

Similarly, Zeidner & Zevulun. (2018). Study the effects on Jewish Gay men of an assumed identity clash between their self-definition as part of the religious community and

being a part of the gay community. The writers assume, and then study the assumption, that many religious communities in general, and Judaism in particular, have been slow to accept homosexuality as an equal part of the religious value system, that this leads to a split in identity among the members of both groups, as belonging to both groups have an apparent contradiction. They explain that in these situations there are various ways of dealing with identity conflict and found literature relating to four main methods adopted by the individual with dual identity:1. Repressing one of the identities. 2. Hiding one of the identities from the community. 3. Internally compartmentalizing the two identities. And 4. Integrating the two identities. Zeidner, & Zevulun. (2018) explores how individuals cope with the issue and whether their coping strategies have an impact on their mental health. They describe three common strategies for "coping." The first Problem focused - on dealing with the problem and removing it as a source of stress. The second is emotion-focused, which eliminates negative emotions caused by the problem, and the third is avoidance, which involves developing strategies to avoid the issue. An additional angle of the research is that it is focused on Israel and the Israeli culture as a hub for Gay Jewish men and discusses the change over the past few decades in how the change in local culture and opinions has created a change in the attitude towards homosexual relations in both the Israeli and religious approaches to this issue. Zeidner, & Zevulun. (2018) created an empirical study of 140 gay men in Israel, with independent variables defined as "level" of religiosity and current relationships. The study was done using various Likert scale questionnaires to test KPIs on topics of mental health, loneliness, identity, anxiety, and coping methods. As predicted, Jewish gay men who reported greater dual-identity conflict also reported poorer mental health. The research found that religious identification was positively and strongly related to the magnitude of the dual-identity conflict experienced by gay Jewish men in Israel. Presumably, the confusion Jewish gay religious men experience surrounding their dual identities makes it difficult for them to

reconcile and integrate their religious/spiritual and sexual identities. The intensity of this conflict may be exacerbated by mandatory daily religious practices dictated by Jewish law (praying three times a day, reciting blessings before and after meals, etc.), continually priming their religious identity at periodic intervals day after day. Furthermore, dual-identity conflict was negatively related to self-reported mental health in Jewish gay men in Israel. Religious gays were reported to be more distressed and to experience poorer mental health than their secular counterparts. Research, in fact, suggests that although gay men, in general, may be more vulnerable to poor mental health than heterosexual men (Marshal et al., 2011; Shenkman & Shmotkin, 2011), religious gay men are especially vulnerable to psychological distress, including high levels of anxiety, depression, and loneliness (Barnes & Meyer, 2012; Dahl & Galliher, 2010; Levy & Reeves, 2011). The greater distress and loneliness of religious gays may be due to their relatively greater social isolation within their religious community compared to their secular gay counterparts, who are part of secular society. In addition, the secular homosexual community, which is a natural support group for religious gay men, is not always forthcoming as a support network for religious gay men (Ariel, 2007). This serious conflict is not easily reconcilable among Jewish gay men, possibly resulting in dual-identity conflict and poorer mental health. Regrettably, the current religious establishment in Israel has failed to offer any practical solution to religious gay men who wish to live productive lives as Jewish, religious, and gay individuals. Many religious gay Jewish men in modern Israel continue to struggle with an irreconcilable conflict between their gay identity and religious orientation. Research regarding women's experiences is still required and needed to understand the similarities and differences between the experience of gay Orthodox men and Orthodox women who had a sexual experience with another woman within the Orthodox world.

Barnes, & Meyer. (2012) investigated the relationship between exposure to non-affirming religious environments and internalized homophobia and mental health in a sample of lesbians, gay men, and bisexuals (LGBs) in New York City. In their research, they examine the impact of religious affiliation on mental health in LGB individuals. The research demonstrates how many religions (not necessarily Jewish) have a negative attitude towards LGBT people. Explains that research has shown that this negative attitude affects the individual and creates shame, stigma, prejudice, and distress. It also shows that LGB people growing up in nonaffirming religious settings, religious teachings can be an important part of their socialization into antigay attitudes, stigma, and internalized homophobia. Data came from Project Stride, a study designed to explore relationships between stress, identity, and health outcomes in a diverse sample of LGBs in New York City. The study was conducted in New York City over an 11-month period in 2004 and 2005. the investigators used a community-based venue sampling approach. Twenty-five outreach workers recruited potential participants in 274 venues representing a wide array of communities across 32 New York City zip codes. Sampling venues included those that cater especially to LGB populations and general population venues, including business establishments such as bookstores and cafes. Prospective participants completed brief screening forms at the venues and were eligible if they were between 18 and 59 years old, had lived in New York City for at least two years, self-identified as lesbian, gay, or bisexual, Black, Latino, or White; and as male or female (which matched their gender at birth). The final sample included 396 participants who resided in 128 New York City zip codes. Data were gathered through in-person interviews using computer-assisted personal interviewing.

The study shows that LGBs affiliated with nonaffirming religious settings had higher levels of internalized homophobia than those affiliated with affirming settings. Consistent with their hypothesis, participants who attended in non-affirming religious settings had

significantly higher internalized homophobia than those who attended in affirming settings and those who never attended. Barnes, & Meyer. (2012) conclude that non-affirming religious settings present a hostile social environment to LGB individuals. Using minority stress theory as a framework, they tested the general hypothesis that non-affirming religion is associated with internalized homophobia and mental health problems. Barnes, & Meyer. (2012) showed that affiliation with non-affirming religious settings was significantly associated with greater internalized homophobia. They also showed that this association was specific to internalized homophobia and did not generalize to self-esteem.

It is important to remember that internalized homophobia is not an individual trait as much as it is a reflection of an interaction between the person and her or his environment (Frost & Meyer, 2009; Russell & Bohan, 2006). In all likelihood, the causal relationship between religious affiliation and internalized homophobia begins early in life and is reiterated through continued participation in non-affirming religious settings throughout life. Children and youth are partly inducted into homophobic beliefs through places of worship at a time when they are most susceptible to internalizing such beliefs. The authority of the religious environment and the apparent concurrence of an entire community give such early socialization a special force. LGB persons raised in non-affirming religious environments may become inured to their homophobic messages. Such acquired homophobic beliefs are internalized and are difficult to shake off when individuals begin to see themselves as LGB persons.

These findings correlate with the understanding of the culture within the Orthodox community and affirm the inner conflict an orthodox Jew who had sexual encounters with a person of the same gender would have. Barnes, & Meyer. (2012) note that it is interesting to note the connection a person has to their community and religion even though that same religion condemns their sexual orientation. This is also similar within the Orthodox

community. Minority stress theory suggests that disparities in mental health between LGB and heterosexual populations are explained by differential exposure to stigma and prejudice. It suggests that because LGB people are exposed to more stigma and prejudice than heterosexuals in our society, they will experience greater stress and resultant negative health effects (Meyer, 2003). Minority stress theory identifies the quality of the social environment as the source of stress. On the basis of this theory, we assess whether exposure to nonaffirming religious settings is related to internalized homophobia—one of the stress processes described by minority stress theory—and mental health outcomes in LGBs.

Barnes, & Meyer. (2012) results contribute to the increasing evidence that clinicians working with LGBs need to be attuned to their clients' religious backgrounds and current religious commitments (Bartoli & Gillem, 2008; Haldeman, 2004; Morrow, 2003).

The focus of the proposed research is in regard to the Orthodox community; as such, the environment is non-affirming and even hostile to the LGBT person, making same-sex relationships a taboo in the Orthodox community. The consequences of one coming out within the Orthodox community are harsh and detrimental.

Abes (2011) Explored the Relationship between Sexual Orientation and Religious Identities for Jewish Lesbian College Students. The researcher interviewed ten lesbian college students and focused on 2 Jewish lesbian students and their narratives at three different stages of their student life. Data came from three phases of a constructivist longitudinal study of lesbian identity in which narrative inquiry methodology was used. The purpose of the narrative inquiry was to understand experiences through stories (Lieblich et al., 1998) and was well-suited to identity studies because stories offer glimpses into the self (Lieblich et al.). In the first phase of the longitudinal study, the researcher identified 10 participants through purposeful sampling, which was used to obtain information-rich cases

for in-depth study (Patton, 2001). Eight of these original ten participated in the second and third phases; two were not available. All participants signed informed consent forms approved by the Institutional Review Board prior to each study phase. All participants were aged 18–25 over the three study phases. The sample was diverse in terms of race, social class, and religion. As part of the criteria for sampling, all identified as lesbian or queer and attended the same large, public university in the Midwest during phase one of the study. This university, located in a fairly progressive city with a visible gay and lesbian population, offered diverse forms of support for gay and lesbian students, including multiple student organizations, administrative support services, and academic courses.

The research focused on different stages of development, such as the desire for wholeness in identity, integrating and connecting Jewish and sexual identity into wholeness, and how identity develops on a continuum. The information shows there is very limited research regarding lesbian women and the incorporation of their sexual identity and ethnic/religious identity. The research showed that integrating one's homosexual identity, specifically lesbian identity and Jewish identity, is difficult but possible. However, this is acceptable only in the more liberal and progressive Jewish world. Both participants in the study were from conservative or reform affiliations.

It is clear that there is a difference between the willingness and acceptance of the Orthodox community of LGBT people in the more liberal Jewish communities, such as reform and conservative. Therefore, there is research that needs to be conducted regarding the Orthodox community and the ramifications and communal and emotional price that one pays when identifying oneself as a lesbian in the Orthodox community or even having a sexual experience with the same sex within the Orthodox community.

The three first taboos have to do with the feelings a victim of sexual abuse might experience regarding Shame and guilt, which prevents one from disclosing what has happened. This is reinforced by the second taboo regarding the ramifications of being sexually abused within the Orthodox community, which is a closed community where sexual discourse is considered private and improper. The third taboo regarding same-sex relationships within the orthodox community is another added barrier when a woman is sexually abused by other women. The fourth taboo is a more global one regarding gender roles and not viewing women as perpetrators.

Fourth Taboo: Woman Perpetrators**:**

There are limited findings on the impact of female-perpetrated sexual abuse on children, and they are often contradictory, particularly in relation to males. Deering and Mellor (2011) studied the impact of female-perpetrated childhood sexual abuse through an exploratory qualitative study. A sample of nine men and five women who reported that they had been sexually abused by women in their childhood were recruited from the general community. The participants completed a questionnaire that asked them to describe various aspects of their abuse experiences and the perceived consequences. For both men and women, the abuse was associated with negative outcomes across a range of functional areas in both childhood and adulthood. The results of this study show similar impacts reported between female-perpetrated and male-perpetrated victims of sexual abuse. However, there is an argument to be made that the consequences of female-perpetrated child sexual abuse require deeply serious further research to bring these issues to the awareness of both the public and professionals working in the field of child protection and counseling.

The very limited research that has examined the impact of female-perpetrated child sexual abuse includes research by Ogilvie & Daniluk (1995), Rosencrans (1997), and Denov

(2004), who found that females who experience female-perpetrated child sexual abuse report similar negative effects to those of their male counterparts concerning behavioral, sexual, relationship, emotional, physical, and psychological problems, and identity confusion.

In Deering & Mellor (2011) research, nine males (M = 45.2 years, SD = 9.6, range: 29–64) and five females (M = 44.0 years, SD = 5.70, range: 37–52) who reported that they had been sexually abused in childhood by a female participated in the study. The participant survey used in this study was originally developed by Mitchell and Morse (1998). The participants answered a survey consisting of five sections. The first section collected demographic information, including age, sex, occupation, and sexual orientation. The second section consisted of open-ended questions asking about the respondents' history of sexual abuse. Areas probed included how and at what age the abuse began, as well as the respondents' short-term responses and reactions to the abuse. The third section asked the respondents to describe the long-term impact of the abuse experiences on aspects of their functioning (e.g., sexual, relationships with men and women, emotional and physical adjustment). The fourth section inquired about aspects of family history, including relationships between family members, whether anyone in the family knew about the abuse, and what their response was. The final section of the questionnaire asked respondents to describe activities, people, or relationships that had been helpful in the healing process following the sexual abuse they had experienced.

The study shows that when the victims tried to disclose what had happened to them both as children and as adults, they were disbelieved, told they were making up stories, punished for lying, and even, in one case, committed to psychiatric care as suffering from mental illness. For some of the males who disclosed being sexually abused by a female, the reaction from the environment was admiration and reinforcement for their masculinity.

The sexual abuse reported by the participants typically occurred over a long period of time and covered a broad spectrum of behaviors. However, most commonly, it involved severe acts of oral sex and/or sexual intercourse. Such findings are contrary to early understandings that, as reported by Mathis (1972) and Walters (1975), ultimately discounted females as being capable of sexually offending children and argued that the phenomenon did not exist.

The participants reported that many difficulties often developed as a child while the abuse was occurring, and these persisted into adulthood and remained prominent within their current lives. All participants, irrespective of gender, reported adult emotional/psychological difficulties following the female sexual abuse. The most common problems included symptoms of depression, anger, low self-esteem, overwhelming fear, difficulties in trusting others, suicidal ideation, self-harming behaviors, and sexual difficulties/dysfunction. These emotional/psychological difficulties appear to have affected participants' social functioning. Common social difficulties described by the participants include difficulties trusting others (particularly women), low self-confidence, isolation, and being withdrawn from other people/social interactions. Such findings are in line with those reported by Hislop (2001), who suggested that when sexual abuse is perpetrated by women, the victims often experience intense feelings of isolation and desolation. She argues that such feelings occur as a result of the silence that surrounds female-perpetrated child sexual abuse. This hypothesis appears to appropriately reflect the reports provided by the participants in the current study who were unable to disclose the sexual abuse as it was occurring. Therefore, the participants in this study suffered sexual abuse in silence.

The inability to trust women following the abuse often led to sexual and relationship problems for participants and some differences emerged between the genders. For example, more male participants than female participants reported an inability to form healthy intimate

relationships with the opposite sex, and they either attributed this to excessive sexual needs/desires or a failure to enjoy sexual relations with women. For three men, the impact was so extreme that they chose to remain celibate. Women also reported relationship and sexual difficulties as a result of the abuse. However, in contrast to their male counterparts, they most commonly reported a lack of sexual desire and/or an inability to enjoy sexual relations with their spouses.

The aftermath of female-perpetrated child sexual abuse reported by the participants is similar to that described by those who experience sexual abuse perpetrated by males, such as difficulties in emotional and psychological functioning, sexual difficulties, and problems in relationships with others (e.g., Finkelhor, 1986; Rosencrans, 1997). However, the results of this study differ in several ways, such as the commonly identified mistrust and fear of women. Additionally, the participants involved in the current study frequently expressed intense anger/rage directed toward women following the sexual abuse. They also expressed frustration toward society in general for the perception that female sexual offending does not occur and for the differential treatment of sexual offenders based on perpetrator gender.

There are a few studies that attempt to show how prevalent and damaging it is when women assault women. The first is an "Empirical Investigation of a Model of Sexual Minority Specific and General Risk Factors for Intimate Partner Violence Among Lesbian Women" by Robin J. Lewis, Tyler B. Mason, Barbara A. Winstead, and Michelle L. Kelley (2017). In this study, self-identified lesbian women (N= 1,048) were recruited from online market research panels. Participants completed an online survey that included measures of minority stress, anger, alcohol use and alcohol-related problems, relationship satisfaction, psychological aggression, and physical violence. The authors explored the question of how different stressors (such as discrimination and internalized homophobia) and general risk factors (perpetrator and partner alcohol use, anger, and relationship satisfaction) affect

intimate partner violence (IPV) among partnered lesbian women. The researchers expected partner alcohol use to contribute to perpetrator relationship dissatisfaction, partner psychological and physical relationship aggression, and perpetrator alcohol problems to contribute to physical IPV by way of psychological aggression. They hypothesized that perpetrator relationship dissatisfaction would predict perpetrator psychological aggression, which would lead to physical IPV. Being the first study to be done within the lesbian community, without a control group of women who identify as lesbians, the researchers used a cross-sectional design. Allowing for the largest sample size possible. The constraints of the study are evident in the driving model, which focused on a community sample of young lesbian women (age 18 –35 years). The authors rationalized focusing on young lesbian women as previous research stipulates that partner violence is more common among young women (Thompson et al., 2006). Despite the constraints and assumptions made of the population, the advantage was receiving information from a large number of participants and many levels of information regarding what can affect IPV within lesbian relationships. The disadvantages have to do with understanding in more depth the dynamics of each couple and the history of each participant. The authors try to address the missing data in the study by explaining: "missing data were handled through full information maximum likelihood estimation" (Lewis et al., 2017, p.114). The authors do provide their perceived limitations, stating, "support for the hypothesized conceptual model, the data collected to test this model are cross-sectional limiting our ability to confirm directionality. Therefore, replication of these findings with longitudinal data is also necessary" (Lewis et al., 2017, p.114). Overall, this study holds relevance by showing a direct situation in which women are aggressive toward other women, especially if influenced by drugs and alcohol.

Colson, Boyer, Baumstarck, and Loundou (2013), in their article: "Female sex offenders: A challenge to certain paradigms. Meta-analysis," supports the statistical

significance regarding the prevalence of women perpetrators (between 5%-10%). This research by Colson, Boyer, Baumstark, and Loundou provides insight into historical and present types of abuse women commit. In this meta-analysis, a total of 4,712 publications, identified using keyword searches on Medline, EMBASE, and PsycINFO (1984 to December 2011), were studied. The researchers selected 61 papers using methodological criteria of evidence-based medicine. Their literature review studied 6,293 cases of female sex offenders in these 611 publications. They confirmed three already-known beliefs: (1) female sex offenders have themselves often been victims not only of sex abuse (49.1%) but perhaps more importantly, of other types of family violence and instability (55.4%); (2) 51.2% suffer from psychiatric disorders, depression and/or mental retardation; (3) they are more likely to attack their own children or other close relatives before looking for victims outside of their family unit (63.9%). Additional findings were: 1) alcohol and drug abuse appeared in their series as less significant (29.1%) than previously described in older research; 2) female sex offenders are more likely to choose male victims (60%) over female victims (40%); 13.3% of them do not have any sexual preference; 3) contrary to popular belief, more female sex offenders commit their first crime alone than with an accomplice (66.7% of them act alone); 4) violence and coercion is far from absent when a female commits a sex offense (45.8% of cases); 5) although repeat sex offenses are rare, in a large number of cases (40.3%), female sex offenders have already been charged with other criminal offenses, or have repeat offenses in non-sexual criminal acts. Of particular note is the research by Denov 2004 and Dube 2005. The authors note that these studies reveal that survivors of female sexual abuse have reported that sexual abuse by women was more harmful and detrimental than any sexual abuse they had experienced from men (Denov, 2004; Dube, 2005). Since the publication of this review, there continues to be a lack of empirical research into this part of the phenomenon regarding female perpetrators and abuse victims. Therefore, it is of utmost importance to provide

insight into these issues for proper treatment purposes. Overall, this review crystallizes the fact that research proves regarding women perpetrators,

> "It seems clear that part of this form of crime goes undetected. The women: mothers, sisters, aunties, carers, and babysitters all have much freer access to children and can touch them much more freely than men (Marvasti, 1986; Faller, 1995; Rowan et al., 1990; Saradjian, 1996). Incest can go unnoticed for a long time or might even never be revealed. Children who are victims of incest find it very difficult to talk about the subject, and the medical world still finds it difficult to accept the idea that it exists at all (Elliott & Peterson, 1993)" (Colson et al., 2013, p.115).

This conclusion correlates with the general findings regarding sexual abuse but also specifically with the other cultural biases within the Orthodox community. However, there are other generally held beliefs that do not seem to be based on fact and should certainly be reviewed, in particular concerning the belief that female sex offenders are not dangerous and need further research.

Tsopelas, Tsetsou, Ntounas, and Douzenis's (2012) research adds another layer to the need for further understanding of female perpetrators by highlighting the fact that historically, it was considered that only males committed sexual abuse. The aim of their research was to expand the literature by focusing on the consequences of sexual abuse in minors when the perpetrator is female. The authors chose 52 studies that were obtained and are included in their review. The authors limited the scope of the review to European and North American literature due to perceived cultural differences. What was found was that victims of sexual abuse by female perpetrators are usually friends or relatives of the abuser. The victims sometimes find themselves under persuasion and psychological coercion to participate in sexual acts. They also found that the percentage of male victims is growing.

Contemporary studies offer limited information about this issue and the consequences it has on the victims. They noted that the majority of such cases are not reported. Sometimes, sexual abuse by female perpetrators is perceived by the victim as more acceptable than sexual abuse by males. Authors noted psychological interventions could be a powerful tool in the

reduction of female sexual abuse and its consequences on the victims. In this study, it was also noted: "bearing in mind that women are perceived as "safe" and "caring" one can easily assume that sexual assaults by female perpetrators are still underreported" (Tsopelas et al., 2012, p.307). When talking about the consequences of female abusers on the victims, as in other cases of child abuse, they note:

> The children victims of sexual abuse by women are overwhelmed by conflicting feelings about the perpetrator, especially if the perpetrator possesses the role of caregiver to them. It is characteristic that they accuse themselves for anything that happens, and they believe that they have done something extremely bad so that their own mother reaches the point of abusing them. It is much easier for a child to believe that the occurring sexual abuse is a response to their own error than to admit that the person who acts as his/her caregiver does harm to him intentionally (Munro, 2000) (Tsopelas et al., 2012, p.308).

Generally, researchers (Dube et al., 2005; Faller, 1987; Munro, 2000) agree that the victims of sexual abuse by female perpetrators present the following symptoms/behaviors according to the age at which they were victimized.

In the early years, the main symptom was that of self-blame. The research agrees that victims who are abused early in childhood believe that the abuser, as their guardian, would not manhandle them sexually. The victim believes that they are exclusively in charge of what happened. The victim assumes that their behavior is inappropriate and wrong and submits to the female caregiver to act as a perpetrator to use abuse as a disciplinary action. The research explains that victims of this type of abuse are scared to disclose the experience despite the need to talk about it (Tsopelas et al., 2012). Social work guidelines recommend that victims speak about the abuse as part of a therapeutic process; however, victims often expect that nobody will trust or believe them. Adding to the trauma, research suggests that mothers and female culprits shroud their activities under the auspice of the role of guardian (Tsopelas et al., 2012). Furthermore, the kids want to safeguard their particular mother and remain nearby with her since they trust that the abuse will stop if they do not act out. Female victims feel embarrassed about their bodies and overwhelmingly of their ladylike traits. They are worried

about the possibility that from the minute they have been victims of abuse performed by a lady, they will naturally secure homosexual inclinations. This last finding can likewise correlate with the disarray and humiliation religious women feel, having understood they have partaken in sexual activity with another woman. In adolescents, the main behavior of victims of abuse is to run away from home. It is understandable that in cases where the victims experience repetitive sexual abuse at home and do not get any help, they choose to flee.

In adulthood, the main consequences are both behavior and symptomatic. Researchers see disorders of identity develop; victims identify with the perpetrator, and this creates an identity crisis. The cascading effect of this crisis is that by identifying with their abuser, the victim often commits acts of abuse on others. Furthermore, the effect extends into all aspects of life. Difficulties in creating and maintaining societal relationships arise. For example, victims lose the ability to create correct boundaries within other relationships (mainly with women). They reach extremes of closeness or distance. The difficulties in maintaining interpersonal relationships reach into their relationships with their own children. This is expressed by uncertainty, lack of confidence in the physical relationship with their children, and difficulty in expressing their feelings of love. (Tsopelas et al., 2012) This particular outcome of abuse and trauma is integral to understanding so that a proper therapeutic approach can be developed.

Chandy, Blum, and Resnick (1996) and Dube et al. (2005) studied the differences in psychological problems of victims from female perpetrators depending on their sex and showed that: 1. During adolescence, different reactions are had by male and female victims. Male victims are more likely to turn to alcohol or drugs, whereas female victims will express their affliction through eating disorders. 2. In adulthood, the victims of both sexes present similar types of behavior and problems, such as substance use, mental illnesses, and

difficulties with interpersonal family relationships (Chandy et al., 1996; Dube et al., 2005). The fact that there is a close and sometimes lasting relationship between the victim and the female sex abuser is one of the main factors by which victims of abuse by female perpetrators differ from victims of male sexual abusers. Women who sexually abuse children are found in their familiar or close social environment. There are views that the female perpetrators select places of work that allow them accessibility to young victims. The long-lasting and often deep connection between the abuser and the abused makes the abuse that much more damaging. The consequences may be a singular event or may lead to a psychotic state. Sexual maltreatment by female culprits in this way prompts the advancement of mental issues either as an inclining variable or as an immediate outcome of the abuse. Young people exhibit remarkable resilience. Children who experience childhood abuse do not necessarily go on to commit sexual crimes (Wilcox & Richards, 2002). These researchers conclude that effective services for young people who display inappropriate sexual behavior are needed to work towards processing their trauma and strengthening personal resilience. The role of family and friends in supporting and enabling this process is crucial (Wilcox et al., 2004). This relates to ramifications for the social work profession by proposing that through proper education and interventions regarding sexuality, we can reduce traumatic effects and assault. This is also enforced by the findings within the article: "It is also important to start education on sexual issues early at school to educate children so they can understand which form of bodily contact is innocent and which is instigated by sexual motives. The presence of a child–psychologist in schools is crucial for the child victim to find space to discuss, receive support and deal with these issues" (Chandy et al., 1996; Dube et al., 2005, p. 434).

Similarly, (Stemple et al., 2017) researched the prevalence of female perpetrators in their article "Sexual victimization perpetrated by women: Federal data reveal surprising prevalence." This article examines female sexual perpetration in the United States. To do so,

the researchers analyzed data from four large-scale federal agency surveys conducted independently by the Centers for Disease Control and Prevention and the Bureau of Justice Statistics from 2008 through 2013. They suggested that professionals addressing this issue should avoid gender stereotypes that downplay the frequency and impact of female sexual perpetration to comprehensively address sexual victimization in all forms. They address the fact that still today, the

> Contemporary understandings of sexual victimization have been informed by the reality that men's sexual violence toward women was ignored for centuries and remains dangerously well tolerated in many regions of the world. Feminist approaches have long challenged the assumption that male-on-female sexual abuse is an inevitable outgrowth of preordained differences between the sexes. Instead, feminist theory posits that sexual victimization is a result of socially constructed male power and privilege employed as a tool to subordinate women (Brownmiller, 1975). This male-on-female construct remains the dominant paradigm through which sexual victimization is understood and addressed (Stemple et al., 2017, p.303).

This idea in the article affirms the notion that 'women are safe' and are victims, not predators. The researchers continue to say that "stereotypes about women, which reflect gender and heterosexist biases, include the notion that women are nurturing, submissive helpmates to men. The idea that women can be sexually manipulative, dominant, and even violent runs counter to these stereotypes (Byers, 1996; Pflugradt & Allen, 2012)." (Stemple et al., 2017) The researchers found that female perpetrators (acting without male co-perpetrators) were reported in 28.0% of rape/sexual assault incidents involving male victims and 4.1% of incidents involving female victims. Incidents of rape/assault involving at least one female perpetrator were reported in 34.7% of incidents involving male victims and 4.2% of incidents involving female victims. Their analysis also found that, among those reporting rape/sexual assault by a female perpetrator, 57.6% of male victims and 41.4% of female victims reported that the incident involved an attack, meaning the offender hit, knocked down, or otherwise attacked the victim. Of those who were attacked, 95.7% of male victims of female offenders and 47.0% of female victims of female offenders also reported that they

were injured in the incident. There are two significant conclusions from this research. The first is that the prevalence of female perpetrators assaulting men is higher than in other surveys and stands at 28%; women assaulting women revolve around 4%. Another major finding is the aggression factor that seems to be prevalent in women offenders. The researchers stress that the norms and myths that were once common need to be reassessed both by health professionals so that they can identify and intervene and by the justice system and the media so that awareness can be raised and addressed more accurately.

Another relevant article is Long-term Consequences of childhood sexual abuse by Gender of Victim By Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles (2005). Due to noticing that the majority of research on the effects of childhood sexual abuse (CSA) has focused on girls who were victims, less is known about its long-term effects on the lives of boys. By presenting the effects of CSA side-by-side for men and women, this study demonstrates that the effects on the risks of multiple behavioral, mental, and social outcomes were nearly identical. These similarities among men and women suggest the need to identify and treat all adults affected by CSA. The added value of this study was researching the connection between the gender of the perpetrator and the outcomes for the victims. It shows that women perpetrators abused boys more than girls. It also shows that the effect in some areas is worse when the perpetrator is a woman.

A retrospective cohort study was conducted from 1995 to 1997 among 17,337 adult HMO members in San Diego, California. Participants completed a survey about abuse or household dysfunction during childhood and multiple other health-related issues. Multivariate logistic regression was used to examine the relationships between the severity of CSA (intercourse vs. no intercourse) and long-term health and social problems (substance use and abuse, mental illness, and current problems with marriage and family) by the gender of the victim. Models controlled for exposure to other forms of adverse childhood experiences that

co-occur with CSA. Among men, the relationship between the gender of the CSA perpetrator and the outcomes was also examined. The researchers studied the prevalence and adjusted odds ratios of the relationship of the gender of perpetrators to substance abuse, mental illness, and social outcomes. It showed that in cases of child sexual abuse where the women were the perpetrators, there is a larger outcome of current family problems and the use of illicit drugs.

This section demonstrates the complexity, where the prevalence of women perpetrators is substantiated and, side by side, the bias and notion still held by the professionals and social environment that women are not perpetrators. This notion complies with the fourth taboo, where an orthodox female who was sexually abused by other women would not define her experience as sexual abuse. However, the confusion, guilt, Shame, and other emotions correlated to sexual abuse prevail. Additionally, part of the healing process related to sexual abuse is defining and giving a name to the experience. Therefore, understanding this complexity and opening a discourse around this issue is part of the education clinicians need to be aware of when treating these cases.

Transference and Countertransference:

Since this research will focus both on the experience of the victim and the experience of the therapist, it is important to explore the research done regarding transference or countertransference within the orthodox community regarding same-sex relationships and women perpetrators. The bulk of the literature in this field of research consists largely of theoretical discussions on the complexity of transference and countertransference. The research platforms for finding literature on this area were done primarily using Google Scholar, Yeshiva University Library Central search, ScienceDirect, and APA PsychNet. The search strategies for finding the research included search terms and phases such as sexual abuse and transference and therapist and empirical evidence, childhood sexual abuse

"transference countertransference paradigms," and orthodox Jews and therapy and transference. Of the literature found, very few research articles explore transference and countertransference with empirical research, either qualitative or quantitatively, and even fewer, if any, within the four taboos that have been discussed. This gap in the existing literature highlights the strong need for this research. The one article that provides insight is focused primarily on art therapy. In their article ‘Non-Haredi Arts Therapists' Perceptions of Therapy With Ultra-Orthodox Children,’ Keidar et al. research the perceptions of non-Orthodox art therapists regarding work with children from the Orthodox community. In addition to findings regarding the Orthodox community, they also bring the perspective of therapists in relation to their clients. They don’t discuss transference and countertransference directly. However, they do explain how some therapists had to make adaptations in language, which affected their ability to act authentically. Additionally, they explained that some therapists spoke of the obstacles cultural differences face in the development of therapeutic relationships. These therapists described the difficulty on the part of the clients in trusting and bonding with the therapist, who is perceived as a foreigner. This is especially true for clients whose distress is underlain by an impaired ability to trust, such as victims of sexual assault. The therapists explained that there are significant limitations in terms of language that references the body, to the point where the children have no words to describe various body parts, especially when it comes to private parts. Some therapists recounted that content related to sex and sexuality seldom arises during therapy sessions, even with adolescents. A few of the therapists underscored that when there is any mention of sexuality, they tend to see it as a red flag. Moreover, a few of the therapists described ambivalence and apprehension on behalf of the parents in cases where they need to focus on this area, such as incidents of sexual assault or an unusual preoccupation with sex on the part of the child. As described in Keidar et al. (2021), these findings appear to be consistent with the literature, which claims

that the restrictions on lifestyle in the Orthodox community limit the therapeutic discourse within the boundaries of the permissible and the forbidden according to religious laws and cultural norms (Hess & Pitariu, 2011).

The article Empirically supported perspectives on transference. Marmarosh (2012) gives an overview of three articles written on transference. The author concludes that within the data, therapists had a problem with one of the measures regarding transference, and it was not researched properly due to different interpretations of the therapeutic relationship.

In an attempt to find research regarding transference and the therapeutic relationship within a closed community Piché et al., (2015) A qualitative study was conducted to explore the experiences of twelve social workers or social service workers practicing in northern and northwestern Ontario. The research explored Mental health professionals who work in small, rural communities who often have to contend with dual and multiple relationships. The more integrated service providers are within the community, the more likely they will encounter overlapping personal and professional relationships with clients.

In their article, they discuss boundary crossing or boundary violation. This is especially the case in rural and remote communities that involve a more extensive inter-connected network of a person's life, where overlapping relationships readily occur. And perhaps can relate to the Orthodox community.

Participants included ten females and two males, and their ages ranged from 20 to 50 years. Of the sample, three participants worked in supervisory roles while the remainder (n = 9) provided front-line service; all worked in mental health and counseling. Four of the participants were original residents working in their community of origin, while the remainder (n = 8) had migrated to the community, usually from a larger center. Interviews

and analysis followed generally accepted qualitative methods and utilized a descriptive phenomenological approach (Creswell, 2007; Laverty, 2003; Moustakas, 1994).

Specifically, three main factors emerged from the participant interviews: social and family life, interconnectedness and layers of knowing, and the complexity of rural social work practice. These factors appeared to be fluid in nature, and the degree to which they affected individual workers varied. However, transference or countertransference was not explored.

Another aspect that was explored within the four taboos was connected to the treatment of sexual abuse within the therapeutic relationship. Bradley & Follingstad, (2001) Wrote an empirical review of studies that directly address therapy for symptoms related to a history of childhood sexual abuse. They wrote, "Given the paucity of the empirical literature on treatment of the sequelae related to CSA, the authors felt it was important not to delimit studies on a strict methodological basis, as indicated in the criteria for inclusion. However, it is crucial to look at the implications related to the methodology of the reviewed studies." (Bradley & Follingstad, 2001). Within their findings, they discuss articles relating to Disclosure-in-relationship. When the victim discloses the sexual abuse within the therapeutic relationship as part of the healing process, the note:

> The transferential relationship with the therapist is crucial to this aspect of treatment because it is through the dynamics with the therapist that the interpersonal dynamics of the abuse are repeated. Transference-countertransference themes that arise commonly in therapy with women with a history of CSA have been identified (Briere, 1996; Davies & Frawley, 1994; Pearlman & Saakvitne, 1995). The ability to respond to these relational dynamics in a way that does not recreate the abusive relationship, but instead provides an alternate framework for creating a sense of self, is seen as crucial to treatment. The relationship with the therapist provides a format for identifying and interpreting interpersonal patterns, as well as a template for new internal representations of self and others (Davies & Frawley, 1994; Grand & Alpert, 1993; Price, 1993, 1994). As the client discloses her abuse memories, the relationship with the therapist allows her to create a new interpersonal experience that helps the client to contain overwhelming emotions and to maintain a sense of connection to the therapist. (Bradley & Follingstad, n.d.)

Even though (Bradley & Follingstad, n.d.) address transference and countertransference as part of the therapeutic process of a victim of sexual abuse; they don't explore them from the therapist's perspective. This aligns with limited research regarding the four taboos and the experience of not only the victims but of the added value the proposed research can add regarding the experience of the therapist as well.

To summarize, the key findings that have informed the understanding of the four taboos within this study are the shame and guilt preempted by sexual assault. The characteristics of the Orthodox community as a closed community have many ramifications when one deviates from the guidelines and rules of the community. Additionally, sexuality, sexual abuse, or sexual conduct is not discussed openly within the orthodox community, which preempts misinformation, miscommunication, and silencing when sexuality or sexual issues come about. Furthermore, same-sex relations are not accepted within the Orthodox community, and there is a significant gap in research regarding same-sex relationships between women within the Orthodox community. Finally, the issue of women perpetrators is still developing and needs more analysis. Therefore, studying these four taboos is essential both on a clinical level to better inform clinicians working with women whom other orthodox women sexually abused and enhance the knowledge socially regarding this issue. An additional added value would be understanding the relationship and elements of transference and countertransference within these issues between the therapist and the client.

The literature that was explored and referenced above delved deeply into the phenomenon of sexual abuse of orthodox women by other women through the perspective of the therapist. There is limited research and information regarding this phenomenon due to the suggested taboos. Therefore, in an effort to estimate the dimensions of this phenomenon and its various characteristics, it is necessary to undertake qualitative research exploring the sexual abuse of orthodox women by women. Through the study results, treatment methods

tailored to the various findings that arise can be developed to optimize the treatment in these cases.

SECTION FOUR: THEORY

The phenomenon and experience of Orthodox women who were sexually abused by other women can be explored through various lenses and theories. Biological Theory focuses on organic explanations of human behavior. The theory emphasizes the role of physiological factors, such as hormone levels and chromosomal makeup, on behavior (Berlin,1983; Marshall & Barbaree, 1990) (Nisha, 2014). Psychodynamic Theory is built on Freud's four states of childhood development, viz. oral, anal, phallic, and genital. The theory explains sexual deviance as an expression of the unresolved conflicts experienced during the stages of development (Nisha, 2014). Behavioral Theory explains deviant sexual behavior as a learned condition. According to attachment theory, humans have an innate tendency to establish strong emotional bonds with others, and when individuals have some loss or emotional distress, they act out as a result of their loneliness and isolation. The theory asserts the belief that an adequate parenting style fosters appropriate social skills in children and facilitates balanced development. Cognitive-behavioral theory addresses how offenders' thoughts affect their behavior; the overall focus is on the way in which sex offenders diminish their feelings of guilt and shame by rationalizing them through excuses and justifications. Integrated Theory focuses on the presumption that there are preconditions to child sexual abuse, which integrates the various theories about why individuals begin to participate in sexually deviant behavior (Nisha, 2014). Each of these theories explains the phenomenon in various ways and affects the way a practitioner treats their client.

All the above theories are complex and enlightening, but for this study, the premise of the Quadruple Taboo means the most compatible theory to understand the phenomenon is the theory of Stigma. Stigma is a special kind of relationship between attributes and stereotypes. (Goffman, 2009). The term stigma dates back to the Greeks, who cut or burned marks into the skin of criminals, slaves, and traitors in order to identify them as tainted or immoral people who should be avoided (Goffman, 1963). Within today's cultural context, stigma is not merely a physical mark but rather an attribute that results in widespread social disapproval—a discrediting social difference that yields a "spoiled social identity," according to Goffman. Most definitions of stigma comprise two fundamental components, namely, the recognition of difference and devaluation (Dovidio et al., 2000) (Bos et al., 2013). Understanding the theory of stigma is monumental for this research and for understanding the ramifications of stigma within the orthodox community.

According to Goffman, society categorizes people based on normative expectations; some individuals are 'normal' and separated from those considered 'deviants.' These deviants become socially discounted as they are reduced to their stigma, or an 'attribute that is deeply discrediting 'and reducing the person that possesses a particular quality 'from a whole and usual person to a tainted and discredited one.' Stigmatic qualities can relate to physical or character 'deformities' or membership in a 'marginal' social group (Carnevale, 2007)

The underlying principles of Goffman's theory are group stigma due to race and ethnicity (tribal stigma) alongside examples of stigma due to disabilities and moral infractions (abominations of the body and character blemishes). Changes in psychology, particularly within social psychology, have shifted the perspective to the study of prejudice and the study of stigma as discrete ideas. Stigmatization occurs on societal, interpersonal, and individual levels. Recently, Pryor and Reeder (2011) articulated a conceptual model that seeks to bring greater clarity to the current but diverse literature on stigma. Building on

previous theories (Corrigan, 2004; Herek, 2007), this model depicts four dynamically interrelated manifestations of stigma. Public stigma is at the core of Pryor and Reeder's model and represents people's social and psychological reactions to someone they perceive to have a stigmatized condition. Public stigma comprises the cognitive, affective, and behavioral reactions of those who stigmatize (perceivers). The second type of stigma in Pryor and Reeder's model is self-stigma. Self-stigma reflects the social and psychological impact of possessing a stigma. It includes both the apprehension of being exposed to stigmatization and the potential internalization of the negative beliefs and feelings associated with the stigmatized condition. The third type of stigma is stigma by association. Stigma by association is analogous to Goffman's (1963) courtesy stigma and entails social and psychological reactions to people associated with a stigmatized person (e.g., family and friends) as well as people's reactions to being associated with a stigmatized person. Finally, structural stigma is defined as the "legitimatization and perpetuation of a stigmatized status by society's institutions and ideological systems" (Pryor & Reeder, 2011, p.4).

Child sexual abuse, sexual assault, and intimate partner violence occur within social contexts that shape how survivors judge themselves and are evaluated by others. Since these are gendered sexual and intimate crimes that violate social norms about what is appropriate and acceptable, survivors may experience stigma that includes victim blaming from the broader society as well as stigmatizing reactions from others in response to disclosure. Goffman, in his work on stigma theory (1963), conceptualized stigma as a dynamic social process that discounts certain groups or individuals based on their perceived inferior moral status and rationalizes animosity toward them; his work explored how those who are stigmatized internalize this discounting as self-blame, shame, and the anticipation of negative judgments by others should their secret be revealed. Stigma theorists have explored the intricacies of both stigma and stigmatization and early conceptual work by Finkelhor and

Browne (1985) vividly captures the role of stigma by external others and how it may become internalized as stigmatization by sexual abuse survivors:

> [Stigma and stigmatization refer] to the negative connotations— e.g., badness, shame, and guilt—that are communicated to the child around the experiences and that then become incorporated into the child's self-image. These negative meanings are communicated in many ways. They can come directly from the abuser, who may blame the victim for the activity, demean the victim, or furtively convey a sense of shame about the behavior. Pressure for secrecy can also convey powerful messages of shame and guilt. But stigmatization is also reinforced by attitudes that the victim infers or hears from other persons in the family or community. Stigmatization may thus grow out of the child's prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria or blame the child for what has transpired. (pp. 532–533, italics in original)

Thus, from this perspective, a survivor of abuse or assault may learn through the broader societal context, via media representations, dominant narratives, stereotypes, and other mechanisms, that certain behaviors are considered to be morally and socially unacceptable, and certain statuses—incest victim, rape victim, and abused woman—are stigmatized and blameworthy. (Kennedy & Prock, 2018).

Kennedy & Prock (2018) explain that shame is the key affective component of stigmatization following abuse or assault; it is defined as a moral, emotional response in which the survivor feels deeply unworthy, defective, and debased in comparison to others (Bonanno et al., 2002); (Negrao et al., 2005). Internalized stigma is a merged concept that includes aspects of self-blame, shame, and anticipatory stigma (Gibson & Leitenberg, 2001). Anticipatory stigma is a belief by the survivor that, should they reveal the abuse or assault to others, they will be stigmatized as blameworthy and lesser (Goffman, 1963; Overstreet & Quinn, 2013) (Kennedy & Prock, 2018).

The Orthodox community holds all four types of stigmas regarding people who are 'deviant of the normal.' Within the orthodox community, there are very strict norms and rules. Anyone who deviates from those norms and rules can suffer from becoming an outcast due to the stigma that their deviant behavior creates. Additionally, due to the structure of the

orthodox community where one's family status and good name are treasured, there can also be stigma by association when one deviates from the norms of the community. Shin et al. investigated the role of culture in stigmatizing reactions and found that group-oriented cultures are more likely than individual-oriented cultures to stigmatize nonnormative groups. (Bos et al., 2013) This study attempts to research the effects of the stigma when an orthodox woman is sexually abused by another orthodox woman. Due to the fact that there is a stigma regarding sexuality and abuse within the Orthodox community on all levels (public stigma, self-stigma, and stigma by association), there is a need to explore the effect of these stigmas on a victim of same-sex abuse.

The four taboos explored in this research encompass many aspects of stigma. With the first taboo, when one is sexually abused, the shame and guilt that arise from the abuse are internalized. Furthermore, the added layer of the second taboo is that within the orthodox community, any sexual behavior, conduct, or discourse is forbidden and considered private. This coincides with creating a situation where when one is sexually abused, there is both public stigma and self-stigma. Since the status within the community is based on one's good name when one is sexually abused, there is also stigma by association. Finally, the third and fourth taboos add an additional layer by exploring the complexity that same-sex relationships still suffer from public stigma within different communities. Within the Orthodox community, same-sex relationships are considered an abomination. Therefore, the stigma that arises from this situation is clear and severe. Women are considered gentle nurturers and mothers and have a social role of being pretty and accommodating within society. The thought that a woman is a perpetrator goes against this public stigma and, therefore, makes it even harder for a victim to acknowledge and disclose that they were abused by another woman.

Considering that stigma causes shame, which is derived from the traumatic experience and the way the public and the victim view themselves, a constructive therapy modality to work with these victims would be trauma-informed practice.

Judith Herman, in her book Trauma and Recovery (1992), explains that the core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery, Herman continues, can take place only within the context of relationships. Therefore, the therapeutic relationship can be a corrective and healing process for a trauma victim. Herman continues to explain the core principles of treating a victim of trauma. The first principle of recovery is the empowerment of the survivor. The victim must be the author and arbiter of their own recovery. Since the abusive experience which happened to them was not within the victim's control. Having the victim in control of their own recovery restores the feeling of control in life, which was taken from her through the abuse.

The therapeutic relationship is unique in several respects. First, its sole purpose is to promote the recovery of the patient. In the furtherance of this goal, the therapist becomes the patient's ally, placing all the resources of her knowledge, skill, and experience at the patient's disposal. Second, the therapy relationship is unique because of the contract between patient and therapist regarding the use of power. In a way, this reconstructs the relationship of imbalanced power with the abuser. However, by not abusing this power against the victim, the relationship therefore takes on a healing and corrective effect. Within these principles, the therapist is called upon to bear witness to a crime. The therapist cannot stay neutral and must affirm a position of solidarity with the victim. Understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice. This will usually help the victim to differentiate what is just since what was done to her was wrong and to restore some faith in her surroundings and the world. By doing so, the therapist models

honesty to the victim without evasion or disguise. The therapist's role is both intellectual and relational, fostering both insight and empathic connection. Trauma damages the patient's ability to enter into a trusting relationship, but by adhering to these core principles, we restore the trust of the victim in the human relationship.

Herman's principles for treating trauma have developed into trauma-informed practice.

"Trauma-informed practitioners are sensitive to the ways in which the client's current difficulties can be understood in the context of the past trauma. Further, they validate and normalize the client's experiences. Trauma-informed practice requires the practitioner to understand how the working alliance itself can be used to address the long-term effects of the trauma. Emphasis is placed on helping survivors understand how their past influences the present and on empowering them to manage their present lives more effectively, using core skills of social work practice" (Knight, 2015, p.25).

Knight (2015) continues to explain that unlike trauma-centered intervention, where the underlying trauma is the primary focus of the intervention, trauma-informed practice helps survivors ''develop their capacities for managing distress and for engaging in more effective daily functioning (Gold, 2001, p. 60)" (Knight, 2015, p.26).

Trauma-informed practice recognizes that this method provides a deep benefit of a corrective emotional experience for survivors (Banks, 2006). For example, there are means for the victim to challenge distortions in thinking about their own self and others, leading to the ability of the victim to develop their own self-capacities (McCann & Pearlman, 1990). For example, when practitioners understand and anticipate ''traumatic transference'' (Spiegel, 1986), meaning the therapist understands that they represent those who have exploited the survivor, the practitioner can assist the client in confronting directly fear and mistrust of others (Dalenberg, 2004; Horvath, 2000). Another aspect of this dynamic is that therapists' reactions affirm and give a voice to the client's own reactions (Courtois, 2001). The outcome of this positive relationship is that the victim is able to rectify the internal and social stigma experienced from abuse. (Knight, 2015)

To practice trauma-informed therapy, it is important for the therapist to be aware of the complexity involved. The four-fold principles of trauma-informed practice, according to Knight (2015), are normalizing and validating clients' feelings and experiences; assisting them in understanding the past and its emotional impact; empowering survivors to manage their current lives better; and helping them understand current challenges considering the past victimization (Courtois, 2001; Martsolf & Draucker, 2005; Wright et al., 2003).

In a qualitative study regarding trauma-informed care with domestic violence victims, the research came up with six principles that are included in trauma-informed care. These principles are establishing emotional safety, restoring choice and control, facilitating connection, supporting coping, responding to identity and context, and building strengths, each of which comprises a set of concrete practices. (Wilson et al., 2015).

The most recent set of Trauma Informed Care guidelines developed by SAMHSA encompasses Harris & Fallot's (2001a, 2001b) foundational principles and the later contributions of the WCDVS (Elliott et al., 2005) as well as new additions that attend to social oppression and identity. These guidelines include establishing a safe environment; developing trustworthiness and transparency; offering systems of peer support; promoting collaboration and mutuality between staff and participants; supporting the empowerment, voice, and choice of survivors; and attending to cultural, gender, and historical issues (SAMHSA, 2014b) (Wilson et al., 2015).

Under these principles, it would be understandable that a practitioner would follow the lead of the victim when discussing their trauma. It would explain why a practitioner would not suggest questions regarding same-sex abuse due to the stigma of both the client and the therapist. The therapist would tread very carefully around these issues so that the

client can be in control of her own narrative, experience, and feelings. Many times, this process can take time and caution on behalf of the therapist.

Van Der Kolk explains in his book *The Body Keeps the Score (2015) how it is seen in different MRI scans that people who suffer from flashbacks and are triggered by* their trauma lose the ability to formulate speech and to express in words what they are feeling and experiencing. His book provides practitioners insight into the long-term effects of trauma; with years following an event or occurrence, the victim may still not be able to provide a coherent account of the trauma. Rather, the victim may re-experience the physical terror, rage, helplessness, or even impulse to fight or flee without the ability to articulate the experience. The victim's experience of a nightmare or flashback once again triggers in the brain a sense that the trauma is actually occurring.

Understanding what happens in the brain of a victim of trauma can also explain why a therapist will not want to trigger their client or ask them to narrate their experience when, clearly, they do not have the words to express what has happened. Insights from Van Der Kolk's work allow for insight into the physiological changes occurring, corroborating the victims' personal experiences. During a flashback, brain scans show activity only in the right hemisphere of the brain while the left side is dormant. Generally, both sides of the brain work together more or less smoothly; this, even temporary balance, is debilitating.

Van Der Kolk brings different aspects and modalities which can help working with trauma victims. One of the modalities he elaborates on is Eye Movement Desensitization and Reprocessing (EMDR), which by stimulating both sides of the brain helps to connect the right and left hemispheres. Through dialectical movement between the hemispheres while bringing up the trauma, the therapist helps the victim process the trauma.

Another aspect to be considered regarding the reluctance of the therapist to ask about same-sex abuse might be the therapist's own religious beliefs, bias, worldview, and feelings. Since these taboos are substantial, an Orthodox therapist might not be open to exploring these issues and stay under the narrative that there is no such thing as sexual abuse from a woman or that from a religious standpoint, since they are two women, there is no need to explore the nature of the relationship, which would keep both therapist and client in their mental 'comfort-zone.'

It is imperative for clinicians who deal with issues of same-sex abuse and sexual abuse within the orthodox community to be educated in trauma-informed care and the different modalities of treating trauma so that they can help their clients and not continue the undercurrent of shame that stigma and taboos create. To be better informed and know how to help the particular issue due to these four taboos, research is needed regarding the phenomenon of Orthodox women being sexually abused by other women.

SECTION FIVE: THE RESEARCH QUESTIONS

The purpose of this study is to examine and attempt to understand the experience, through the lens of the therapist, of an Orthodox woman who has been sexually abused by another woman.. The issue of sexual abuse may affect the individual psychologically and culturally, both in their family and community. Due to the stigma resulting from sexual abuse and the additional stigma within the Orthodox community based on its culture, this dissertation has demonstrated the importance of race, ethnicity, and cultural sensitivity in the treatment of sexual abuse. The main research question refers to the overall experience of a

victim of sexual abuse by other women within the Orthodox community. The Sub Questions refer to the different dimensions of the Quadruple Taboo:

RQ: What is the psychosocial experience of an orthodox woman abused by another woman?

SQ1: How does the experience differ from experiences of women being abused by men?

SQ2: What are the psychosocial implications of being an Orthodox Jewish woman, and how did that affect the therapy?

SQ3: Does sexual orientation come up in the therapy sessions?

SQ4: How does the gender of the perpetrator affect the therapeutic process?

Conducting qualitative research to explore this phenomenon will hopefully be able to answer these questions and give us insight into the experience of a victim from the orthodox community who was sexually abused by another woman. These findings will allow the creation of better interventions that take into consideration the religious and cultural sensitivities of the client.

SECTION SIX: RESEARCH METHODOLOGY

This study will explore, by using a qualitative research approach and through the lens of their therapist, the experience of Orthodox women who were sexually abused by other women. This research will discuss the problems affecting individuals or groups (Creswell & Poth, 2016). The qualitative method enables a deep and thorough investigation of the personal experience of therapists who treat Orthodox women who were sexually abused by other women and is a necessary approach because of the limited existing research. A qualitative approach allows for exploring the problems plaguing the day-to-day life of sexually abused orthodox women by other women on a deeper and more personal level.

There are five qualitative approaches: narrative research, which explores an individual's life; the *phenomenological* approach, which understands the essence of an experience or lived phenomenon. G*rounded theory* research develops a theory grounded in data from the field, the *ethnographic* approach, which describes and interprets shared patterns of a culture of a group, and *case study* research, which develops an in-depth description and analysis of a case or multiple cases (Creswell, Poth 2018). The phenomenological approach involves a detailed examination of the participant's life; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself (Smith & Osborn, 2007). Sexual abuse of women by women is a global phenomenon, with particular cultural, communal, psychological, and mental experiences and ramifications that require research in order to provide therapists with tools to be more aware of and attuned to treat this phenomenon. Conducting in-depth interviews with therapists and professionals who treat Orthodox women who were sexually abused by other women, with the objective of observing themes that are common to all participants, enables an outcome of producing an objective statement regarding the phenomenon of Orthodox women who were sexually abused by other women.

Incorporating a phenomenological study is an important addition to the methodology as it describes "the common meaning for several individuals of their lived experiences of a concept or a phenomenon. Phenomenologists focus on describing what all participants have in common as they experience a phenomenon" (Creswell, Poth 2018, p. 2955). Researching the phenomenon of orthodox women who were sexually abused by other women has not been explored before. Therefore, qualitative research is more open to the personal experiences of the subjects, which the researcher will follow as the subject unfolds. Providing a space for the subject to explore the issue widens the field and is, therefore, appropriate for a study.

As established in the literature review, sexual abuse is a taboo due to the shame and stigma created. Authors Steine et al., 2016; Easton, 2013 note it takes many years, if at all until a victim discloses that they have been sexually abused. Whereas authors Crisma et al., 2004 Paine & Hansen, 2002 Reitsema & Grietens, 2015 demonstrate that discussing sexual abuse can provoke many uncomfortable feelings and fear of judgment from society. Additionally, the literature reveals that the orthodox community does not discuss sexual behaviors or refer to any form of sexuality, whether it be body parts or sexual behavior (Taragin-Zeller, 2014; Yafeh, 2007) (Keidar et al., 2021). This community behavior reinforces not disclosing sexual abuse when it occurs. Therefore, the ramifications of social and communal disclosure of sexual abuse are severe (Ben-Ezra et al., 2010). For example, same-sex relationships are forbidden within the orthodox community and can have severe ramifications (Itzhaky & Kissil, 2015); therefore, being sexually abused by a woman is considered an abomination for women. Suskin and Al-Yagon (2020) established that gender roles are very prominent within orthodox society. Therefore, seeing a woman as a perpetrator and not in the traditional role of nurture and caregiver is hard to fathom. The literature review established that the current taboos being explored are actual forces within society. Even with all this research regarding one or two of the taboos, no research has been found regarding the phenomenon of Orthodox women who were sexually abused by other women.

The proposed research regarding the four taboos has not yet been explored.. The first taboo is the shame and guilt which emerges from the sexual abuse. The second taboo is the ramifications of discussing anything sexual within the close-knit Orthodox community. The third is the taboo regarding same-sex relationships within the Orthodox community. While the fourth is a broader taboo regarding the perception of women and gender roles, which exclude the notion of women as perpetrators. Researching the experience of victims through the therapist's perspective will enable them to receive information both regarding the

therapist's experience and of the client. Exploring each one of the taboos will enable the extrapolation of themes that can further assist a client or therapist when dealing with women who were sexually abused within the orthodox community by other women. Understanding the benefits of discussing sexual abuse in a culturally sensitive format can bring relief and healing to women who were sexually abused. Exploring the ramifications of being part of the orthodox community and understanding how that affects a woman who was sexually abused by another woman can help develop ways for treatment and prevention for future victims. Addressing the same-sex taboo within the orthodox community regarding women can help raise awareness, eliminate the stigma, and bring relief to victims by other women within the orthodox community. Finally, addressing women as perpetrators can provide information and help implement programs to create a safer environment for women within the orthodox community and within society. Within the phenomenological approach, the proposed research is an interpretative phenomenological analysis using a Semi-structured interview. This format will enhance reliability and efficiency by combining specific questions to collect data and open-ended questions to allow for an in-depth understanding of the interviewee's experience (Smith & Osborn, 2007). This form of interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of the participants' responses, and the investigator is able to probe interesting and important areas that arise (Smith & Osborn, 2007).

Instrument

The interview guide (Appendix 2) consists of 22 questions. The first nine were demographic questions about the therapists, and the remaining 12 were about the actual abuse, what happened, how it was disclosed, the therapy process, etc through the lens of the therapist.

Questions regarding demographic information and professional experience were asked, such as years in practice, main specialization, religious affiliation, gender/gender identity (personal), age, training (degree specific to trauma and sexual abuse), and supervision. There were also questions about the professional's education, whether they received any training, and what their sexual identity is.

Lastly, questions regarding the therapeutic relationship and countertransference were also asked to provide more information from the therapist's point of view. The full interview guide appears in Appendix II.

Data collection / Sample:

Using snowball and purposive sampling, the researcher reached out to professionals through different forums of therapists who specialize in treating sexual abuse, such as social media and other professional groups.

The purposeful and snowball sampling technique is a qualitative investigation based on active interviews. Because the phenomenon of orthodox women being sexually abused by other women received minimal empirical examination, an explorative, descriptive approach is used. Interpretative Phenomenological Analysis (IPA) studies are conducted on small sample sizes. The detailed case-by-case analysis of individual transcripts takes a long time, and the aim of the study is to say something in detail about the perceptions and understandings of this particular group rather than prematurely making more general claims (Smith & Osborn, 2007).

The interviews were conducted by the principal investigator on Zoom following the interview guidelines. However, the principal investigator did not interview herself, and when she discussed her experiences, she was interviewed by another therapist following the same guidelines. The interviews were all recorded. In total, there were a total of 10 therapists who were interviewed for 25 cases of same-sex sexual abuse. Four therapists were interviewed about only one victim, whereas the rest were interviewed about multiple cases, ranging from two to five. All of the therapists were female, heterosexuals who identified as Jewish Orthodox. Orthodoxy was not defined by the principal investigator but was self-reported by the therapists during their interview. One therapist she is "modern" Orthodox, whereas all of the remaining therapists just said they were "Orthodox."

Each interview will be recorded and then transcribed. Then, the data will be analyzed to look for themes. This study will use ATLAS. ti software. "ATLAS.ti belongs to the genre of CAQDAS programs. CAQDAS stands for Computer-Aided Qualitative Data Analysis Software" (Friese, 2014).

Sample size changes depending on different variables: "The topic under investigation may itself be rare and define the boundaries of the relevant sample" (Smith & Osborn, p. 56). There is no right answer to the question of the sample size. It depends on several factors: the degree of commitment to the case study level of analysis and reporting, the richness of the individual cases, and the constraints one is operating under. (Smith & Osborn, 2007)

Inclusion and exclusion criteria will be drawn from professionals worldwide in different settings working with Orthodox Jewish women whom other women sexually abused. The Orthodox community follows the same religious guidelines and, therefore, culturally demonstrates the same taboos all around the world. This will include therapists and professionals working with Orthodox women who are willing to interview in either Hebrew

or English in Israel, the US, or any other English-speaking countries, in alignment with Patton's (1990) guidelines for sampling who, suggest that the sample should be information rich. Israel, the US, and other English-speaking countries all belong to the International Federation of Social Workers, sharing the same values and core principles of working with people (International Federation of Social Workers, 2023). The participants will be located by means of advertisements, social media, personal connections, and the chain sample technique. In the research, the initial contact with the participants will be by telephone/Zoom meetings, during which the study will be explained to them. The interviewees will receive information regarding the research, they will be protected by informed consent, and they can decide to stop the interview and not participate at any time (Appendix I). The primary researcher will help them find resources for emotional counseling or any other resource to help them process countertransference or any other emotional or ethical issues that might arise.

Research questions:

The research questions include the various dimensions of the Quadruple Taboo. The questions are structured to understand what therapists can reveal about the complexity of Orthodox Jewish women abused by other women. The goal of the questions is to generate knowledge about the interplay of the components of the Quadruple Taboo by investigating the psychological and social impact of the abuse. Ultimately, the research questions are as follows:

1) What is the psychological and social impact of an orthodox Jewish woman abused by another orthodox Jewish woman? 2) How does the experience differ from the experiences of orthodox Jewish women being abused by men? 3) How do the religious practices affect the response to sexual abuse of orthodox Jewish women? 4) What are the implications of sexual

abuse of orthodox Jewish women for psychotherapy, especially on subjects such as sexual orientation and gender of the perpetrator?

SECTION SEVEN: ANTICIPATED CONTRIBUTIONS

The phenomenon of women being sexually abused by other women within the orthodox community has not been explored in the findings of this literature review. Therefore, this research will provide an initial assessment and exploration of the phenomena, its prominence, and its ramifications. The study will enable empirical data on the phenomena's prevalence, allowing for further examination and studies in the future. The study provides a more profound and in-depth understanding of what a victim experiences when sexually abused by another woman. Moreover, this research provides a deeper understanding of helping women within the orthodox community who were sexually abused. As identified in the literature review, the Orthodox community is a closed community. This research can provide an in-depth understanding of the multi-faceted layers and insight into the complexity caused by being abused in a closed society where the social structure can create shame. The information gathered from this research can extend beyond the Orthodox Jewish community to other communities that are closed or hold similar values.

The main contribution of this study is related to the best and most accurate treatment for women whom other women in the religious society have sexually abused. Therefore, this study examines the main characteristics that should be highlighted and addressed for the

treatment to be as beneficial as possible for these women. Once that data is collected, different protocols can be suggested regarding the therapy to ensure the implementation of the findings.

An added value of this research is exploring the therapeutic relationship from the therapist's point of view. Hopefully, through the information collected in this research, we can create guidelines and training for therapists treating this phenomenon.

SECTION EIGHT: RESULTS

Sample:

A total of 25 cases of Orthodox Jewish women being abused by women were revealed by ten therapists through interviews. All of the therapists identify as Orthodox female heterosexual individuals who predominantly practice within the Orthodox population. The ten therapists have been practicing for an average of 19.75 years with an SD of 14.04 (ranging from 2.5 to 40) and, combined, have seen more than 30 cases of sexual abuse of women by women in the Orthodox community. All therapists were located in Israel. However, not all of the instances that were disclosed took place in Israel.

The ten therapists had varying degrees, with the majority (70%) having a master's in social work (MSW), one having a master's in sociology, one having a PhD, and one being a PhD student.

In addition, all of the therapists had additional training beyond their degrees. The most common additional training listed were EMDR (60%), IFS (40%), and Somatic training (40%). Others were play therapy, CASAC, CBT, Mbsr, DBT, narrative therapy, feminist therapy, and complex PTSD.

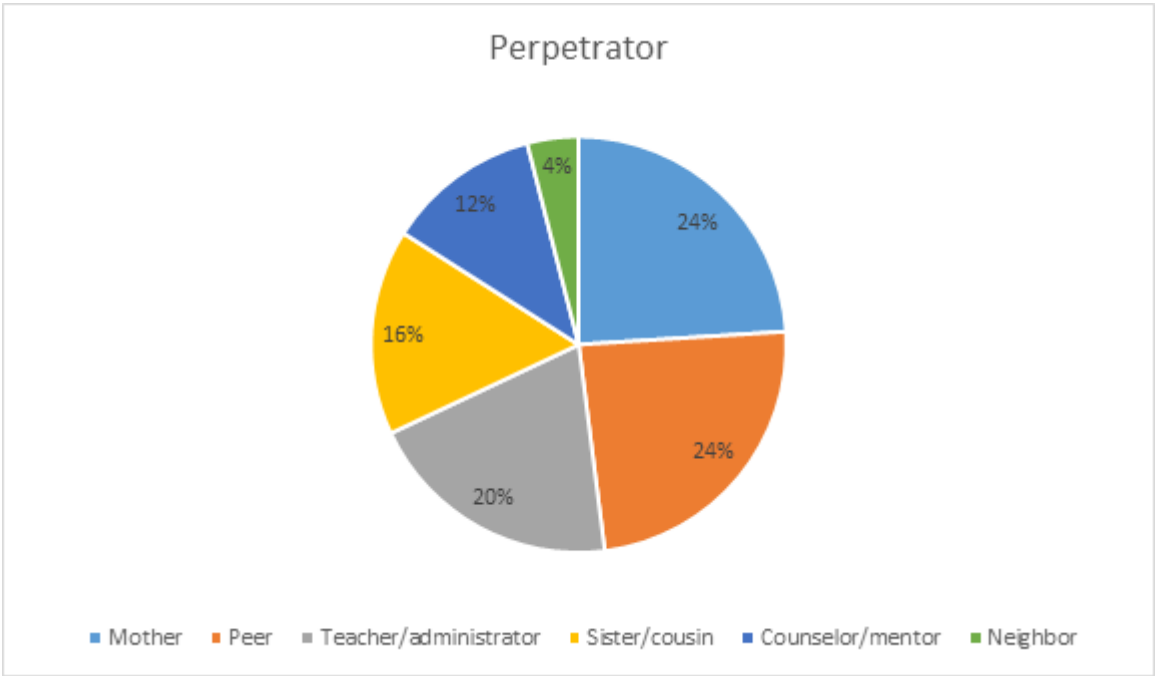
All except three (70%) of the therapists also had additional training in sexual abuse. However, none of the therapists had specific additional training in the area of LGBTQ.

Demographics:

In every case, the perpetrator was someone familiar to the abused woman. The most common was a family member, where 24% (N=6) were mothers and 16% (N=4) were either a sister or cousin. The next most common were peers (N=6, 24%); an additional 20% (N=5) of cases were a teacher/administrator. Twelve percent (N=3) were counselors, and one was a neighbor (4%). See Figure 1 below for the breakdown.

Figure 1

Breakdown of the relationship between the perpetrator and the survivor



Twenty-five interviews were conducted over Zoom to understand the phenomenon of sexual abuse of women by women in the Orthodox community and its' apparent and substantial psychosocial and emotional effects. The interviews were conducted to understand what happened, how it happened, the immediate and long-term impact on the survivor, and the psychosocial and therapeutic implications. Through the data collected and analyzed from the interviews, there was an evident emotional struggle for the survivors of sexual abuse by women in the Orthodox community in the following areas: guilt, shame, confusion, dissociation, body/sexual issues, anger, hopelessness, and lack of trust and lack of education. The findings are summarized based on specific research questions to discern the different feelings and taboos better.

RQ: What is the psychosocial experience of an orthodox woman abused by another woman?
SQ1: Specifically, how does the experience differ from the experiences of women being abused by men?

During the interview, the therapists were asked how the gender of the perpetrator played a role in the client's narrative and thereby psychosocially affected the survivor. Due to the perpetrator being a female and, in all cases, someone that the woman knew, the main themes that emerged were confusion, ambiguity, and lack of definition of what happened. Based on the therapists' accounts, there were two ways that the confusion was expressed. One way was that the narrative was blurred because the perpetrator was a female, and therefore, it was not immediately apparent that it was inappropriate. These survivors went through the abuse, not realizing that what they experienced was wrong. The second way the confusion was expressed was through the survivor being confused about when "normal friendship" boundaries were breached. Physical contact is a common way to demonstrate support and emotional connection. In the Orthodox community, physical contact between men and women is prohibited and appears in particular situations. Between women, however,

it is “normal” to give each other friendly hugs, demonstrate support by physical touch, and give each other massages, etc., so it leaves the survivor feeling confused about what is considered normal in a female friendship relationship, especially as the perpetrator often reassured them that they were not doing anything wrong. The survivor felt uncomfortable and knew something was inappropriate, but it was unclear when the lines were crossed, as they had not been taught about it. They were in a situation where they knew what they were doing was wrong, but they didn’t have enough knowledge to know at what point they started doing something wrong. This confusion, especially if they had any enjoyment, led to self-identity questions and uncertainty about their sexuality. For some of the survivors, the confusion was cleared up either on their own or during therapy, whereas for others, it remained.

Other themes that emerged were that it would have been obvious that it would never have happened with a male because of the apparent gender boundaries in the Orthodox community, specifically that the girls would not have been alone with a male (22%) and that it was challenging to open up to the therapist due to the taboo and her gender (22%). Other survivors were in shock and froze (17%), whereas 13% ended up questioning their sexuality, and 6% experienced shame and lack of trust in others.

Other themes that were less prominent in their occurrence or the implications are looking for a replacement mother and watching porn. The two most prominent themes that emerged, which were very similar and intertwined, were the narrative being blurred there was a lack of certainty that abuse occurred (48%, N=11) and being confused about when the boundaries were crossed and when the relationship moved past normal friendship such as friendly or supportive touch (48%, N=11).

Narrative responses: Lack of Certainty that the Abuse Occurred

The narrative was often blurred because the perpetrator told the survivors that it was okay, and the survivors knew that they were allowed to speak with other women and touch other women. This was especially true when the perpetrator was someone older, such as a mentor, teacher, or mother, where it was even more unclear because these are people looked up to for support and advice. They are supposed to teach what is correct and incorrect. One therapist recounts:

> Very confusing, made it much more confusing, especially because it was not forbidden, so to speak, for women to touch each other. She really craved contact, especially from a mother figure, and so that piece was very relevant. This was a relationship that was accessible, and it was close. (Therapist #6 about Survivor # 16)

Two therapists describe the uncertainty the survivors experienced in whether they understood it to be abuse.

"Well, that is the piece about not really knowing that it could be abuse, not being able to describe it." (Therapist # 4 about Survivor # 9)

The other clearly described the gender of the perpetrator as being the reason for the uncertainty: "I think that the fact that the perpetrator was female took a while for the client to understand that what was going on was not appropriate. I think she was not sure about that at first." (Therapist #2 about Survivor # 4)

Even when the survivors understood that this was not something that should be happening between women, they were often pushed off or told that it was okay.

> So, it was affected by the fact that she understood that this was not something that was supposed to be happening between women. For her, anyway. Moreover, when she brought it up to the perpetrator, the perpetrator would rate her and say, you have an issue. You have a problem. There is nothing wrong with us doing this. Etc.

> However, very, very clearly, it was something that she felt uncomfortable with. (Therapist #2 about Survivor # 25)

The confusion blurred the narrative, as demonstrated by therapist #1 about survivor # 2,

> Her question was, how does this happen? There was very much an experience of something that happened to me, not what was wrong with me that I did this. It was like, I do not know what happened. Moreover, I think that was affected by the fact that it was a female.

Moreover, even further explained therapist #4 about survivor # 12: “It was very confusing about whether it was wrong, whose fault it was, if something had been wrong at all. It was a female, and it was also a family friend. “

Similarly, when the survivor felt uncomfortable, it still was not thought of as abuse by many survivors, as therapist #2 explained about survivor 4): “It did not feel right, but It was not conceptualized as wrong until she was a little older.”

Theme 2: Confusion about Sexuality

This blurred narrative and confusion of when the boundaries were crossed may have led to confusion about their sexuality, as 13% started questioning their sexuality. Once they understood that the boundaries had been breached, they were concerned about what that meant for them personally, especially if they experienced enjoyment. As therapist #1 put it bluntly, for survivor24, “She felt very confused about whether or not she was lesbian.” A couple of other therapists noted that their client did feel a bit attracted at the time, which made it even more confusing.

Theme 3: Gender of Abuser Affected Survivor Response

Twenty-two percent of therapists said, quite a matter of fact, that it would have never happened if it were a male because there are clear boundaries, and the girls would not have been alone with them. A few clear examples where the therapists relayed this theme are:

> The client would have known to be wary of this sort of discussion or these sorts of acts if the client was male because then that would be clear to her that something here is wrong because that is how we were raised as religious people. (Therapist #2 about Survivor # 5)

Another more blatant example is when the therapist noted, “This would not have happened with a male because she would not have been spending the night with a boy.” (Therapist #6 about Survivor # 18) Moreover, one therapist even went so far as to say that the girl would have never allowed it, even if a male had tried to abuse her, “I think she would have punched her brother. I mean, I say, that literally she's a tough girl, but she was absolutely stunned.” (Therapist #1 about Survivor # 24)

Theme 4: Distrust in Others

There was an acknowledgment of distrust in others, which was expressed in difficulty relating to people, maintaining friendships, and having a more difficult time opening up due to working with a female therapist or the taboo involved in [speaking about] what happened (22%). As therapist # 5 put it regarding survivor # 14,

> The fact that it was a woman and the fact that she was in the room with me made it so uncomfortable to disclose it to me. There was so much about the nature of it being from a female that impacted her ability to tell me and her shame regarding it. Both of the clients felt like they should have been able to stop it.

Theme 5: Shock

Seventeen percent were in utter shock, as noted by therapist #5 regarding survivor # 15, “It was shocking to her that she was attracted to a female, and then that a female could hurt her so badly.”

SQ2: What are the psychosocial implications of being an Orthodox Jewish woman, and how did that affect the therapy?

The researcher asked about the emotional impact of religious affiliation on the experience. The majority of therapists reported that their clients had a lack of knowledge and education regarding sexuality, which expressed itself by the lack of terminology to describe what happened and how it was abuse. Similarly, most therapists stated that the survivors, living in an Orthodox world, were dealing with religious taboos and, therefore, thought that what happened to them was unheard of and could not be spoken about. Below is a breakdown of the themes that emerged from this research question.

Theme 6: Lack of Sexual Education

A majority (60%) of responses focused on the fact that these women, because they were religious, had a lack of knowledge and sexual education, and therefore, many did not have the language to express what happened to them. Here are some examples that demonstrate this theme based on the therapist's reports.

Narrative responses:

“At 14, she knew very little. She did not know how to categorize this. I do not even think she categorized it as a sexual experience. She did not have those words.” (Therapist # 1 about Survivor # 1)

The following therapist explained the difficulty in explaining what happened as being due to a combination of lack of knowledge/education and cultural sensitivities/taboo.

So, the disclosure of the abuse was pretty upfront. However, the description of what was going on was very difficult. She did not have words to explain what exactly went on. She had a hard time. Part of it involved her not having words because she was not taught words. Part of it had to do culturally with her not feeling comfortable. (Therapist #2 about Survivor #4)

Theme 7: Difficulty in Speaking about What Happened

More than half of the therapists (60%) also described the taboo that the survivors felt, such as what happened to them was unheard of, not normalized, and therefore, they could not speak about it, and they had no one to open up to about it. This inability to openly discuss what happened led to implications that seeped into their personal relationships, both with friends and intimacy. Some examples of this were expressed as follows:

There was a lot of confusion about what was ok and what isn't okay. It definitely impacted the way she felt about sexuality in general. There were certain things that we had to learn, the words that were comfortable for her to say in the room about body parts and the actions that were going on. (Therapist #2 about Survivor #6)

Certainly, that this would have been considered abuse did not occur to her at all. In general, shame around her sexuality discussing it, the taboos discussing it, or having difficulty with intimacy in her current relationship, there is a tremendous amount of shame around them. (Therapist 4 about Survivor # 11)

Theme 8: Confusion about Whether they did Something Wrong

Forty-four percent were confused about what happened and whether they did something wrong, stemming from their Orthodox upbringing and likely a trickle effect of their lack of education. Specifically, as mentioned in research question one above, what are the boundaries, and when would they have changed, such as when this went beyond regular friendship touch?

This was explained by a couple of therapists: “So much confusion about what this was and what this means. Moreover, if it was not a man, maybe it was not abuse, and you know things like that.” (Therapist #1 about Survivor #3) Another therapist bluntly said, “There was a lot of confusion around what is ok, what isn't okay.” (Therapist #2 about Survivor #6)

Theme 9: Lack of Conceptualization of what Happened

Related to the lack of education and taboo, there were also 24% of cases that mentioned a lack of conceptualization of what happened to her, as described by therapist #2 for survivor # 4, “…and not having a fluid narrative of what was going on. I think she did not have words to say what happened. I think that is because of the cultural upbringing where that has come up.”

Theme 10: Shame

Twenty-four percent Experienced much shame, as described by a therapist regarding client 11, “And in general shame around her sexuality discussing it, the taboos discussing it, or having difficulty with intimacy in her current relationship, there is a tremendous amount of shame around them.” (Therapist #4 for Survivor #11)

Due to being a religious individual and being hurt by fellow religious individuals, 20% lost trust in religious people, as expressed by therapist #1 for Survivor #1: “Maybe shame for believing in people, like that, was really the religious per se.” one therapist even stated that her client left Orthodoxy for a while as a result.

Sixteen percent were left with the question of what it all means and whether it affects their sexuality.

SQ3: Does the subject of sexual orientation come up in the therapy sessions?

Overall, throughout the entire interviews, 36% of therapists disclosed that at some point during the therapy, the client discussed sexual orientation. Some of the questions that came up were: Who am I, and who am I attracted to? Am I a lesbian? What does this say about me? To some, this was the overarching question they came to therapy for, more than actually working out the incident.

Narrative responses:

As one therapist #6 describes survivor # 18, "With this client, I think it just kind of lent itself to other things that were much more pressing to her about her sexuality, and less about the incident itself."

When describing survivor # 21, therapist #8states the confusion about sexuality that the client experienced, "The process also created other questions, about themselves as females, and being comfortable with men, and because they feel comfortable with females."

There was much confusion about sexual orientation that was expressed in some way or another. Sometimes, the survivor felt some enjoyment or pleasure from the experience, which made it much more sexually confusing, such as when therapist #1 describes survivor # 24, "I think she did develop certain feelings for the girl or woman that confused her and scared her."

The confusion about sexual orientation also led to shame and fear of being an Orthodox female and what it might imply, as displayed by therapist #4's account of survivor # 9

Meaning, what does it mean to have a fantasy about sex with a woman? What does that mean? If that automatically means something about her gender, or wanting something, or imagining something, or thinking about something that the understanding they have because of the closed nature of the culture is that they are then going to assume that means that they must be lesbian.

SQ4: How does the gender of the perpetrator affect the therapeutic process?

When asked specifically how the gender of the perpetrator affected the therapeutic process, the main themes that emerged were: lack of trust in women in general (28%), anxiety/caution of connecting with people (28%), self-identity and sexuality (28%), and taboos withheld them from speaking (19%).

One more theme in several places, especially regarding the treatment plan, is the number of layers the experience created. For many of these clients, the taboo created layers and layers of issues that needed to be dissected individually.

13% mentioned during the therapeutic process that they had to go through every layer slowly to regulate them, and 33% said they used a very client-centered-trauma-focused approach due to the layers involved.

Summary

In summary, the main findings that emerged from the research align with the four taboos regarding feelings of guilt, anger, and shame. A major issue that came up showed the immense confusion that survivors of sexual abuse by women feel regarding what happened to them. Issues regarding sexual identity and attraction emerged. However, implications of the Jewish Orthodox belief system created more complexity for these survivors regarding the ability to disclose and discuss the events and their feelings, which affects their therapeutic process. The fact that the perpetrator was female created doubt in the survivor's experience as

to defining what happened as abuse. Moreover, understanding, conceptualizing, and defining what happened as sexual abuse shaped the therapeutic process regarding trust issues within the therapy and without regarding relationships.

SECTION NINE: DISCUSSION

The results demonstrate that feelings of guilt, anger, shame, and helplessness, which are commonly associated with sexual abuse and sexual trauma (Crisma et al., 2004; Paine & Hansen, 2002), are also apparent in the phenomenon of women being sexually abused by other women in the Orthodox community. However, the main contribution of this study shows that these feelings appear for each aspect of the four taboos: sexual abuse, sexuality within the Orthodox community, same-sex sexual interactions, and considering women perpetrators. The feelings of shame, guilt, helplessness, and anger appear within each of the abovementioned taboos; therefore, they are layered and require attention separately for each layer and dimension.

Additionally, there seems to be a fluctuating flow between the different taboos regarding feelings and aspects that might affect the treatment and the therapy.

Each one of these taboos perpetuates shame. Sexual abuse perpetrates shame for having breached physical boundaries. Within the Orthodox community, being involved in a sexual act has ramifications for your “good name” and standard in the community, thereby creating shame when one is either active or is a survivor of sexual acts out of wedlock. Same-sex relationships are taboo; therefore, having these events happen between two women evokes shame. Being sexually assaulted by women is not an event an Orthodox female anticipated; therefore, when it happens, taking into consideration the three first taboos, where there was a sexual assault by the same sex within the Orthodox community perpetuates shame.

A significant theme that emerged from the findings is a sense of confusion regarding the incidents of what happened. Almost every therapist (84%) mentioned that their client felt confused. The confusion was manifested in different ways. There was confusion regarding the inappropriateness, definition, and interpretation of what happened. As mentioned above, there is a flow and fluctuation between these emotions and taboos, enhancing confusion. In an attempt to clarify, it is suggested that the confusion might have multiple reasons that may be intertwined. Many of the survivors described that they did not know whether what happened to them was permitted or not regarding Jewish law and social norms. The lack of knowledge and clarity regarding these issues has to do with the perpetrator convincing and telling the survivor that their sexual touch and actions were permitted by Jewish law, and since Jewish law permits physical interaction between women, the survivor, though sometimes felt uncomfortable, believed the perpetrator. There was increased confusion when the perpetrator was someone the survivor should respect, such as a parent, teacher, or mentor (56% of the cases). They told them that everything they were doing was okay and allowed. One clear example of the confusion was expressed by one of the therapists who described the perpetrator throwing the client on a bed and ripping open her shirt. Only when the therapist asked her client to imagine how she would define it if the same action had happened with a male perpetrator did the survivor understand that what happened was wrong.

Building on the confusion that many survivors were unclear whether there was something wrong was the added layer of the limited education and discourse in the Orthodox community regarding intimacy, sexuality, touch, and the boundaries of each of these issues (Zalcberg & Zalcberg, 2016). The lack of discourse and education regarding sexuality, intimacy, and physical touch leads to blurred definitions and boundaries. Therefore, when one breaches those boundaries, it is not clear to the survivor and creates confusion and a breach in the survivor's safety. Oz (2005) refers to it as “the gray dissociative cloud” (Oz,

2005). This correlates with other common reactions when there is a breach of safety in a person. When a person feels a breach of safety, they often go into the survival mode of fight, flight, or fright (Seng & Group, 2019). It is common for sexual abuse survivors to freeze or to experience dissociation, which was explicitly mentioned in 26% of the cases, and adds a dimension where the client does not understand what is happening to her, to the sense of confusion.

An additional source of confusion might be the combination of lack of knowledge and discourse regarding sexuality and the physical feelings that this touch has brought up. This means feeling conflicted between enjoying the physical touch and simultaneously feeling uncomfortable with the sexual touch, especially knowing that same-gender intimate relationships are forbidden in the Orthodox world. As one therapist described regarding her client: “At first, the client felt that the way the perpetrator was touching her was pleasant when the perpetrator was arousing the client sexually, the client started to feel conflicting emotions of pleasure and dread due to her social and religious values and beliefs that sexual touch was meant for marriage and knowing that she(the client) wanted to marry a man.”

This conflict between enjoying the physical touch and simultaneously being uncomfortable with it led 36% of the cases to question their sexual orientation. The survivors were left with questions on whether they were lesbian and to whom they were attracted, especially in situations where the abuse was more manipulative and less violent. Being actively involved, rather than being abused by force, more often leads to the arousal of sexual feelings (Finkelhor & Browne, 1985; Morrison et al., 2018), which would lead to increased confusion about their sexuality. This confusion regarding their sexual orientation and shame since same-sex relationships are forbidden within the orthodox community was clearly part of the therapeutic process for these clients. For some, these incidents manifested themselves into

a sense of betrayal and lack of trust in others and their religion, leading some clients to leave the religious way of life, at least temporarily.

Another theme that was apparent from the findings was the effect these actions had on the client's understanding and feelings of intimacy and trust. All of the incidents were with someone the survivor knew, and most happened within a relationship. For many of the clients, this was their first interaction with sexuality and touch with sexual connotations. Thereby introducing intimacy and sexuality to the clients, negatively tainting these actions and experiences. For some of these clients, sexual feelings and sexual touch are perceived as harmful, dirty, uncomfortable, and scary. This can be due to the experiences eliciting misconceptions about sexual relationships and skewed emotional responses to intimacy in general (Morrison et al., 2018). Due to the relationship between the perpetrator and the client, there were times when clients were asked to be active and convinced that what they were doing was appropriate to appease the perpetrator, creating additional guilt for the client since they no longer could view what happened as something that happened *to* them rather something they were part of actively.

Findings show that the ramifications of the perpetrator being female had two main effects. The first, expressed 52% of the time, is trusting the therapeutic relationship and alliance because the therapists were female themselves. Some of the therapists conveyed that there was a lack of trust or difficulty opening up, hindering the therapeutic relationship. In fewer cases, the therapist communicated feelings of sexual currents and vibes during the therapy session and that the client was attracted to the therapist. However, mainly, the therapists described a large sense of embarrassment from the client when trying to disclose what had happened. The other effect of the perpetrator being a woman in the therapeutic

sessions had to do with a sense of betrayal that the client described regarding whom they could trust in the world. They were taught to be cautious of men since the orthodox community encourages segregation between men and women, and they were told that in times of need, women were their safe option; however, women have also hurt them and betrayed them. This betrayal is a result of the harm caused by someone they were dependent on (Morrison et al., 2018). Therefore, using the therapy also to repair and build the trust of the client in women.

Implications

The phenomenon of sexual abuse of women by women in the orthodox community is one that needs to be explored further. There needs to be a better understanding of the prevalence of this phenomenon and the ability to interview survivors personally about what was beneficial to them and what they needed within a therapeutic process. Hearing from the survivors themselves will shed light on the areas that should be focused on rather than just through the lens of the therapists. Also, it would be beneficial to ask the survivors directly about what social and psychosocial interventions can be done to prevent these incidents as much as possible.

Within the therapeutic relationship, there are a few points of focus for direct practitioners. Initially, it would be important to ensure that the therapists dealing with these situations feel comfortable discussing the different taboos mentioned in this paper and managing them in a therapeutic setting. Many therapists within the orthodox community were raised with limitations and restrictions regarding discussing sexuality. Therefore, the therapists themselves need to be comfortable with the topic and have the tools to discuss these issues in an open and non-judgmental atmosphere, hence providing culturally sensitive

therapeutic interventions. Furthermore, since cultural discussions regarding sexuality within the orthodox community are considered socially unacceptable, there may be an interpretation of culturally sensitive therapy as avoiding discussing sexuality and intimacy. However, in reality, culturally sensitive interventions need to address all of the issues through appropriate language, with collaboration and ongoing checking in with the client, which will allow discussion in a way that will be acceptable and engaging with a client instead of avoiding or intimidating the client.

A practitioner treating a Jewish Orthodox female client who was sexually abused by another female should position themselves and expect a great deal of confusion that may come up in the sessions and be prepared to help the client navigate the content to help create clarity and understanding of their experience. This should include psychoeducation regarding sexuality and a healthy and culturally appropriate understanding of personal, social, and physical boundaries.

Within therapy, normalizing and providing legitimacy to the client regarding what happened is greatly important. Due to the segregation between men and women within the orthodox community and the social norm avoiding discourse regarding sexuality, many of the survivors didn't fully understand what was happening to them, and they were never taught to be cautious of other female touch. Hence, they had no way of preparing themselves for this sort of situation and, therefore, may have experienced many uncomfortable feelings due to the confusion about the experience and the undefined feelings. Acknowledging and validating clients is extremely important for their therapeutic and healing process.

Additionally, there seems to be a fluctuation and flow between the taboos regarding different feelings and aspects that might affect the treatment and the therapy. Therefore, the therapist would need to be prepared to go through the different feelings that arise from these

situations and fluctuate between the different layers of processing the sexual abuse, the ramifications that can arise from being part of the orthodox community, the fact that the perpetrator was a woman and the discussion and processing of the client's sexual orientation.

Similarly, it is necessary for the therapist to understand the implications and processing involved in the fact that the perpetrator was a woman. The results uncovered that the perpetrator being a female-led tool led to a lack of trust in women, not understanding that what happened was wrong, at least initially, and allowing it to go further than it would have if it were a male. Therefore, it is important for the therapist to work through these issues for the client and, at the same time, to be mindful of the countertransference since she is female. Addressing these issues in therapy can be an opportunity to restore, repair, and build the trust of the client in women.

Additionally, this study has social and educational implications. Educationally, the Orthodox community should focus on creating educational workshops that include discussions of different types of physical touch. In a broader realm, educationally, within parenting, there should be guidance to encourage parents to teach their children the ability to communicate their emotions and feelings. Teaching to differentiate between the legitimacy of sharing one's feelings and emotions as opposed to accepting behaviors will solidify the notion that feelings and thoughts are always acceptable, regardless of what they are, but behaviors are not always acceptable and need to be controlled. Enhancing a child's ability to trust their own emotions and feelings creates an atmosphere of open- communication where discussion and feelings are acceptable. If a child grows up in an atmosphere where his feelings and emotions are encouraged and communication is open, they will have more ability and agency to determine when someone is doing something that doesn't feel right to them and discuss it with their caregivers, or others that can be helpful, therefore, preventing and avoiding perpetuated situations of abuse.

On a broader level of the social work field, any therapeutic process regarding sexual abuse and same-sex abuse would require a culturally sensitive approach. Female therapists treating women whom other women sexually abused would benefit from awareness of the countertransference, lack of trust in women, and confusion that can accrue from different upbringings and values.

In times such as ours, where sexual identity can be fluid, and confusion can prosper as a result. Validation, sensitivity, and a trauma-focused approach are valuable to allow for healing and clarity.

SECTION TEN: LIMITATIONS

The main limitation of the study is that it's a small, unique, exploratory study. Exploring this phenomenon with a group of individuals who have all experienced the phenomenon can lead to a limited sample size (Creswell & Poth, 2018). Working exclusively with clinicians and therapists servicing Orthodox communities focuses on an exceedingly limited population.

Since the specific variables being examined limited the research to orthodox women whom other women abused, it created a very small segment of the population being explored. The specific and isolated population of the Orthodox community lent itself to a snowball sampling method (Padget, 2017), and since there was such a small subset of the population that was of interest, the results cannot be generalized to the broader population. It would be valuable to expand the research further to include different elements of same-sex abuse within same-sex relationships, including male or non-orthodox and non-Jewish participants. Another limitation of working with an Orthodox community, besides being small, is that it is also very closed. This uniqueness in the community being studied decreases the sense of generalizability.

Initially, the proposed research was focused on victims of sexual abuse by other women in the Orthodox community. However, a few issues arose regarding interviewing victims. First, there was the concern of re-traumatizing victims along with the professional and ethical concern of clinically opening issues outside of a therapeutic setting. Therefore, to resolve these concerns, there was the necessity to interview therapists who treated women who were sexually abused within the orthodox community. By interviewing therapists, the added value of the perspective and process of the therapist and the victim was gained. The research will recruit therapists who have treated orthodox women abused sexually by other women globally. Using a purposive and snowball sampling approach to sample the largest population of therapists, a selection of places will be approached, such as women's religious programs, dormitories, and other spiritual institutions catering to religious women.

Additionally, although the reasoning behind interviewing therapists and not the survivors themselves is to avoid causing additional trauma or harm to the survivors, it limits understanding of the survivor's experience and perhaps the contributions that researching the survivors themselves can achieve.

Finally, during the interviews, the interviewer did not state a definition of "sexual abuse," which therefore left the therapists to use their own definition. The limitation to that is that each therapist may have had a different definition as the types of cases varied.

SECTION TEN: CONCLUSIONS

This exploratory research aimed to examine the phenomenon of Orthodox Jewish women who were sexually abused by other women in their community**.** The premise of this research was regarding four taboos that impact the experience of a survivor within the orthodox community whom another woman sexually abuses. The first was the idea that

sexual abuse, due to its emotional implications, creates shame and guilt, blaming the survivor and the survivor blaming themselves, and therefore, it becomes a taboo. The second pertains to the orthodox community being a closed community where the topic of sexuality is avoided and not discussed. Therefore, when one is sexually abused, the survivors don't have the language or the definitions to understand what happened to them and, therefore, have a difficult time seeking guidance and help, which creates a sense of secrecy and shame. The third refers to being abused by another female, which falls under the category of same-sex relationships. This is considered an abomination and a disgrace within the Orthodox community, therefore making it a taboo. The fourth is the fact that the perpetrator was another female. Both in society and in the orthodox community, physical touch between females is acceptable and can express affection and support. Women are perceived as nurturers, motherly figures, empathic and sensitive. Therefore, they are perceived as safe. Being abused by a female breaches that safety and challenges the worldview and values of the survivor. Additionally, when physical touch is misused and manipulated to breach personal boundaries, especially within a community that does not teach or discuss the difference between physical touch, sexual touch, supportive touch, or any discussion regarding personal boundaries between women, it undermines basic assumptions of safety.

The research was conducted in a qualitative format of interviewing therapists who have worked with orthodox females whom other females sexually abused. The findings show that this phenomenon exists in the orthodox community and has unique characteristics that need to be addressed.

The four taboos clearly affect the client's reaction and feelings to what happened to her. The taboos need to be defined and expressed within the therapeutic relationship. Narrating and normalizing the different elements of the four taboos can assist the client's understanding of what happened and, from there, begin the healing process.

The main findings that emerged were confusion, lack of education, difficulty opening up, shame, questioning sexuality, and lack of trust. The findings showed an element of confusion regarding defining the incidents and knowing how to process them. The confusion was expressed in many variations. Survivors did not know what happened to them, whether it was wrong, and at what point the boundaries were crossed. As such, the findings imply the need for clarity, guidance, and psychoeducation regarding sexuality, which can be done by finding the right words and language that would be comfortable for the client to understand, describe, and process what happened to her. Psycho-educating and finding the right vocabulary for the client to feel culturally comfortable requires cultural sensitivity and knowledge of the Orthodox community. Discussion regarding sexual identity was another thing that came up within the research. Furthermore, issues of trust and countertransference with females, including the therapist, were prominent.

For direct practitioners, being mindful of these findings, especially the confusion that arises due to the cultural implications, is important. Additionally, before treating a female from the orthodox community who was sexually abused by another female, the clinician needs to ensure that the client feels comfortable with the therapist and with discussing sexuality and the elements of the four taboos. A practitioner working with these clients must use a trauma-informed, culturally sensitive approach in order to be in a helping position and allow for healing. A practitioner treating these survivors should also use psychoeducation to ensure clarity for the client. In therapy, the practitioner should expect the different layers of guilt and shame throughout the process.

On a broader level, creating educational workshops within the orthodox community to teach about feelings and validation in addition to different types of physical touch and their implications will help prevent these situations. These workshops should also focus on

boundaries and the concept of trusting inner gut feelings and open communication to prevent these situations and hopefully avoid prolonged suffering.

In general, any clinician treating a person who was sexually abused by women, regardless of the social environment, would benefit from the awareness that in society, women are perceived as nurturers, sensitive, and empathic. Therefore, the survivors are not prepared for the abuse, which adds dimensions of shame and confusion that should be addressed in culturally sensitive therapy.

Finally, further research might examine a broader scope of interviewees to establish the actual prevalence. Additionally, further research that interviews survivors themselves would give a better understanding of different elements that would be beneficial in a therapeutic and social setting. Lastly, research regarding sexual abuse within same-sex relationships outside of the orthodox community can also shed more light as to elements that might be unique to these situations to allow for better therapeutic interventions.

Appendix 1: Information Letter

Dear participant,

The following dissertation research is about your experience as a therapist and your work with female clients. The specific topic is focused on female Jewish Orthodox clients who have been sexually abused by other women. First, the survey will ask a little about you (with no identifying information) and then ask several questions about your perception and experience working with your female clients who have been sexually abused by women, specifically regarding the impacts of sexual abuse, the orthodox community, the same-sex factor, and the fact that the perpetrators were women.

We are studying these issues so that social workers and other mental health care providers will be better prepared to assess and treat female clients who have been sexually abused within the orthodox community.

This study has been approved by the Institutional Review Board of Yeshiva University. Your participation is entirely voluntary and entirely anonymous. You can discontinue participating in the study at any time without any penalty. All written and published information will be reported as group data with no references to agencies or names.

Thank you for your participation.

Should you have any questions, I can be contacted at the information below.

N. Munk

PhD Candidate

Appendix 2: Interview guide

Interview Guide:

I'm currently a PhD student at Wurzweiler School of Social Work. For my dissertation, I am exploring and examining the phenomenon of Orthodox women who were sexually abused by other women. The questions I will be asking you revolve around this topic and your experience working with female clients who were sexually abused by other women. My name is *(name omitted)*. Before we start, I want to remind you that this interview is voluntary, and you are free to stop at any time.

For research and convenience purposes, do I have your consent to record the Interview?

Section 1: Please provide some background information about yourself.

1. Please provide your degree _____

2. How long in therapeutic practice_____

3. Please describe any additional training you have received (such as licenses) and how long you have been practicing in the field (in years) _____

4. Do you have any additional training in the area of Sexual Abuse? (Outside of orientation or HR onboarding training)

- Yes or No
- If yes, please describe _____

5. Do you have any additional training in the area of LGBTQ? (Outside of orientation or HR onboarding training)

- Yes or No
- If yes, please describe _____

6. Do you identify as Orthodox?

- Yes or No
- If yes, please describe Modern, Reformed, Conservative or_____ other_____

7. Is your therapy practice focused predominantly on the Orthodox Jewish Community?

- Yes or No

8. How do you identify your gender?

o Female

- Male
- Other _____

9.. How would you describe your sexual orientation?

A. Heterosexual

- Female – involved with men
- Male – involved with women

B. Gay

- Female – involved with women
- Male – involved with men

C. Other

_____

Section 2: Incidence of Sexual Abuse in Women

10. Have you ever worked with a female client who disclosed an incidence of sexual abuse by another woman?

- Yes or No?
- If yes, please proceed to answer the following x # of questions.
- How many separate occurrences/clients?
- 1-3
- 4-5
- five or more
- For each client, please provide separate information for the following x # of questions.
- What was disclosed by the client regarding the abuse? Can you tell me the client's narrative?
- What was the psychological, social impact (on the client) of this abuse? Such as:
- Depression
- PTSD
- Anxiety
- Other_____
- How was the abuse discovered/disclosed?
- As the therapist, were you able to extract/notice the signs of abuse before the client disclosed it?

- Did the client directly disclose the incident?
  - During intake
  - After a certain number of sessions? How many?
- What was the treatment plan for handling the abuse?
  - Trauma-informed
  - Client-Centered
  - Somatic/EMDR
- In your professional opinion, what was the emotional impact of the client's religious orientation (Orthodox) regarding:
  - Disclosure of the abuse
  - Discussion regarding the incidence
  - Stages of treatment
  -
- How did the gender of the perpetrator (female) affect the narrative of the client?

- How did the gender of the perpetrator (female) affect the therapeutic process?

- Have you been aware of any countertransference during your time working with the client?
  - Yes or No
  - If yes, please describe _____
- How did this client-worker relationship shift your understanding of this phenomenon?
- Is there anything else you would like to add regarding this discussion?

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