“THERAPY – IT’S A TWO-WAY THING”

WOMEN SURVIVORS OF CHILD SEXUAL ABUSE DESCRIBE THEIR THERAPY EXPERIENCES

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ABSTRACT

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 advertized 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.

ACKNOWLEDGEMENTS

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).

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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).

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TERMS AND DEFINITIONS

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'.