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“THERAPY – IT’S A TWO-WAY THING”

WOMEN SURVIVORS OF CHILD SEXUAL ABUSE DESCRIBE THEIR THERAPY EXPERIENCES

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This thesis gives a voice to women who have been sexually abused and subsequently received therapy. It contributes to the scarce international literature on evaluations of therapy by women survivors of child sexual abuse (CSA). It is hoped that policies and clinical practices for survivors of CSA will be improved as a result of this research. The study was advertised in the general public to women survivors of CSA who were over the age of 20, who had had at least five therapy sessions but were not currently in therapy. One hundred and ninety-one women completed a postal questionnaire that included open and closed questions about their CSA and disclosure experiences and about what they found helpful and unhelpful in therapy. Twenty respondents took part in follow-up interviews of up to two hours. Themes from the questionnaires and the interviews were analysed using EpiInfo6 and the data management tool NVivo. The majority of participants (91%) experienced CSA to the level of genital contact, or attempted penetration or penetration. Participants took over 16 years on average to disclose the CSA. The majority of participants (86%) reported that, overall, therapy was either somewhat or very helpful. Participants who had over 50 sessions of therapy were significantly more likely to report improved emotional well-being compared with those who had 50 sessions or less. Obstacles to participants gaining sufficient therapy for their needs included the cost of therapy and/or a restricted number of therapy hours subsidized by ACC. Participants reported that helpful therapy included a supportive, interactive therapy relationship with a therapist who was knowledgeable about the dynamics and effects of CSA and of abuse-focused therapy. Acknowledgement, understanding, normalisation and assistance to talk about the CSA and work through the effects on their lives were valued. Unhelpful therapy included a therapy relationship where the therapist was not affectively available or knowledgeable about the dynamics and effects of CSA. Therapists who were unable to support participants to talk about the CSA and work through the effects on their lives were criticized. There were also a few examples of harmful practices. The limitations of the study are the lack of a control group, the fact that participants were self-selected and the retrospective nature of their reports. It was concluded that most therapists were doing an effective job in difficult circumstances. However, some therapists need to develop a more open therapeutic relationship that would allow clients to give feedback about the impact of the therapy.
DEDICATION

This study is dedicated to survivors of all forms of childhood abuse.

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Enormous thanks must first go to the women survivors of child sexual abuse (CSA) who generously shared their experiences of CSA and therapy. Both topics required participants to revisit past experiences that were sometimes distressing. Even though taking part in this study was emotionally taxing for some, most reported that they took part in the hope that they were helping other survivors of CSA by informing therapists and funders of ways to improve the future provision of abuse-focused therapy. It is due to the courage of these women that this study was possible.

The fact that the majority of participants in this study found therapy to be helpful (and in some cases life-saving) is a tribute to the therapists in this country – many of whom have faced a great many obstacles to providing good care for their clients. Working with the effects of CSA can be emotionally difficult and clinically complex. CSA can cause people to set off on a path of vicious self-destruction. Many therapists find it painful to watch their clients as they struggle with the drive to hurt or kill themselves. Much of the therapy work with survivors of CSA relies on the commitment therapists have to their clients and the dedication to take part in the on-going training required in this fast developing field. In addition, therapy for CSA is regularly surrounded by controversy and backlash. Therapists require a great deal of courage and compassion to do this work. They are frequently called on to be advocates and supports as their clients attempt to gain understanding from their loved ones and from bureaucracies that control the type and amount of therapy and support they receive. Some therapists working in this field face the added burden of working in over-stretched and under-resourced agencies.

Most of the participants in this study had some therapy subsidized by the ACC. Acknowledgement must go to the Aotearoa/New Zealand Government for ensuring that this support has been available to survivors of CSA. Without their support many would not have been able to access specialist abuse-focused therapy, reported by many as valuable and life enhancing. Over the years, the part of ACC that funds therapy for CSA has faced threats of closure from previous governments and numerous challenges as it has attempted to be true to its governing legislation, fiscally prudent, as well as fair and
compassionate. Research data suggests that at least up until the time of this study (2001) for many participants they struck a reasonable balance.

This PhD journey has produced a book-length review of abuse-focused therapy guidelines (McGregor, 2000), a more concise set of abuse-focused therapy guidelines for therapists registered with ACC (McGregor, 2001), and this thesis. For support during this journey I am indebted to the University of Auckland (for my doctoral scholarship), the Oakley Mental Health Foundation (for assistance during the pilot study), the ACC and in particular, Dr David Rankin, (for support to publish the therapy guidelines for ACC), and the Health Research Council (for the support to train as a Research Fellow).

Throughout this process I have been privileged to have three caring and supportive supervisors. Each brought their individual expertise and skills. The melding of the different perspectives has been valuable, if not also, at times, challenging to us all.

I asked Dr John Read to be my supervisor mid-1997 when I had a ‘rough idea’ for a PhD topic. As my primary supervisor, John has been my constant support and guide as the ‘rough idea’ was developed, modified, implemented, analysed, and ‘written-up’. Thank you John for your support of me, for your constancy, and for your enduring commitment to this field. You are an inspiration to me and to many others (the most important of whom are survivors of child abuse and consumers of therapy).

To help me learn ‘how to do’ qualitative research, I asked Professor David Thomas to be a joint supervisor. It was comforting to know that, due to his vast experience, no matter what technical question I put to him, David always had an answer. Thank you David. I learned a great deal from you.

Associate Professor Carolyn Coggan has been a wonderful mentor. She generously ‘took me in’ to the Injury Prevention Research Centre (IPRC) at the end of 1999 and provided me with an office that not only had the luxury of a phone but a window as well! Carolyn brought her outstanding clarity of thinking to the research project and helped me move it on from the pilot study to the main study. Carolyn’s commitment to

iv
supporting research that ‘gives back’ to the community is admirable. Without Carolyn’s support the three documents produced from this research would not have been possible.

Dr Janet Fanslow became an Advisor to the research at the time when the postal questionnaire was being developed. Thank you Janet for your on-going support, clarity of thought and enthusiasm for ‘research that can make a difference’.

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I would also like to thank the clients I have worked with over the last 17 years for teaching me so much.

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TABLE OF CONTENTS

ABSTRACT .................................................................................................................... II
DEDICATION ................................................................................................................ III
ACKNOWLEDGEMENTS ........................................................................................... III
TABLE OF CONTENTS ............................................................................................ VI
LIST OF TABLES ........................................................................................................ VIII
LIST OF FIGURES ...................................................................................................... IX
TERMS AND DEFINITIONS ...................................................................................... X

CHAPTER ONE – INTRODUCTION ........................................................................ 1
  Outline Of Thesis ................................................................................................. 1
  Context Of The Study .......................................................................................... 2
  Background To The Study ................................................................................... 3
  A Template Of Best Practice ................................................................................ 5
  Pressures On CSA Survivors, Therapists And Researchers ............................... 8
  Summary ................................................................................................................ 14

CHAPTER TWO – BEST PRACTICE ABUSE-FOCUSED THERAPY ....................... 15
  Section One – Prevalence and Effects .............................................................. 15
  Section Two – Therapy for CSA ........................................................................ 29
  Section Three – Clients’ Evaluations of Therapy for CSA ............................... 49
  Aims Of This Study .............................................................................................. 68

CHAPTER THREE – METHODOLOGY ..................................................................... 69
  Section One – Consultation Process ................................................................ 69
  Section Two – Postal Questionnaire ................................................................... 71
  Section Three – Interviews ................................................................................. 85
  Summary ................................................................................................................ 95

CHAPTER FOUR - CHILD SEXUAL ABUSE AND DISCLOSURE EXPERIENCES ........ 96
  Section One – Child Sexual Abuse Experiences ............................................... 96
  Section Two - Disclosure Experiences ............................................................... 102
  Section Three - Summary Of Key Points .......................................................... 108

CHAPTER FIVE – ASSESSMENT OF THERAPY EXPERIENCES ............................ 110
  Reasons For Entering Therapy .......................................................................... 110
  Years When Therapy Took Place ...................................................................... 116
  Number Of Therapists Seen ............................................................................. 116
  Emotional Well-Being Ratings Before And After Therapy ............................. 118
  Current Well-Being ............................................................................................ 120
  Participants’ Overall Assessment Of Therapy .................................................. 121
  Ratings For Individual Therapists ..................................................................... 121
  Funding For Therapy .......................................................................................... 123
  Summary Of Key Findings .................................................................................. 126
LIST OF TABLES

Table 1. Armsworth (1989): Mean Helpfulness Ratings ............................................. 51
Table 2. Feinauer (1989) Therapy Ratings ................................................................. 53
Table 3. Feinauer (1989) Number Of Sessions Attended ....................................... 54
Table 4. Feinauer (1989) Levels Of Distress When Therapy Was Initiated, Terminated,
And At Time Of Study .......................................................................................... 54
Table 5. Client Evaluation Of The First Four Contact With Professionals .............. 56
Table 6. Dale et al. (1998) Clients’ Overall Rating Of Counselling Experiences .... 58
Table 7. Respondents’ Ratings On “Helpfulness For Each Professional Or Service” .. 65
Table 8. Inter-Rater Reliability Scores For Questions 12, 13 and 14 ......................... 83
Table 9. Profile Of Interview Sub-sample .................................................................. 86
Table 10. Who Was First Told About The CSA? ....................................................... 103
Table 11. Responses To Disclosures Of CSA ............................................................ 104
Table 12. Reasons For Contact With Mental Health Services ................................ 107
Table 13. What First Led To Therapy For CSA? ....................................................... 111
Table 14. Number Of Therapy Sessions Per Participant ......................................... 118
Table 15. Participants’ Ratings Of Their Emotional Well-Being Prior To Therapy, After
Therapy And At The Time Of The Study ............................................................... 119
Table 16. How Participants Rated Individual Therapists .......................................... 122
Table 17. Participants’ Mean Ratings Of Therapists ............................................... 123
Table 18. Multiple Sources Of Funding ................................................................... 124
Table 19. How Participants Coped If They Could Not Afford Therapy .................... 125
Table 20. What Was Helpful .................................................................................... 129
Table 21. What Was Unhelpful ................................................................................ 143
Table 22. What Was Missing From Therapy ............................................................ 156
Table 23. Main Reason Therapy Ended – Type And Frequency Of Participant
Responses .............................................................................................................. 162
Table 24. Comparison of Present Study with Other Studies by CSA Severity Factors.
.............................................................................................................................. 217
Table 25. Sample, Methods, Number Of Professionals Seen And Therapy Ratings Of
Six Studies ................................................................................................................ 221
LIST OF FIGURES

Figure 1. Age When CSA Started................................................................. 96
Figure 2. Age When CSA Ended............................................................... 97
Figure 3. Duration Of The CSA................................................................. 98
Figure 4. Type Of Offenders..................................................................... 99
Figure 5. Most Severe Level Of CSA....................................................... 100
Figure 6. Time Taken Between CSA And Disclosure Of CSA............... 102
Figure 7. Number Of Therapists Seen By Participants............................ 116
Figure 8. Number Of Therapists Seen By Severity Of CSA.................... 117
Figure 9. Emotional Well-Being Before And After Therapy For CSA...... 120
Figure 10. Assessments Of Overall Effectiveness Of Therapy............... 122
Figure 11. Adequacy Of ACC Therapy Sessions .................................... 124
Abuse-focused therapy – Abuse-focused therapy draws upon a wide range of theoretical models and perspectives including: self development/self psychology theories; traumatic stress/victimization theory; humanist theory; cognitive and behavioural therapies; psychoanalysis; feminist theory; and systemic therapies. Clinicians who specialize in therapy for abuse and trauma sometimes give a name to their particular model of therapy. Examples include: Meiselman’s (1990) ‘Reintegration therapy’; McCann and Pearlman’s (1990) ‘Constructivist Self Development Theory’; and Briere’s (1996) ‘Self-trauma’ model. Often the more generic term ‘trauma therapy’ is used (Herman, 1992a; Salter, 1995; van der Kolk, McFarlane & Weisaeth, 1996). However, because some early trauma therapies were developed without reference to child abuse (CA) and child sexual abuse (CSA), for this thesis the most appropriate term is ‘abuse-focused therapy’.

Limitation of therapy focus – The focus of this thesis is one-to-one talk therapy with women survivors of CSA rather than other therapies such as: group therapy; body therapy; couple therapy; or family therapy. The abuse-focused therapy model is based on Western ideas and this model may be partially or wholly inappropriate to members of other cultural groups.

Therapist/counsellor – For this thesis, the terms ‘therapist’ or ‘counsellor’ refer to clinicians who work one-to-one, using talk therapy with survivors of CSA – particularly counsellors, psychotherapists, and psychologists but also sometimes psychiatrists, general practitioners, nurses, community mental health workers, and social workers.

Client/Effects – The term ‘client’ is used rather than ‘patient’ and often the term ‘effects’ is used instead of ‘sequelae’ or ‘symptoms’. Because the effects of CSA are caused by human action (interpersonal violence) and are not the result of a ‘disease’ or ‘illness’, where possible the use of medical terms is avoided.

Gender of client/therapist/perpetrator – Because the majority of survivors of CSA and incest are female (see Chapter Two), and this thesis is focused on women survivors of CSA, the female pronoun will be used when referring to clients. As women clients often
seek women therapists (see Chapter Eight), the therapist is also frequently referred to as female. Finally, because the vast majority of sex offenders are male (Matthews, 1999 p. 3) the offender is mostly referred to as male.

*Victim/survivor* – Abuse-focused therapy focuses on a person’s strengths; therefore the term ‘survivor’ has been adopted throughout this thesis. It is acknowledged however, that some people who have been sexually abused as children will not always feel as though they are ‘survivors’ and will sometimes feel they have been ‘victimized’.