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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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of
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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).

Thoroughout 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.

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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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Thank you to my family of colleagues for their support and/or ideas including: Dr Leah Andrews; Johnella Bird; Dr Fiona Cram; Sue Cowie; Dr Emma Davies; Jacqui Fill; Matthew Fitzsimons; Dr Christine Foley; Dr Nicola Gavey; Fiona Howard; Dr Sue Henderson; Claire Hurst; Dr Shirley Julich; Dr Ian Lambie; John McCarthy; Dr Heather McDowell; Kathryn McPhillips; Dr Jeffrey Masson; Dr Andrew Mosowitz; Anthea Randell; Dr Miriam Saphira; Associate Professor Fred Seymour; Tina Sharman; Dr Linda Smith; Puawai Solo; Eileen Swan; Sue Trainor and Dr Heather Worth.

I am grateful to the overseas experts that I have had the privilege to meet and who have influenced my thinking including: Lucy Berliner; Associate Professor John Briere; Dr James Chu; Dr Christine Courtois; Dr Peter Dale; Associate Professor Constance Dalenberg; Professor Michelle Fine; Professor Jennifer Freyd; Professor Judith Herman; Professor Bessel van der Kolk; and Dr Margaret Wetherall.

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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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'.

CHAPTER ONE – INTRODUCTION

The aims of this study were to:

1) give voice to clients' experiences of therapy related to CSA;
2) document specific aspects of the therapy that clients found helpful and unhelpful in dealing with the effects of CSA;
3) compare clients' experiences with 'best practice' guidelines;
4) use data gathered from clients to inform therapists, funders, and therapist trainers; and
5) work towards improving the delivery of therapy to survivors of CSA by providing recommendations based on the findings of this study.

Outline Of Thesis

This study gathered 191 postal questionnaires and a sub-sample of 20 face-to-face interviews from women survivors of CSA who were over the age of 20 years, had had at least five sessions of therapy, and were not currently in therapy.

This introductory chapter provides the personal and political context of this study and the rationale for the inclusion in Chapter Two of a template of 'Best Practice Abuse-Focused Therapy' guidelines for CSA, in addition to a literature review. Chapter Three 'Methodology' outlines the methods used to collect and analyse the postal questionnaire data and the sub-sample of interview data. There are six findings chapters (the first four present the findings from the postal questionnaire and the remaining two describe the findings from the interview sub-sample). Chapter Four 'CSA and Disclosure Experiences' reports the extent of the CSA experienced and responses to disclosures of CSA. Chapter Five 'Assessments of Therapy Experiences' contains participants' ratings of therapy. Chapters Six and Seven report what the participants experienced as 'Helpful therapy' and 'Unhelpful therapy'. Chapter Eight 'The Interviews' provides key themes from the sub-sample of face-to-face interviews and compares these themes with the best-practice therapy guidelines and previous studies reviewed in Chapter Two. Chapter Nine 'Three Women' also provides data from the face-to-face interviews by presenting the stories of three women that highlight aspects of helpful and unhelpful therapy.

Chapter Ten 'Discussion' evaluates whether the aims of this study were accomplished, sets out some of the strengths and limitations of the research, compares findings from the present study with other similar studies, comments on implications for future research and provides a set of recommendations for improving policy and practice.

This present chapter sets the context for the study and outlines the aims, rationale and influences on the design of the study. In addition there is a brief discussion about some of the social and financial pressures that have the potential to impact on the delivery of therapy to the client.

Context Of The Study

Many survivors of CSA experience significant biopsychosocial effects from the abuse (Briere & Runtz, 1993; Browne & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Russell, 1983) and therefore are high users of health and mental health services (van der Kolk, McFarlane et al., 1996). The costs of treating the effects of violence against children are enormous (Julich, 2001; van der Kolk, Crozier, & Hopper, 2001). In the United States in 1991, for example, between 3.1 and 4.7 million individuals received some form of mental health counselling or therapy for victimization (Cohn & Miller, 1998 p. 106). More than half of these adults were seen for child sexual or physical abuse. A recent study of the costs of CSA in Aotearoa/New Zealand estimated that when health, mental health, and legal costs were combined with losses in earnings and the loss of potential in a survivor's life, the overall cost of CSA to the country is $2.4 billion per year (Julich, 2001).

Since 1974, in New Zealand, the Accident Rehabilitation and Compensation Insurance Corporation (ACC) has received more than 50,000 claims for sexual abuse perpetrated against adults and children (Medcalf, 1998). The section of the ACC that administers the allocation of subsidized therapy sessions for rape, CSA, and incest is the Sensitive Claims Unit (SCU) established in 1992. In recent years between 600-800 counsellors, psychologists, psychotherapists and psychiatrists have been registered with the SCU to work with survivors of rape, CSA, and incest. Consequently the ACC is likely to be the largest funder in this country of abuse-focused therapy for those who have experienced sexual violence covered under the Crimes Act 1961 (Appendix 1). In May 1999 the

SCU managed 9,399 (male and female, adult and child) sexual abuse claims (Matthews, 1999, p. 2). The majority (5,771) were undertaking counselling.

Background To The Study

My interest in this topic dates back to 1986 when I began working in a community agency as an ACC registered therapist, mostly working with women survivors of CSA and adult rape. Although I have learned a great deal from the many hundreds of clients I have worked with, I have often wondered about the effectiveness of my own work and about the general effectiveness of therapy for CSA. The main focus of this study therefore has been to ask women survivors of CSA about their therapy experiences. What sorts of therapy approaches did they find helpful and not helpful?

It is relatively rare for survivors of child abuse to be asked about their experiences of therapy (Dale, 1999). A major aim of this study has been to rectify this. The more informed we (therapists, therapist trainers, policy makers and funders) are about consumer experiences of our health and mental health services, the more able we will be to improve our techniques, policies and the standard of the service we deliver. It was hoped that giving clients a voice about their therapy experiences would assist therapists, trainers, professional bodies and funders to improve therapy for survivors of CSA.

When I began designing this study in 1997 I assumed that a huge number of outcome studies and/or consumer evaluations of therapy for CSA would already have been conducted. A literature search of evaluation studies was carried out to determine what had been found to be the most effective ways to work with survivors of CSA. There were, however, few outcome studies of individual, long-term therapy with this population. A number of therapist/researchers have commented on this situation:

> With only a few exceptions, there is no research available to the practitioner on what works and what does not in the treatment of long-term, abuse-related psychological trauma (Briere, 1992a p. xvii).

Courtois (1997) stated:

> It should be noted that research and theory pertaining to trauma, abuse, and dissociation are at a relatively early stage of development and that post-abuse treatment is an evolving speciality in clinical practice (p. 466).

Dale (1999) commented that, despite the wealth of research in the fields of child abuse and of psychotherapy, very little has been published about clients' and therapists' experiences of CSA therapy.

The process of trying to understand why there was a lack of evaluation studies of therapy for CSA led me to discover a number of social and historical factors that had mediated against such research being undertaken. Although there have been witnesses to child abuse and child sexual abuse since records began, it seems scientists and physicians paid very little attention to the plight of abused children (Rush, 1980). The era, from Biblical times to the 1800s, has been called the "Age of Permitted Abuse" (Armstrong, 1996, p. 14). There appears to have been a brief period when CSA was acknowledged – from the mid 1800s (at least by French physicians, who documented tens of thousands of cases of CSA) (Olafson, Corwin, & Summit, 1993) to 1896 when Freud presented his paper "The Aetiology of Hysteria". At this point Freud believed his clients' reports of CSA and thought he had discovered the link between CSA and adult psychological and somatic symptoms. In his paper he announced:

> I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, occurrences which belong to the earliest years of childhood (Freud, 1962, p. 203).

This theory is referred to as Freud's 'seduction theory'. However, Freud soon turned his back on this theory. There are several reasons put forward about why Freud turned this theory on its head and, instead of believing his clients' accounts of CSA, decided that their accounts were fantasies. Some suggest that Freud was avoiding implicating some of his colleagues, (one of whom was having a sexual relationship with a colleague's young daughter) (Rush, 1980). Others suggest that Freud's retraction of this theory was due to the immediate and intense ostracism that Freud suffered (Masson, 1992). Whatever the reasons, by 1905 Freud publicly retracted his seduction theory and replaced it with the 'Oedipus Complex' (Masson, 1992; Meiselman, 1990). He stated:

> Almost all my women patients told me that they had been seduced by their fathers. I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences (Freud, 1966, p. 584).

From 1905 on, psychiatry followed Freud in ignoring the impact of real-life CSA and adopting fantasy as an explanation for the accounts and effects of CSA (van der Kolk,

Weisaeth, & van der Hart, 1996). Hence, the development of therapy for survivors of CSA ('abuse-focused therapy') was neglected for around 70 years. This period is referred to as 'The Age of Denial' (Armstrong, 1996).

It seems that although CSA was 'discovered' by members of the medical profession and researchers on a number of occasions over the last one hundred or more years, (Courtois, 1988; Herman, 1992b; Masson, 1992; Olafson et al., 1993), it took the child protection movement (Finkelhor, 2002; Meiselman, 1990) and the women's movement (Rush, 1980; Russell, 1986) of the 1960s and 1970s to finally acknowledge the reality of CSA. Hence, as Meiselman (1994) commented:

> Child sexual abuse has only been recognized as a major etiological factor in the development of adult psychopathology within the last fifteen years. Therefore it is not surprising that the formulation of treatment principles for survivors began only about ten years ago (p. 91).

A Template Of Best Practice

The late 1980s saw the beginnings of treatment guidelines for those working with adult survivors of incest and CSA. Overseas these works included Briere (1989), Courtois (1988), Gil (1988), Jehu (1988), and Sgroi (1989). In Aotearoa/New Zealand one of the few treatment models in the 1980s was based on Saphira's (1981) work. In the 1990s, international abuse-focused therapists, building upon earlier works, developed a substantial number of increasingly sophisticated clinical guidelines for survivors of a range of interpersonal traumas. Some were written specifically for survivors of incest (Courtois, 1997, 1999; Meiselman, 1990, 1994), some for both CSA and incest (Davies & Frawley, 1994; Pearlman & Saakvitne, 1995; Salter, 1995), and some for survivors of all forms of child abuse and neglect (Briere, 1992a, 1996b, 2002). Other works and guidelines focused on the trauma experienced by rape survivors, combat veterans and survivors of all forms of child abuse (Herman, 1992b; McCann & Pearlman, 1990; van der Kolk, McFarlane et al., 1996).

Given the lack of outcome studies in the literature that could answer my question about what was 'the' best therapy for survivors of CSA, I turned to the large number of abuse-focused therapy guidelines, research papers and self-help books published during the 1980s and 1990s for survivors of rape, CSA, and war trauma. My aim was to draw

together an overview of what these guidelines stated was 'ideal' therapy for adult survivors of CSA so that I could compare clients' reports of therapy to this template. However, because there were so many abuse-focused therapy guidelines published during the 1990s, I narrowed my review, predominantly to those abuse-focused therapy guidelines largely based on all possible effects that may be experienced by survivors of CSA and incest, and excluded therapy guidelines for one specific effect common to CSA, for example dissociation, self-harming or borderline personality disorder (BPD).

Courtois (1999) has drawn a distinction between 'first generation' professional literature on abuse, trauma and treatment (developed since the two World Wars until the late 1970s), more recent 'second generation' treatment models (including Briere, 1992a; Courtois, 1991; Davies & Frawley, 1994; Herman, 1992b; Kroll, 1993; McCann & Pearlman, 1990; Meiselman, 1990; Pearlman & Saakvitne, 1995; Salter, 1995; Wilson & Lindy, 1994) and 'third generation' therapy models (including Briere, 1996a; Chu, 1998; Courtois, 1997; van der Kolk, McFarlane et al., 1996). Courtois (1999) considered that second and third generation abuse-focused guidelines had a wider focus than first generation models. My review of abuse-focused therapy guidelines was mostly drawn from second and third generation treatment literature (see Chapter Two). Furthermore, my review focused in particular on abuse-focused authors who had visited Aotearoa/New Zealand in the last ten years (such as Briere; Courtois; Dalenberg; Herman; and van der Kolk) because it was likely that these authors (who provided training to Aotearoa/New Zealand clinicians) would have had an effect on clinician practice in this country.

The final selection of therapy guidelines for review included several texts and papers published from 1990 onward that were written by specialist abuse-focused therapists and researchers including: Briere, 1992a, 1996b, 2002; Courtois, 1991, 1997, 1999; Dalenberg, 2000; Herman, 1992a, 1992b; McCann & Pearlman, 1990; Meiselman, 1990, 1994; Pearlman & Saakvitne, 1995; Salter, 1995 and van der Kolk, McFarlane, & Weisaeth, 1996. This template of 'best practice' is outlined in Chapter Two. Two different versions have previously been published (McGregor, 2000, 2001).

Once I had a description of 'best' therapy practice for survivors of CSA (based on clinical theory), I went on to ask clients about their actual experiences of therapy – and in particular what they found helpful and not helpful in therapy, so that I could draw comparisons between clients' reported experiences of therapy and the theoretically based 'ideal' therapy practice.

When designing the postal questionnaire and interview schedule for this study, I also reviewed the small number of studies that included clients' self-reported evaluations of therapy for CSA. Because the focus of this thesis was one-to-one therapy, studies that focused on the evaluation of group therapy were excluded. When initially reviewing the literature in 1997/1998 this only left me with three studies that were similar to the study I would be conducting: Armsworth's (1989) study carried out in the USA; Feinauer's (1989) study carried out in the USA; and Frenken and van Stolk's (1990) study carried out in the Netherlands (See Chapter Two). Although these studies were considered relevant to the current study, all three studies were conducted in the 1980s. This meant that their findings were based on therapy in the decade when the effects of CSA were still being substantiated (Finkelhor, 1996, 2002) and when therapy for CSA was in the early stages of development (Courtois, 1997). Supporting this distinction were the findings from two of these earlier studies (Armsworth, 1989; Frenken & Van Stolk, 1990) of clients that reported that their therapists minimized or disbelieved their reports of CSA. In contrast, I expected to find that clients in this country would not have encountered similar levels of disbelief or minimization of their CSA experiences. The first reason for my optimism was because my research was being carried out a decade later. The second reason was because in this country there are approximately 600-800 specialist therapists who work with survivors of sexual abuse. Therefore, my expectation was that survivors of CSA in this country would have had a reasonable chance of having had therapy that was fairly close to the 'ideal practice' as set out in the best practice template in Chapter Two.

While the initial study design was being finalized, the Dale et al. (1998) study was published (Chapter Two). Because of the similarity of its design to this current study and its recency, this UK study was drawn upon for comparisons with the findings from this PhD. Another key influence in the later design stages of this study was Dr Constance Dalenberg who first lectured in Aotearoa/New Zealand in 1998/1999. At the

time, Dr Dalenberg's primary focus was investigating countertransference issues in trauma therapy for her book "Countertransference and the Treatment of Trauma" (2000). Dr Dalenberg generously shared with me some of the questions she used in her face-to-face interviews with clients. Her questions focused on areas of miscommunications between therapists and clients and on therapeutic errors and impasses. Some of her questions were used in the present study, in the sub-sample of face-to-face interviews.

While designing this study I also wanted to explore a number of other questions that I had about issues surrounding therapy for survivors of CSA. These related to whether: 1) survivors of CSA experienced obstacles to therapy such as cost or the limited availability of therapists; 2) clients felt they had sufficient therapy from the subsidized therapy hours allocated by third party funders (particularly the ACC SCU); and 3) having a third party funder influenced the clients' therapy experiences in areas such as pace and focus. These questions stemmed from my clinical experiences of witnessing long waiting-lists, of clients expressing difficulties in paying for therapy and, as a clinician, feeling pressured by third party providers to complete therapy with clients before I considered they were ready to complete. In addition, although in the final design of the study no questions were asked about the impact on clients from the so-called 'false memory' debate that frequently surrounds therapy for CSA, I wondered if any participant of the study would mention being affected by this debate. (No questions were asked on this topic mainly due to the number of questions and topics already covered in this study and the view that such a topic deserved a specifically focused study). Because of these additional clinical questions, I have included a brief discussion about the climate of backlash that surrounds therapy for CSA and some of the issues about funding from third party providers.

Pressures On CSA Survivors, Therapists And Researchers

Each time a client/survivor of CSA sits down with a therapist there are a range of pressures that can impact from the personal, social, political, economic, and legal spheres (Courtois, 1997). The history of the treatment of CSA demonstrates that this situation is not new (van der Kolk, Weisaeth et al., 1996).

Backlash

The re-discovery of child abuse and the subsequent early research (1970s and 1980s) that substantiated the seriousness of the issues has been referred to as 'the first stage' (Finkelhor, 2002). In the last decade or so, child abuse has moved out of the stage where it has had to struggle for public attention to be heard and has entered a 'second stage' (Finkelhor, 2002). This stage has been characterized by greater demands for accountability of professionals working in this field (Courtois, 1999), although therapists have often felt ill-prepared to work effectively with survivors of CSA trauma (Salter, 1995). As well as a lack of proven treatment options, therapists who work with survivors of CSA have to be prepared to work within a context of polemic debates about all aspects of their work. Public arguments have frequently flared over prevalence figures, whether memories of CSA are real, false or implanted (Courtois, 1999; Finkelhor, 2002; Loftus, 1993; van der Kolk & Fisler, 1995), and whether or not therapy for CSA is effective (Clarkson, 1994).

In a prominent 1975 psychiatric textbook, the prevalence of incest was reported as one in a million (Henderson, 1975). Within one decade, prevalence figures for incest had rocketed to around one in ten, and the prevalence of all forms of CSA is now estimated to be around one in four girls (Chapter Two). Given the recency of awareness of the high levels of CSA (Finkelhor, 1994; Russell, 1983) it was perhaps naive not to expect some kind of public registering of shock at this unpalatable information (Dalenberg, 1998a). Well-organized political opposition to those working to acknowledge and treat CSA became a problem during the 'second stage' of development (Finkelhor, 2002). The polemic situation that arose caused McFarlane and van der Kolk (1996) to complain:

> With the increasing suspicion (and an absence of scientific evidence) that many of their traumatic memories are 'implanted' by their therapists, victims are readily suspected of making false accusations, whereas perpetrators are given the benefit of the doubt and may escape appropriate punishment (p. 36).

The rise of the "countermovement spearheaded by the False Memory Syndrome Foundation (FMS)" (Courtois, 1997 p. 465-466) has been referred to as the "backlash" (Armstrong, 1996; Finkelhor, 2002; van der Kolk, McFarlane et al., 1996). This movement has contributed to an adversarial environment for those who advocate for abused children (Finkelhor, 2002). Cheit (1998) discussed how therapists in particular

have been subjected to enormous pressure including having their offices and houses picketed. McFarlane and van der Kolk (1996) stated that the FMS organisation claimed that there has been an 'epidemic' of false accusations created by psychotherapists (p. 37). Cheit (1998) and Freyd (1996) have discussed the ways that attacks can emanate from a wide range of sources emerging not only through professional and legal channels but also frequently via the media.

This discourse has spread to Aotearoa/New Zealand and, as in the USA, therapists and researchers who work in this field routinely face criticisms of their work (McGregor, 1994). Critics dispute the prevalence and effects of CSA (Goodyear-Smith, 1993). Critics are not restricted to those who work in the mental health field but have included supporters and members of a New Zealand group 'Casualties of Sexual Allegations' (COSA) – (an organization that has links on their web-site to the False Memory Syndrome Foundation in the USA, the Australian False Memory Association and the British False Memory Society), those who belong to Men's Rights groups, and academics from a variety of unrelated disciplines – many of whom (as in the USA) feel competent to present themselves as experts to comment in this field (Masculinist Evolution New Zealand, 2003). The possibility that this hostile environment may have influenced clinical practice is raised by the finding that among Aotearoa/New Zealand mental health professionals, the higher the proportion of abuse disclosures they believed to be false, the less likely they were to inquire about abuse (Young, Read, Barker-Collo, & Harrison, 2001).

It has been argued that the backlash may have provided a brake to curb any excesses of early zeal in the diagnosis and treatment of CSA (Finkelhor, 2002). For example, criticisms of the early treatment of CSA were that some ill-trained or authoritarian professionals may have diagnosed CSA from only one or two symptoms and that others may have 're-traumatized' survivors of CSA by pressuring them to disclose details of their CSA experiences before they felt ready to do so (Briere, 1998; Courtois, 1999). However, Brown (1996) and others such as Courtois (1997) have stated that, ironically, abuse-focused therapy that has, in part, developed from feminist therapy in the 1980s would have been the least likely form of therapy to 'create' 'false' memories. Because feminist therapy is client-centred, non-authoritarian, non-directive, and views the client as the expert over her own history, this form of therapy may be regarded as one of the

safest of therapies to avoid the ‘creating’ of ‘false’ memories. In addition, as Dalenberg (1998a) commented: “the fear that clients will develop complex abuse memories from single questions by therapists … seems ill-founded” (p. 13). Furthermore, the allegation that therapists implant false memories must be called into question, when an Aotearoa/New Zealand study found that in a community sample of 252 abused women only two reported remembering their abuse during the course of therapy (Morris, Martin, & Romans, 1998a).

Costs of Therapy for CSA

> In the mental health climate of today there is diminishing financial support for psychotherapy. Yet helping a person re-examine his (or her) entire early context and overcome and rework lifelong patterns of managing affect and relationships is long-term work. Childhood sexual abuse survivors require and deserve this commitment to heal from their traumatic injuries (Pearlman & Saakvitne, 1995, p. 18-19).

Brief therapy may be useful for those adults who have experienced a single acute trauma as an adult (McCann & Pearlman, 1990). However, some expert clinicians suggest that for many of those who have survived prolonged, repeated trauma as an adult or as a child, brief therapy is unlikely to be sufficient (Courtois, 1991, 1997; Herman, 1992b; McCann & Pearlman, 1990; Meiselman, 1990). Some survivors of severe childhood abuse are likely to require, at minimum, several years of therapy, and may ultimately need substantially more (Briere, 1992a).

> Long-term treatment is generally necessary ... due to the pervasive effects of abuse, the compounding of effects over time, and the complexity, tenacity, and range of symptoms. The development of the therapeutic relationship takes time as does identity consolidation, personal stabilization, cognitive and emotional modification, and skill-building (Courtois, 1997, p. 475).

Meiselman (1990) and other abuse-focused therapists (Briere, 1992a; Courtois, 1997; Herman, 1992b; McCann & Pearlman, 1990) consider that pushing the client’s natural rate of change can be counterproductive and can result in lengthening the need for therapy. Yet, given the huge number of annual referrals to treat survivors of CSA there has been “relentless pressure” from health budgets and insurance companies to “provide ever-briefer forms of treatment” – even though many clients have had a “compelling need (for) longer treatment” (Meyer, 1993, p. 571).

> A treatment and ethical dilemma of major proportions is being created by the service limitations imposed by managed care; it is not too strong to say that the

> longer-term and more intensive treatment requirements of many adult survivors and the limitations imposed by many insurance plans are on a collision course (Courtois, 1997, p. 475-476).

As world-wide therapy costs have escalated, health insurance corporations have found themselves under increasing financial pressure and have begun to search for cost-containment plans (Sperry, Brill, Howard, & Grissom, 1996). Through managed care policies, third party providers have been able to make it more difficult for clients to obtain care by making it a requirement that the client receive permission from a case manager before visiting a therapist, and by increasing the client's co-payments. Other strategies used by managed care companies to put pressure on therapist providers have included: profiling providers on their average number of sessions per case; and only using 'managed care-friendly' providers (i.e. providers who would not challenge the reducing number of sessions allocated by the managed care companies) (Sperry et al., 1996). Given the pressure on therapists from managed care providers and insurance companies, concern has been expressed that: 1) therapists will capitulate to the pressure to treat symptoms rather than people; 2) clients will feel pressure to hurry to complete therapy; 3) clients will feel they are defective if they cannot complete therapy fast enough; and 4) survivors of CSA may feel rejected, and/or abandoned if their therapy is cut short (Courtois, 1997; Meyer, 1993).

It seems that although in the USA some victims of crime may only receive a maximum of ten sessions of therapy from private insurance companies (personal communication with Briere 25/3/03), there is still easy access to sufficient therapy from government mental health services (personal communication with Dr Dalenberg 23/4/2003). In Aotearoa/New Zealand however, evidence of the mounting pressure to limit and tighten the control of the amount of therapy sessions subsidized by ACC may be found in complaints from therapists to ACC (personal communications with ACC registered therapists) and in communications from professional bodies (Crowe, 2002; Marriott, 2002). The ACC has been clear that therapy funded by the SCU is only for the "mental injury" that is as a result of the sexual abuse and not for any other mental or physical health difficulties the claimant has (Rankin, 2002). Tensions have arisen in clinical practice when attempting to differentiate (in a person's life) the effects of CSA and the effects of other life occurrences. For example, there are difficulties for clinicians

attempting to measure (for ACC) how much of a client's current depression relates to the long-term effects of CSA and how much relates to other issues such as their unemployment. In addition, how much of their unemployment relates to, for example, their interpersonal difficulties that have arisen from their history of CSA?

In recent years therapists registered with ACC have been subjected to 'provider profiling' and a regular process where therapists must re-register with ACC. To be able to be re-registered they must provide evidence of recent training in the field of abuse-focused therapy, an appropriate level of cultural safety, and they must also have maintained a certain level of ACC-subsidized clients (in relation to their other generic client load) – that is, the number of clients with a history of sexual abuse must not be too low or too high (personal communications with ACC staff and therapists). Some ACC therapists who were not accepted through the most recent re-registration process (2001-2002) have alleged that the process was in part designed to de-register 'non-ACC friendly' therapists such as those who provided long-term therapy (personal communication with a number of ACC registered therapists). Counter to this allegation, ACC personnel argue that the recent re-registration process was designed to retain only those therapists who were "committed and capable of providing the best possible service to claimants" (Rankin, 2002, p. 6).

In addition, some ACC-registered therapists have complained about the bureaucratic obstacles and the ethical dilemmas they face when they are required to provide detailed and sensitive client information to the ACC in order to gain subsidized therapy hours for their clients (Dale, 2002). There is a tension between a therapist needing to gain sufficient information from a client about the CSA in the first few sessions to submit a claim for the therapy, and the therapist's ethical training to allow the client to talk about the abuse at their own pace. Furthermore, to gain each new allocation of subsidized therapy hours, lengthy and detailed reports are usually required. Some claimants have complained to their therapists about the amount and type of information required (personal communications with therapists). Concerning these complaints ACC argue that they are governed by legislation; must be fiscally responsible and only provide subsidized therapy for those who are entitled to cover; and they should not use tax-payer funds to provide therapy for pre-existing mental health conditions. It is not clear

whether it has been bureaucratic obstacles or other factors that has led 80% of ACC claimants to finish therapy in fewer than 15 sessions (Dale 2002).

Summary

Therapy for CSA appears to have taken place with a backdrop of the late development of therapy guidelines, polemic debates about the accuracy of survivor memories, and clashes between funders and providers over the provision of treatment. Pressures on the provision of therapy for CSA have been intense. Despite these conflicts, the following chapter will outline a synopsis of what was described through the 1990s as the best practice abuse-focused therapy survivors of CSA.

CHAPTER TWO – BEST PRACTICE ABUSE-FOCUSED THERAPY

This chapter reviews abuse-focused therapy guidelines literature. The first two sections summarize the specialized knowledge and skills needed for therapists working with survivors of CSA to provide 'best' practice. Section Three outlines five consumer evaluations studies.

Section One – Prevalence and Effects

This section looks at the extent of the problem of CSA, the impact of CSA on a child's development and some of the possible effects in adulthood.

Extent of the Problem

The number of children in the general population who are sexually abused each year may never be known precisely. Overseas, current best estimates of prevalence suggest that, when CSA is defined as sexual contact (ranging from fondling to intercourse) by someone at least five years older than the child, then between one-fifth and one-third of all women have been sexually abused either as a child or as an adolescent (Elliott & Briere, 1992; Finkelhor, 1994; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Russell, 1983; Wyatt, 1985). CSA can begin in infancy and continue throughout childhood, is most likely to begin when children are approximately seven to nine years old (Beitchman et al., 1992; Elliott & Briere, 1992; Finkelhor, Hotaling, Lewis, & Smith, 1990; Polusny & Follette, 1995; Russell, 1983) and children appear to be most vulnerable to CSA from approximately seven to thirteen years old (Finkelhor, 1994; Gomes-Schwartz, Horowitz, & Sauzier, 1985). Girls are more at risk of CSA than boys (Finkelhor, 1994). Intra-familial abuse has been found to continue for a longer period of time compared to extra-familial abuse and has been shown to have more serious consequences (particularly parent-child abuse) (Kendall-Tackett et al., 1993). Clinical populations tend to report higher incidences of CSA, increased severity and increased intra-familial abuse (Berliner & Elliott, 2002). Between 50% and 75% of women attending in-patient or outpatient mental health centres report a history of CSA or incest (Briere & Runtz, 1988; Bryer, Nelson, Miller, & Krol, 1987; Chu & Dill, 1990; Read, 1997). In one clinical sample, of 133 women with histories of CSA, 77% had experienced vaginal, oral or anal penetration and 56% had also been physically abused (Briere & Runtz, 1987). In clinical samples, parents and step-parents tend to make up

between one-quarter and one-third of offenders and all relatives make up about one-half of offenders (Elliott & Briere, 1994; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Ruggiero, McLeer, & Dixon, 2000). Female offenders generally make up less than ten percent of the offender group (Finkelhor, 1994).

Similar to overseas findings, an Aotearoa/New Zealand study (Anderson, Martin, Mullen, Romans, & Herbison, 1993) of the general population found that nearly one in three European women (32%) reported one or more unwanted sexual experiences (ranging from non-contact to contact) before the age of 16 years. Of all the CSA experiences, 70% involved some genital contact, attempted intercourse or actual intercourse. The greatest age of risk was eight to twelve years. The study also found that the duration of the abuse was more than a year for 20% of all abuse episodes; with 10% lasting for more than three years. The offender was a family member in 38% of cases, an acquaintance in a further 46%, with strangers making up 15% of offenders. Two percent of offenders were female.

An ACC SCU report "Focus on Incest" (Matthews, 1998) stated that 37% of all SCU sexual abuse claims (that included adult and child sexual abuse) were perpetrated by close family members (p. 4). This report cited 1,169 incidents of abuse relating to 830 claimants (p. 4). The report found that fathers accounted for 30% of incidents; uncles, 22%; and brothers, 21%. Female perpetrators accounted for fewer than five percent of incidents. Age of onset of abuse by a close family member was: 32% of those aged five years and under; 46% aged between six and eleven years; 21% were aged 11-16 years and 1% percent were over 16 years. The median age for first abusive act was seven years. The most reported incident was genital touching (27%) followed by rape (20%) and oral sex (12%). Eight percent of these incidents involved threats of violence, serious physical attacks, physical coercion or restraint (p. 4). Most (72%) of the sexual abuse incidents were of long duration with 37% of the reported sexual abuse incidents continuing for between one and five years with another 35% of the incidents lasting for over five years.

Another Aotearoa/New Zealand study (Fergusson, Lynskey, & Horwood, 1996) found somewhat lower prevalence rates of 17.3% of females and 3.4% percent of males reporting CSA. However this study asked 18 year olds about abuse they experienced

before the age of 16 years. The researchers suggested that the lower prevalence rate might have been due to the age of the participants. Many might still have been living at home and have felt reluctant to disclose abuse especially if the perpetrator was currently involved in their lives.

Impact on Child Development

Childhood is a critical period when the child is developing physiologically, psychologically and socially (Perry et al., 1995). CSA trauma differs from non-interpersonal trauma such as natural disasters because the source of the trauma is human and frequently intentional (Courtois, 1997; Herman, 1992a, 1992b; McCann & Pearlman, 1990; van der Kolk, McFarlane et al., 1996). A child is dependent on her/his caregivers. The child's 'self' is being shaped – predominantly in their relationship with others (Briere, 1996b). Key people such as parents, caregivers and siblings have a particular role, as it is in these relationships that the child learns about issues such as trust, safety and self-worth (Cicchetti & Toth, 1995). Coping and interpersonal skills are being developed. Assumptions about their identity, others and the world are formed (Briere, 1996a). Abuse by a family member, a person in a trusted role within the child's community, or an acquaintance can involve profound role and relationship betrayal (Courtois, 1997).

The sensitive brain of a child is much more malleable to experience than a mature brain. Although experiences alter an adult's behaviour, they can literally shape a child's. Over 100 billion neurons are organized to sense, process, store, perceive and act on external and internal information (Perry et al., 1995). The more frequently any pattern of information is experienced (whether it be soothing, nurturing, frightening or shameful), the more indelible the internal representation. In children, experiences create a "processing template" through which all new information is filtered (Perry et al., 1995, p. 275). Ongoing CSA differs from a single incident of trauma. However, even a single episode of CSA can have a profound effect on a child's development because a child's brain may generalize aspects of a traumatic response to other similar stimuli. As far as the brain is concerned the trauma can then be re-stimulated even in the absence of actual further incidents of CSA. Furthermore, the effects of CSA are not static and, by its very nature, CSA includes emotional abuse (Alexander, 1992). CSA also often co-occurs with both physical abuse and neglect (Armsworth, 1989; Briere & Runtz, 1991;

Mullen, Martin, Anderson, Romans, & Herbison, 1996; Silverman, Reinherz, & Giaconia, 1996). Despite these possible dynamics, not all children will develop significant effects. There are a number of variables that can reduce the impact on the short and long-term effects of CSA including experiencing less severe CSA (in terms of type, duration and severity) and the inclusion of positive mediating variables such as caregivers' support for the child following the CSA (Barker-Collo & Read, 2003; Conte & Schuerman, 1987; Elliott & Briere, 1994; Gomes-Schwartz et al., 1990). Briere (2002) comments on a range of variables that can have an influence on the impact of child abuse:

> The specific psychological impacts of early maltreatment experiences vary as a function of a number of variables, including temperament and other biopsychological factors, family environment, security of parent-child attachment, and previous history of support or abuse (p. 176).

Some conditions have been found to result in a complex set of adaptations and long-term negative outcomes for a survivor's development (Briere, Woo, McRae, Foltz, & Sitzman, 1997). Conditions that can contribute to long-term negative outcomes not only include CSA at the more severe end of the continuum (in terms of type, duration and severity) and the co-occurrence of other forms of child abuse, but can include: entrapment, dependence and/or subordination to a perpetrator; ongoing contact with the perpetrator, including the constant fear or anticipation that the abuse will recur; the early onset of CSA; inclusion of physical and/or verbal violence; inclusion of threats should the CSA be disclosed; the escalation of CSA over time; the child being 'groomed' to accept or even initiate sexual contact – feelings of complicity; multiple offenders; any particularly sadistic practices associated with the CSA; obstacles to disclosing the CSA and seeking help; the child's guilt of not having 'told' about the abuse, or not having found a way to stop it; and/or guilt of not being able to protect others (often siblings) from the offender (Courtois, 1997; Wyatt, Newcomb, & Notgrass, 1991).

Briere (2002) has outlined a number of ways that CSA can impact on a person's development:

1) The early onset of CSA can impact on the child's internal views of themselves and others. Attempting to make sense of the abuse, a child may make assumptions from the way she was treated by caregivers and others. She may have

assumed that she deserved such maltreatment and come to view herself as wicked and bad, as well as helpless in the face of the powerful 'other'. As her relational schema developed, she may have come to view others as dangerous, rejecting, untrustworthy or unavailable and her future in the world as fearful and hopeless. Over time, these beliefs may have become deeply-held negative 'core beliefs' and relational schemas that later are non-responsive to superficial verbal reassurances (such as those from supporters or therapists).

2) As a result of feeling overwhelmed by the CSA, a child or adolescent may have encoded various aspects of the abuse in different ways and may be triggered by abuse-reminiscent stimuli later in life. Ways the CSA may have been encoded include: a) *Conditioned Emotional Responses (CER)* – at the time of the CSA some aspects of the experience (such as a sexual act) and/or the characteristics of the offender (their gender, age, certain behaviours) can become associated with fear and other emotional distress that may be encoded, not as a memory but as a conditioned emotional response (CER) that may develop into generalized fears (such as fears of men, authority, anger, and/or any aspect of sexuality). Later in life, sudden seemingly irrational fears may be triggered by events similar to the original abuse (such as sexual intimacy) and the survivor's response (such as experiencing nausea and terror during currently 'wanted' sexual intimacy) may appear inappropriate in the current situation to the survivor and others – however these responses can be seen as entirely appropriate to the context in which the CER developed; b) *sensory recollections* – because traumatic events in childhood such as CSA can be overwhelming, and parts of the brain responsible for encoding narrative memory can be flooded or by-passed, the CSA experience may be less integrated and may be primarily encoded as sensory recollections with little autobiographic material or narrative memory. These sensory memories may be triggered on exposure to trauma-reminiscent stimuli and may be experienced as a flashback (such as sights and sounds of the CSA); c) *narrative memories* – at the explicit narrative/autobiographical level, memories of the CSA (such as words used by the abuser) can also be triggered by similar stimuli in the current environment that can then activate negative emotional responses associated with the memory of CSA; d) *suppression* – many survivors of CSA have felt driven to actively avoid or deeply suppress (from everyday surface thinking) distressing abuse-related thoughts often for long periods of time. Occasionally these suppressed thoughts may also be triggered by

exposure to abuse-related stimuli in the environment that are similar to the suppressed material.

3) 'Primitive' coping strategies and defences such as dissociation, thought suppression, or the regular use of distraction can block the development of more sophisticated affect-regulation skills such as learning to tolerate manageable stress and/or modulate (for example by self-soothing) negative affect and everyday stressors. Hence survivors of CSA may grow up with little ability to regulate their moods and may be seen as moody or hyper-sensitive, with the tendency to over-react to negative or stressful events – particularly any that are reminiscent of the abuse. Such individuals may also resort to substance abuse, excessive sexual behaviour, aggression, binging or purging, or self-harming in an attempt to cope with trauma-related triggers, negative affect and apparent everyday stress.

Therapists who understand these abuse-related biopsychosocial processes may be better equipped to help the client make sense of their seemingly irrational responses.

Entrapment

Therapists need to know that despite abuse, betrayal, and entrapment, many children who are sexually abused interpret the abuse as their 'fault' and their responsibility. These same dynamics have been referred to as the 'abuse dichotomy' (Briere, 1992a), and as a 'benign transformation' (Salter, 1995). Adult survivors often look back and judge themselves harshly for the CSA occurring (Herman, 1992b) and blame themselves for every subsequent negative occurrence in their lives (Briere, 1996a). Learning about the dynamics of CSA can help a client understand the ways some children have been entrapped and forced to accommodate CSA (sometimes over a long period of time). Helpful information can include research that describes offender behaviours. For example, therapists need to be able to explain to their clients (when appropriate) that some offenders target any child they have access to, others select a certain age and type they prefer, and some abuse large numbers of children (Berliner & Conte, 1990; Wolf, 1990). Typically offenders engage a child in a gradual process of sexualizing the relationship over time (Berliner & Conte, 1990; Wolf, 1990); many sexual offenders – including fathers – plan and calculate their approach to the child and use a recognisable step-by-step "grooming process" (Christiansen & Blake, 1990). Some offenders conceal their sexual intent by characterizing the activities as non-

sexual, such as hygiene checks, or games that involve touch or sex education (Saphira, 1981). A number of offenders may also encourage the child to consider the relationship as mutual and many employ elaborate strategies to obtain and maintain their access to the child and prevent the child from reporting the abuse (Conte, Wolfe, & Smith, 1989; Summit, 1983). In many cases the sexual assault will occur without any grooming process taking place and in a substantial number of cases offenders use force, physical assaults, weapons or threats (Elliott & Briere, 1994; Gomes-Schwartz et al., 1990; Saunders, Villeponteaux, Lipovsky, & Kilpatrick, 1992). Summit (1983) described a child sexual abuse accommodation syndrome (CSAAS) that included dynamics of secrecy, helplessness, entrapment and the gradual process by which the child was made to accommodate the CSA. These dynamics delayed the child's disclosure of CSA and led to the disclosure being unconvincing and retracted.

Lack of Reporting

Most CSA is not disclosed at the time of the abuse and little is reported to authorities (Mullen et al., 1993; Russell, 1986; Saunders et al., 1992). Often the public, clinicians and even survivors themselves cannot understand why they did not tell anyone about the CSA at the time or later. Clients often blame themselves for not speaking out sooner (McGregor, 1994). Therapists need to understand some of the pressures that keep children silent, so they can provide clients with this information, if necessary. Therapists should be aware that the 'process' of disclosing CSA for the first time can be an extremely complex one, that can involve a mixture of denials, revelations and recantations (Nagel, Putman, Noll, & Trickett, 1997; Sorensen & Snow, 1991; Summit, 1983). Overseas, clinical and non-clinical studies of adults reveal that less than half of those sexually abused tell anyone at the time of the abuse (Finkelhor et al., 1990). Elliott and Briere (1994) found that 75% of children did not disclose the abuse within the year of the first incident and 18% waited for more than five years. One study of 99 incest survivors found that survivors openly mentioned their incest experiences to professionals for the first time between two and thirty years after the incest, with the average being 9.5 years (Frenken & Van Stolk, 1990).

In an Aotearoa/New Zealand study of 252 women who reported some CSA: 37% reported disclosing the abuse within a year; 10% between 1-10 years; and 24%, ten or more years later; with 28% disclosing the abuse for the first time to the researcher

(Anderson et al., 1993). Later disclosures were most frequently made to adult partners and mental health professionals. Those who told a mental health professional often did so when they saw a counsellor for another reason (Anderson et al., 1993).

There are a number of reasons for not disclosing CSA. Of 164 women in an Aotearoa/New Zealand study who did not disclose CSA at the time of the abuse or later: 29% expected to be blamed; 25% felt too embarrassment to tell; 24% did not want to upset anyone; 23% expected to be disbelieved; 18% reported not being bothered by the abuse; 14% wished to protect the abuser; 11% feared the abuser; and three percent obeyed adults (Morris, Martin, & Romans, 1998b).

The survivor's relationship to the perpetrator is a complicating factor in the process of disclosure. Two-thirds of those abused by father-figures did not disclose the abuse within a year (Morris et al., 1998b). Given that the majority of offenders are likely to be male family members or acquaintances (Anderson et al., 1993), this latter finding could explain much of the silence. As Wyatt and Newcomb (1990) found: "Women who consistently disclosed their abuse to no-one were likely to have been victimized by a family member in close proximity to home" (p. 765).

There are additional problems for children considering reporting CSA by someone close to their families. The closer the perpetrator to the family, the less likely the child is to be believed if they ever do report the CSA (Russell, 1986). In a non-clinical sample of 34 women, Everill and Waller (1995) found that all disclosures to family members received adverse responses. Those who disclosed to friends received more supportive responses. While there may be a number of reasons why children do not disclose CSA, those who do not disclose are at risk of further abuse (Morris et al., 1998b). In addition, those who remain silent have less chance of gaining appropriate support to help them reduce the risk of long-term effects (Morris et al., 1998b). For those who were able to disclose the abuse and received support, the risks of long-term symptoms may be lessened (Edwards & Alexander, 1992). However, those who disclosed and received less than supportive responses may experience increased symptoms (Everill & Waller, 1995). Overseas and Aotearoa/New Zealand research shows that even when the CSA is disclosed to someone close to the survivor, the majority of abuse experiences are not reported to authorities at the time, and only a very small percent may be reported at a

later date (Anderson et al., 1993; Russell, 1986; Saunders et al., 1992). Russell (1986), for example, found that only two percent of intra familial and six percent of extra-familial sexual abuse cases were reported to the police or child protective services. Others have found that between six and twelve percent of cases were reported to the authorities (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999; Saunders et al., 1992). In an Aotearoa/New Zealand study of women survivors of CSA, only 7.5% of the sample reported unwanted sexual experiences to social workers or the police (Anderson et al., 1993). The lack of disclosure suggests that survivors of CSA need to be asked directly about abuse experiences. In one study of children who were outpatients, rates of reported CSA increased from six percent to 31% when asked specifically about a possible abuse history (Lanktree, Briere, & Zaidi, 1991). Similarly, rates of reported sexual abuse among female psychiatric emergency room patients increased from six percent to 70% after clinicians screened for a possible sexual abuse history (Briere & Zaidi, 1989). One Aotearoa/New Zealand in-patient study found that 5.5% of patients not asked about CSA on admission, reported abuse at some point while in hospital. Forty seven percent of those asked on admission reported CSA (Read & Fraser, 1998b).

There are a number of barriers to clinicians asking about abuse histories however. In a Aotearoa/New Zealand survey of psychologists and psychiatrists, common reasons given for clinicians not asking about abuse included: “There are too many more immediate needs and concerns” and “Patients may find the issue too disturbing, or it may cause a deterioration of their psychological state” (Young et al., 2001). Another reason for not inquiring about abuse was the concern: “My inquiry could be suggestive and therefore possibly induce false memories”.

Even when abuse is disclosed to mental health professionals, the abuse may not be reported to legal authorities. Furthermore, Read and Fraser (1998a) found that of 52 cases of abuse known to the staff of an Aotearoa/New Zealand in-patient mental health unit, none were reported to the police by the staff. In another study, none of 92 cases of abuse known to outpatient staff were reported to legal or protective agencies (Read, Agar, Argyle, & Aderhold, 2003).

Long-term Effects of CSA

As with the effects of CSA in children, the longer-term effects of CSA in adulthood are not uniform (Beitchman et al., 1992; Kendall-Tackett et al., 1993). There appears to be no consistent post CSA syndrome and no single pattern of effects in the short or long-term that apply to all survivors (Briere & Runtz, 1993; Green, 1993). Nevertheless, the symptoms found with adult survivors are often an extension of those found in child survivors of CSA. However, given the number of potential positive post-abuse interventions possible during a life-span, negative long-term outcomes are not inevitable following CSA (Mullen & Fleming, 1998). As Romans, Martin, Anderson, Herbison and Mullen's (1995) concluded "events subsequent to the CSA" were "critical" in determining the long-term impact" on women's mental health (p. 140). Yet, in a community study of 930 women in the USA, Russell (1986) found that 78% of women who had been sexually abused as children reported experiencing negative long-term psychological effects.

Using retrospective research methodologies cannot prove a definitive causal relationship between CSA and a wide range of psychological and interpersonal difficulties. Furthermore, there are a number of methodological difficulties when researching the effects of CSA that limit the conclusions that can be made from such studies (Briere, 1992b; Dempster & Roberts, 1991). Yet a number of consistent findings lead researchers and clinicians to conclude that CSA in women is a major risk factor for one or several of the following:

- depression (Bifulco, Brown, & Adler, 1991; Briere & Runtz, 1988; Briere et al., 1997; Mullen et al., 1993; Saunders et al., 1992; Stein, Golding, Siegel, Burman, & Sorrenson, 1988; Thompson et al., 2003);
- symptoms of post traumatic stress (Briere & Runtz, 1987; Lindberg & Distad, 1985; Rodriguez, Ryan, Van de Kemp, & Foy, 1997; Saunders et al., 1992; Thompson et al., 2003);
- a range of self-harming behaviours such as self-mutilation (Briere & Gil, 1998; Briere & Runtz, 1987; Briere & Zaidi, 1989; van der Kolk, Perry, & Herman, 1991);
- suicidal ideation and/or behaviours, (Briere et al., 1997; Briere & Zaidi, 1989; Fergusson, Horwood, & Lynskey, 1996; Mullen et al., 1993; Peters & Range, 1995; Saunders et al., 1992);

- a range of dissociative symptoms (Briere & Runtz, 1991; Chu & Dill, 1990; Putman & Trickett, 1997; Ross, Anderson, Heber, & Norton, 1990; Saxe et al., 1993);
- personality disorders (Briere & Zaidi, 1989; Herman, Perry, & van der Kolk, 1989);
- anxiety disorders and phobias (Briere & Runtz, 1988; Fergusson, Horwood et al., 1996; Mullen et al., 1993; Saunders et al., 1992; Stein et al., 1988; Thompson et al., 2003);
- interpersonal difficulties including: having few friends (Gold, 1986); an increased likelihood of remaining single, and when married, of having marital difficulties, and becoming separated or divorced (Russell, 1986); fears of men and women (Briere & Runtz, 1987); mistrust and/or hostility towards others; a huge need for self-reliance resulting in social isolation; a preoccupation with attaining affirmation through relationships; and/or a high need for validation and acceptance with an avoidance of intimacy; (Alexander & Anderson, 1997; Beitchman et al., 1992; Bifulco et al., 1991; Briere, 2002; Browne & Finkelhor, 1986; Wyatt, Guthrie, & Notgrass, 1992);
- parenting difficulties (Cole, Woolger, Power, & Smith, 1992) such as: a strained survivor/mother-daughter relationship (that can in turn increase a daughter's vulnerability to CSA) (Finkelhor & Baron, 1986); the promotion of extreme autonomy in their children (Cole et al., 1992); and maternal anger stemming from CSA that may increase the risk of the physical abuse of children (Dilillo, Tremblay, & Peterson, 2000);
- chronic irritability, anger, and rage (Briere & Runtz, 1987; Dilillo et al., 2000);
- alcohol or substance abuse (Briere et al., 1997; Fergusson, Horwood et al., 1996; Glover, Janikowski, & Benshoff, 1996; Mullen et al., 1993);
- eating disorders, such as anorexia and bulimia (Mullen et al., 1993; Polusny & Follette, 1995; Thompson et al., 2003);
- somatization disorders (Briere, 1988; Morrison, 1989; Springs & Friedrich, 1992);
- physical symptoms including: headaches; gastrointestinal problems; muscle tension; chronic pain (particularly back and pelvic pain) and pre-menstrual tension (PMS); infertility; a history of complicated pregnancies; and/or sexually transmitted infections (STI) including HIV (Paddison et al., 1990; Springs & Friedrich, 1992);

- early pregnancies and a young age of starting cohabitation (Anderson et al., 1993; Mullen et al., 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Romans, Martin, Anderson, O'Shea, & Mullen, 1995; Russell, 1986);
- using sex to reduce negative abuse-related affect (Briere, 1996b), sexual dysfunctions (Meiselman, 1978; Saunders et al., 1992);
- psychotic or schizophrenic symptoms; (Briere, 1992a; Briere et al., 1997; Bryer et al., 1987; Herman, 1992b; Read, 1997; Ross, Anderson, & Clark, 1994; Salter, 1995; Saunders et al., 1992; Shearer, Peters, Quaytman, & Ogden, 1990) ;
- having been an in-patient or an outpatient (Briere & Runtz, 1988; Bryer et al., 1987; Chu & Dill, 1990; Read, 1997) with a history of frequent psychiatric hospitalisations (Beck & van der Kolk, 1987; Briere et al., 1997; Bryer et al., 1987; Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Goff, Brotman, Kindlon, Waites, & Amico, 1991; Margo & McLees, 1991);
- memory impairment or severe memory deficits (Briere & Conte, 1993; Herman & Harvey, 1997; Herman & Schatzow, 1987; Williams, 1994);
- revictimization experiences such as physical or sexual assaults (Briere & Runtz, 1987; Briere et al., 1997; Follette, Polusny, Bechtle, & Naugle, 1996; Fromuth, 1986; Maker, Kemmelmeier, & Peterson, 2001; Russell, 1986; Wyatt et al., 1992), with increased chances of having been in a domestic violence shelter, having been homeless, in prison, or become involved in sex work (Russell, 1986), and having experienced verbal, physical or sexual abuse from a professional (such as doctors, therapists, psychiatrists) (Kluft, 1990; Pope, 1990; Pope, Sonne, & Holroyd, 1993; Russell, 1993; Rutter, 1989);
- their own children are more likely to have experienced sexual abuse (Egeland, 1993; Perrott, Morris, Martin, & Romans, 1998) and/or;
- being in a lower socio-economic status (SES) than would have been predicted from the SES of their family of origin's background (Julich, 2001; Russell, 1986).

Many of these findings remain after controlling for potentially mediating variables such as poverty, parental substance abuse or psychiatric history, or other forms of abuse (Boney-McCoy & Finkelhor, 1996; Fergusson, Lynskey et al., 1996; Fleming et al., 1999; Mullen et al., 1996; Pettigrew & Burcham, 1997).

Given this extremely wide range of possible effects and psychiatric diagnoses, it is not surprising that some survivors of CSA have been referred to as suffering a "DSM disorder" (Dalenberg, 1999). In addition, given the effects of CSA on their interpersonal relationships, such as high need of validation from others, sometimes coupled with fear of intimacy, women survivors of CSA are often misdiagnosed with the diagnosis Borderline Personality Disorder (BPD) (Briere, 2002; Chu, 1998; Herman, 1992b). The cumulative effects of revictimization following CSA add to the complexity of clients who present for therapeutic assistance. Given that women survivors of CSA are at greater risk of domestic abuse and adult sexual assaults, it is likely that symptoms from recent adult revictimization will exacerbate CSA symptoms and slow their rate of recovery (Follette et al., 1996).

In addition, to the possible wide ranging effects of CSA listed above, Herman (1992b) also noted that "in the most extreme cases, survivors of childhood abuse may find themselves involved in abuse of others, either in the role of passive by-stander or, more rarely, as a perpetrator" (p. 387). Furthermore, Briere (1996b) referred to the enormous struggle with anger that some survivors of CSA feel, and stated that, in a "minority" of cases this anger may be translated into the perpetration of abuse against others or other aggressive acts (p. 22). Herman (1992) commented however that, contrary to the cycle of abuse, the great majority of survivors of CSA do not abuse others or their children and in fact many will frequently attempt to protect their children in a way that they were not protected.

Many survivors of CSA develop a range of coping strategies to assist them manage overwhelming feelings of guilt, shame, betrayal, helplessness, powerlessness and/or stigmatisation (Cody & Woolley, 1997; Finkelhor & Browne, 1985). Coping strategies may include actively trying to suppress, avoid or distract, sometimes by using alcohol, drugs or sex to deal with the memories, conditioned emotional responses (CER's) or other reminders of the CSA (Briere, 2002). Many of these strategies can be understood as the best coping mechanisms available at the time. However, Morrow and Smith (1995) found in a study of women survivors of CSA, that all coping strategies were costly. Many participants in their study reported that they were "barely surviving" and that they were "in pain, exhausted or overwhelmed" trying to cope with the effects of the abuse (p. 31). One participant reported that her attempts to avoid painful abuse-

related feelings worked until she entered therapy. Facing the feelings that she had attempted to bury was overwhelming (Morrow & Smith, 1995). The finding, that coping is costly, was also reported by Leitenberg, Greenwald and Cado (1992) who found that the most frequently used coping strategies following CSA were denial and emotional suppression. Although participants rated these strategies as helpful, such strategies were, however, associated with poorer adult psychological adjustment. Similarly, an Aotearoa/New Zealand study, Perrott et al., (1998) found that some survivors deliberately suppressed thoughts about the CSA. However, these women were also more likely to report low self-esteem. Other women who cognitively 'reframed' the abuse (by minimizing to themselves the significance of the impact on their lives or by minimizing the offender's responsibility in the matter) did not encounter similar negative mental health outcomes. Unfortunately, this latter group was also significantly more likely to report that their own children had been sexually abused (Perrott et al., 1998). This finding is significant when the generational effects of CSA are considered. It suggests that those who attempt to minimize, avoid, or suppress their CSA experiences may miss danger cues in the present and be less able to protect their children from similar experiences.

Summary

CSA is a common experience for girls. CSA has the potential to profoundly affect a person's life because: a) the CSA occurs while the child is developing physically, cognitively, emotionally and socially; b) CSA is usually perpetrated by someone known to the child and therefore often involves significant betrayal; c) CSA is difficult to disclose and therefore is not easily reported or stopped; d) experiences of CSA are often on-going and escalate over time; and e) CSA often co-occurs with other abuse. The result can mean a lifetime of silence, shame and isolation dealing alone with the impact. Initial coping strategies to deal with CSA can continue to have a negative impact on adolescence and adulthood. In order to assist survivors of CSA work through their early traumatic experiences and any ongoing consequences in their lives, therapists need to have an extensive knowledge of a) the ways children can be abused, entrapped and silenced; and b) the potential wide ranging impact CSA can have on a child's development and adult well-being. Given the number of variables and mediating factors that can impact on the trajectory of a child's development following CSA, therapists

should expect that some survivors would describe few disturbances while others may experience many areas of their lives as overwhelming.

Section Two – Therapy for CSA

Section Two outlines: the client's process of entering therapy; issues of client/therapist matching; therapists' suitability to work with survivors of CSA; recent key developments in abuse-focused therapy; an overview of 'best' practice abuse-focused therapy philosophy and practice; and some of the potential difficulties encountered by both clients and therapists within abuse-focused therapy.

Client's Process of Entering Therapy

> It is rare for the adult survivor to enter therapy with the specific goal of working through unresolved child sexual abuse (Meiselman, 1994, p. 94).

As identified in Section One, many survivors of CSA disclose their abuse histories after attending therapy for other reasons (Anderson et al., 1993). Due to their attempts to avoid or suppress their traumatic material, many may be aware of their CSA histories at some levels and aware of their present difficulties, but will not connect their CSA histories with their present difficulties. Many will not understand how something that happened so long ago could affect them in adulthood (McGregor, 1994). Consequently, to engage in abuse-focused therapy, many clients need to go through a process of identifying that their lives have been negatively impacted by the abuse (Courtois, 1988). Many survivors do not identify that their experience of CSA is linked to their current mental health difficulties (Lothian & Read, 2002; Wurr & Partridge, 1996). This step may take some time for some but not others. Usually something, such as a crisis, will have happened recently in the survivor's current life and she will seek therapy for that issue (Dale, 1999; Feinauer, 1989).

After the initial crisis has passed the client may not wish to continue with therapy (Feinauer, 1989; Herman, 1992b). Even if survivors have identified CSA as a cause of their current difficulties, they still have to decide for themselves whether they wish to enter the often painful process of addressing their childhood traumas in therapy (Morrow & Smith, 1995). Those who do make the decision to face past experiences therefore may arrive at therapy feeling fearful and tentative. The survivor may need to

go through a process of 'testing the waters', before feeling ready to fully commit to such a process (Courtois, 1988).

To assist the survivor's decision about therapy, abuse-focused therapists may: 1) acknowledge the difficulties of the decision and the work ahead; 2) reassure them that it is perfectly understandable if they decide the time is not right for them to begin therapy; and 3) ensure that they know that if they begin therapy they have every right to leave therapy at any point, or take a break (Courtois, 1991; Herman, 1992b).

Client/Therapist Matching

Few abuse-focused therapy guidelines seem to discuss the effects of the matching of client and therapist in terms of gender or ethnicity. Briere, (1996b) however, provides a thorough discussion of the dynamics involved in different gender combinations of clients and therapists. One of the problems for a male therapist matched with a female client can be that:

> He is, in a sense, asking the female survivor to forget that he is a male, with all the power and dangerousness that she may associate with that gender. Thus, even the most nonexploitive, caring male begins treatment with female survivors of severe male abuse at a disadvantage (Briere, 1996b, p. 194).

Furthermore, Armsworth (1989) stated that because males perpetrate the majority of CSA, "the presence of a male in authority may be sufficient to trigger reliving (CSA) or dissociative responses" (p. 560). Briere (1996b) and others (Herman, 1981; Saphira, 1981) suggest that (at least initially) a female therapist and female client matching is the most advantageous pairing for survivors of CSA. Women survivors are thought to be less defensive in therapy with women, and a female therapist is more likely to have the necessary empathy and understanding of issues that women face in society. In addition, a female therapist is less likely to "victimize" her female client (Briere, 1996b, p. 198). There is evidence (Carr, Robinson, & Erlick, 1990; Pope, 1990; Pope et al., 1993; Russell, 1986; Rutter, 1989) that survivors of CSA receive sexual attention from some therapists and are sometimes sexually re-victimized by them. For example, of 958 patients who were reported to have engaged in sexual intimacy with a previous therapist, almost a third (32%) were victims of child abuse (Pope et al., 1993, p. 4). The overall figure of sexual re-victimization of clients by (predominantly male)

professionals is thought to range from six to fifteen percent (Russell, 1993; Rutter, 1989).

Despite the difficulties with a male therapist at the beginning of therapy, later in therapy, seeing a safe, nurturing male therapist may be beneficial. Furthermore, a female therapist and female client matching will not always be without difficulties. Problems for woman therapists include being seen as a mother figure, the client feeling competitive (in terms of attractiveness for example) and/or there are often added difficulties for women who have been abused by women (Briere, 1996b; Dale, 1999).

Therapists' Suitability for Abuse-focused Therapy

Therapists who work with survivors of CSA should not only have a good understanding of the dynamics and effects of CSA (Section One) but also a good knowledge of abuse-focused therapy. To heal, survivors of abuse require a relationship with a "real, warm concerned" person who is "…actively involved with them in an empathetic responsive way" (McCann & Pearlman, 1990, p. 93). Survivor/clients tend to be sensitive to "…any signs of phoniness and distance in therapists…" (p. 93). Therefore, meaningful support and genuine empathy in therapy is often more important than clever interventions. The therapist needs to be emotionally present and genuine. Not all therapists are comfortable with affective availability (Meiselman, 1990). Therapists require a willingness to be involved and alert to their clients' needs, and to be known by and vulnerable to them (Pearlman & Saakvitne, 1995). This does not mean that therapists abandon their roles, boundaries or responsibilities or overwhelm their client with their problems, but that, when appropriate, therapists are open to disclosing some of their reactions to the client's processes. For therapists to be affectively available and genuine means they must have good personal and professional self-esteem and have had therapy for any of their own abuse issues (Pearlman & Saakvitne, 1995). Because of these requirements, not all therapists will be automatically suited to abuse-focused therapy. As Courtois comments:

> Therapists must begin by assessing their own professional and emotional competence to treat incestuous abuse. Because trauma (much less incest) and its treatment are topics that are rarely or adequately covered in professional training, therapists must avail themselves of specialized training, consultations, and supervision (1997, p. 473).

Because not all therapists can cope with the challenges presented by the treatment of survivors of CSA, those therapists who recognize that they are not suited to this work have an "obligation" to refer clients on if necessary (Courtois, 1997, p. 474).

Therapists who prefer to be seen as 'the expert', distant, uninvolved, and completely anonymous will face conflicts with the type of therapeutic relationship required in trauma work (Briere, 1992a; Dalenberg, 2000).

Current Best Practice – Abuse-focused Guidelines

The remainder of this section covers: 1) the assessment process; 2) ideal philosophical approaches to survivors of CSA; 3) ways therapists can build therapeutic relationships with their clients; 4) the ideal pace therapy should proceed at; 5) the three stages of therapy; and 6) boundary errors and potential difficulties.

1) The Assessment Process

In abuse-focused therapy assessment and treatment are intertwined. Briere (1992a, p.99) suggests that a "true appraisal of the individual's childhood experience may not be possible until well into the treatment process".

Those who seek therapy are likely to present at the therapist's door with a complex array of difficulties and concerns (Berliner & Elliott, 1996). For many reasons, including that many needed to minimize, avoid or suppress their CSA experiences, some will have little awareness of the link between their childhood trauma(s) and their current difficulties (Mullen et al., 1996). For example, in one study, in 90% of cases the incest experience was not the presenting complaint (Frenken & Van Stolk, 1990, p. 257). Instead, adult incest survivors presented to professionals with a variety of psychological and psychosomatic difficulties whose origins were unclear to the survivor. Furthermore, 44% of psychiatric in-patients in one study saw no connection between their experiences of CSA and their current mental health difficulties (Wurr & Partridge, 1996). Supporting this latter finding, an Aotearoa/New Zealand study of the long-term impact of child abuse found that:

> …the sexually abused women made relatively few attributions of long-term problems to these childhood experiences and that our analysis suggests a greater degree of association between the reported abuse and current difficulties than their subjective assessments of its impact (Mullen et al., 1996, p.17).

Because of the wide range of possible biopsychosocial effects from CSA and mediating variables, individual assessments are essential (Courtois, 1997, p.471). In abuse-focused therapy, the assessment needs to be an on-going process, not a one-off snapshot (Briere, 1992a, 1996b; Courtois, 1991, 1997; Herman, 1992b; McCann & Pearlman, 1990; Salter, 1995).

Courtois (1997, p. 477) has suggested that at the beginning of abuse-focused therapy, the therapist should provide the client with a description of the therapy process and carry out a relatively full assessment (after there has been an explanation of the reason for the assessment, a discussion about informed consent and the limits of confidentiality). She recommended an assessment that focused on a wide range of areas including: 1) the reason for the person seeking therapy; 2) the person's current general level of functioning and any current psychosocial stressors; 3) the severity and course of current difficulties; 4) a preliminary assessment of their self capacities and personality structure; 5) any threats of harm or harming of the self or others; 6) past treatment history; 7) a biopsychosocial assessment of the client's family, developmental, social, medical, and occupational history; 8) any problematic childhood and family experiences (including family violence, sexual abuse, physical abuse, medical traumas, accidents, devastating personal and family losses or natural disasters). Carrying out such a full assessment indicates to the client that all of these issues may be relevant and open to discussion.

Briere (1992a) has cautioned, however, that at the beginning of therapy a therapist will only be able to gather the client's current understanding of their a) childhood history and b) symptoms, problems, strengths, capacities and resources. Knowledge of both these areas are likely to deepen as therapy progresses and symptoms (such as dissociation and anxiety) reduce and self-capacities strengthen.

Particular care must be taken when enquiring about the characteristics of the CSA.

> Although it may be desirable to assess these factors (CSA) as early as possible in therapy, basic clinical judgement must be used in deciding whether the survivor is ready to talk about details of sexual abuse and the emotions experienced at the time, especially because many survivors report that they have <u>never</u> told anyone and that breaking the silence is very frightening. Some

> survivors, in fact, will deny abuse experience when initially asked and disclose them only after testing the therapist's trustworthiness over a period of time (Meiselman, 1994, p. 93-94).

Care of the client must be paramount when asking questions about CSA. These questions are likely to plunge the client back into the past, and although some clients may not show any outward distress, they may be dissociating in the therapy session and may experience delayed distress after the session (Courtois, 1997). When possible, it is good practice to warn clients before sessions when they are to be asked a number of questions about the abuse, and to forewarn them that they may have a delayed reaction. Clients can then make arrangements to cater for their after-therapy needs (for example to have support or space). When asking questions about CSA it is recommended that the therapist ask questions in a supportive, empathetic manner while remaining objective. If the client has significant gaps in their memory, often both the therapist and client need to tolerate the ambiguity (Courtois, 1997). In such cases it is important that the therapist: does not fill-in, confirm or disconfirm the client's suspicions of a non-remembered or partially remembered abuse history; avoids leading questions and a premature focus on sexual abuse as the only possible explanation for these absent memories; and avoids attempting to accelerate their client's pace of remembering through hypnosis or any other method (Courtois, 1997).

Sharing the result of an assessment with a client can be helpful. Having a name for a collection of difficulties may feel like a relief (Herman, 1992b). Naming processes such as 'post-traumatic reactions' can give some survivors a feeling of control. Discussing the impact of CSA on her/his development can help the client to reassess negative assumptions about herself/himself. For example, if the client failed at school, explaining how CSA can disrupt a child's concentration may help the client reassess her/his belief that she/he is unintelligent (Briere, 1996b). Concepts that assist the client to connect present symptoms to the source of their difficulties can also provide the client with a useful framework with which she can continue to sift through and understand the connection with various symptoms experienced in her life (Herman, 1992b).

2) Ideal Philosophical Approaches

Respect/Assumption of growth/Focus on strength

A central goal of abuse-focused therapy is to help the survivor use their existing skills to move beyond their current level of adaptive functioning. A central tenet of abuse-focused therapy is not only respect and positive regard for the client but also the 'assumption of growth' (Briere, 1992a). If the therapist recognizes that adults abused as children are 'survivors' of trauma, this acknowledges strength rather than pathology (Briere, 1992a, 1996b). It acknowledges that the person was strong to have survived conditions that could have destroyed them. Understanding that a maladaptive environment promotes the development of adaptive coping strategies also provides the rationale that in a supportive environment (such as therapy) more positive coping strategies (such as self-caring) may be learned. This view can foster the hope that change is possible. After living with decades of 'just surviving', many clients believe that they are 'genetically impaired' and they are without hope of ever being free of symptoms (Briere, 1992a). Therapists giving hope can be an important motivator to promote change.

Understanding the functionality of 'symptoms'

'Symptoms' or effects of CSA, such as dissociation, overeating, substance abuse, indiscriminate sexual activities and self-harming behaviours are often used to block out painful memories or feelings (Briere, 1996b). To avoid pathologizing a survivor's 'symptoms' the therapist requires an appreciation of the client's need for such behaviours. Such symptoms should be regarded as necessary coping strategies and are therefore not easy to give up. An approach that tries to frighten the client with health or moral warnings or plead with them to promise to stop is unlikely to work (Briere, 1992a).

A flexible framework

Abuse-focused therapy must be uniquely tailored to the survivor. Each survivor of CSA will have developed within a unique set of circumstances. Because the experience of CSA has the potential to effect every aspect of a person's being (biological, psychological and social) abuse-focused therapy must be equally as comprehensive (Briere, 1992a, 1996b; Chu, 1998; Herman, 1992a, 1992b; Meiselman, 1994; van der Kolk, McFarlane et al., 1996). There is no single therapeutic approach that can be applied indiscriminately to survivors of trauma (Briere, 1992a; Herman, 1992b; van

der Kolk, McFarlane et al., 1996). One treatment approach used at one stage may not be useful at another stage, or may even be harmful (Herman, 1992b). Effective treatment is likely to require a staged, multimodal approach (van der Kolk, McFarlane et al., 1996). Clinical guidelines for abuse-focused therapy should only be regarded as a flexible framework. New issues are likely to arise throughout the therapy. Therefore a therapist who is "wedded" to any one modality can disadvantage their client (Meiselman, 1990, 100). Therapists must follow the client's agenda of presenting problems. This process can be frustrating to the "task-oriented" therapist who wants to solve each problem before going on to the next but finds that a new problem often springs up to demand therapeutic attention, before the previous one can be worked through (Meiselman, 1990, p. 100). Within this framework it is recognized that other therapies or techniques may be used such as narrative therapy, family therapy, art therapy, action methods and eye movement desensitisation and reprocessing (EMDR) (Briere, 1992a). Even though many therapies have not been developed specifically for abuse-related issues, they can still be useful in working with survivors. For example, cognitive therapies have proved helpful with depression, behavioural interventions have been shown to be useful in treating anxiety, and a psychodynamic approach may address the effects of developmental disruption, loss and abandonment (Briere, 1992a). However, clinicians are warned that it will rarely be appropriate to accept all the assumptions of any therapeutic approach when applying them to child abuse trauma (Briere, 1992a; van der Kolk, McFarlane et al., 1996).

Reframing 'client resistance'

Abuse-focused therapy challenges traditional therapy interpretations of client resistance that have been used to explain "various negative therapy outcomes, ranging from client hostility to premature termination" (Briere, 1992a, p. 105). Abuse-focused therapy takes into account that the survivor's avoidance of therapy may be based on their response to a situation that was parallel to the abuse or that the client may be understandably fearful of facing overwhelming emotional pain. A client's reluctance to engage in therapy therefore may signal that *the therapist*, not the client, needs to change their behaviour. The therapist may take the client's 'resistance' as a signal to attend to the pace and intensity of the therapy by: re-checking current safety issues in the client's current life; slowing down the pace of the therapy; approaching the trauma in a less direct way; and/or attending to client-therapist trust and safety issues (Briere, 1992a).

3) Building a Therapeutic Relationship

Building trust with the client will be on-going. Many clients will be assessing the therapist's trustworthiness from the very beginning and will be acutely aware of any violations in empathy or boundaries. The therapist must work hard to deserve the client's trust.

Safe therapeutic boundaries

To help the client feel safe the therapist should discuss with the client, from the beginning, a structure that provides the client with safety and the right to self-determination within the therapeutic relationship (Pearlman & Saakvitne, 1995). The client must feel able to be vulnerable as well as self-directed, and experience the intimacy of the therapeutic relationship in safety. The experience of a safe, bounded, supportive and empowering therapeutic relationship may be difficult for clients to comprehend because they may never have experienced such a relationship before (Briere, 1996b). Therapists need to be aware that the therapy relationship may become a vitally important relationship for clients and that this population, in particular, may be harmed by dual role relationships or blurred boundaries, because these dynamics replicate characteristics of abuse (Dalenberg, 2000). Therapy requires a solid framework where it is understood that neither the therapist nor the client can intrude past each other's boundaries (Briere, 1996b; Meiselman, 1990).

One way to empower clients is by letting them know about their rights and responsibilities regarding the therapeutic relationship. For example, Dalenberg (2003) recommended providing the client with a written information sheet at the beginning of therapy that outlined under what circumstances the client was able to contact the therapist. Dalenberg (2003) encouraged therapists not to over extend their offer of availability at the beginning of therapy and only offer what they are able to sustain over a long period of time. If the therapist over extends their availability the chances are that they will later feel resentful if the client makes full use of their offer of contact. Resentment can easily turn into anger directed at the client.

An aim of a bounded therapeutic framework is to prevent the therapist from being able to gratify the client's every need (Meiselman, 1994). To do so risks infantilizing the client. It is essential that the client know that the relationship exists for their needs and it

does not exist for the needs of the therapist. The therapy relationship should be safe from, not only physical and sexual exploitations but also from "harsh criticism, punitiveness, boundary violation, or narcissistic disregard for the client's experience" (Briere, 2002, p. 195).

Equality in the therapeutic relationship

Abuse-focused therapists have criticized traditional therapy models for operating from a 'top-down' approach, with therapists clinging to their status of 'expert', being cold and aloof, and not sharing their power or knowledge (Briere, 1992a, 1996b; Herman, 1992b; McCann & Pearlman, 1990; Meiselman, 1990; Pearlman & Saakvitne, 1995). Remnants of this traditional approach can be particularly counter-productive when working with survivors of CSA, many of whom have had power used against them. Abuse-focused therapy aims to empower the client by teaching them the skills to become self-maintaining. Therefore therapists should avoid directly or indirectly giving the client the message that the therapist is 'the expert', who has all the answers and can 'heal' them by applying their 'expert skills' (Briere, 1992a).

Therapist as ally

Therapists need the capacity to bear witness to extreme levels of pain (Briere, 1992a; Courtois, 1997; Herman, 1992b; McCann & Pearlman, 1990; van der Kolk, McFarlane et al., 1996). Traditional therapies that advocate therapist objectivity can be counterproductive in abuse-focused work because a survivor needs the therapist to be 'on their side' as an ally. Technical neutrality that is designed to allow the client freedom to experience conflict is not the same as moral neutrality (Herman, 1992b). The therapist is asked to bear witness to a crime. The therapist therefore:

> …must affirm a position of solidarity with the victim. This does not mean a simplistic notion that the victim can do no wrong; rather, it involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice. This affirmation expresses itself in the therapist's daily practice, in her language (Herman, 1992b, p. 135).

Healthy attachment

It is accepted by many abuse-focused therapists that a safe and secure attachment to another human being is an essential part of healing (Briere, 1992a, 1996b; Courtois, 1988; Herman, 1992b). To develop a successful therapy relationship the client should be able to attach to the therapist and feel safe in that attachment. To avoid the negative

connotations of the term ‘dependence’, the term ‘attachment’ (Bowlby, 1988) provides a positive replacement. Rather than being discouraged, attachment should be supported (Briere, 1992a). If, during this important and necessary period of attachment, clients are provided with appropriate support from therapists, clients will be able to move on to autonomy at their own pace. If however, a therapist prematurely pushes a client towards independence, the therapist may, ironically, reinforce dependency. Feeling premature abandonment may cause a survivor to cling to a therapist (Briere, 1992a). Should this happen the therapist must take care not to suddenly panic, and reject or distance themself from the client, particularly at times when a client is in crisis (Dalenberg, 1998b).

4) Process and Pace of Abuse-focused Therapy Work

> A major implication of the self-trauma model is that many untreated adult survivors of severe childhood abuse may spend considerable time and energy balancing trauma related distress and intrusion with avoidance mechanisms. (Therefore the therapy process) …must proceed slowly and carefully, both to avoid overwhelming the client and to keep from stimulating further avoidance responses that otherwise would impede further therapeutic progress (Briere, 1996a, p. 145).

Briere (2003) recently described his rationale of the process through which abuse-focused therapy was effective. The process was been described as the client revisiting (being exposed to) manageable parts of their traumatic material, in a safe and supportive therapeutic environment. By activating (talking about, thinking about, and emotionally processing) aspects of the trauma the client will experience disparity by revisiting past traumas and re-experiencing in the present the distress of the past, but in the present environment of safety and support. Through this process the distress and trauma associated with the memories will be extinguished. In other words, by continually being exposed to and activating manageable parts of the trauma and experiencing the disparity between the trauma and the safety and support of the therapeutic relationship, the affect associated with the memories of the trauma are processed and reduced and eventually the memories become “just memories” rather than “traumatic memories” (Briere, 2003). The survivor then no longer needs to use tension reducing behaviours, avoidance or suppression to manage internal distress because the distress has reduced through the therapy process.

Briere (1996a; 2002) does not divide therapy into stages but rather advocates the careful titration of every therapy session using the idea of a "therapeutic window". Working within a therapeutic window involves finding the pace that avoids overwhelming the client, but stimulates the optimal amount of trauma-based material that the client can integrate. Therapists 'undershoot' the therapeutic window if they avoid traumatic material altogether or over focus on validation and support of the client (Briere, 1996a). While undershooting the therapeutic window is not dangerous to the client, it can be a waste of time and resources. 'Overshooting' the window can also cause distress. If the therapist guides the client into too much abuse-focused material too fast the client may not be able to accommodate the material and may resort to tension-reducing behaviours. The client, for example, may begin to dissociate in session (Cornell & Olio, 1991), change the subject or become angry with the therapist (Briere, 1996a).

> In the worst situation, therapeutic interventions that exceed the window can harm the survivor. This occurs when the process errors are too numerous and severe to be balanced or neutralized by client avoidance, or when the client is so impaired in the self-domain or so cowed by the therapist that he or she cannot use self-protective defences. In such instances, the survivor may become flooded with intrusive stimuli, may 'fragment' to the point where he or she appears to be functioning at a primitive (or even psychotic) level, or may become sufficiently overwhelmed that more extreme dissociative behaviours emerge (Briere, 1996a, p. 146).

If this occurs the client then has to not only 'survive the abuse' she has to 'survive therapy' (Briere, 1996a). Such gross errors may lead the client to turn to substance abuse or self-mutilation after the session. While these states may not be permanent, they may be disheartening or stigmatizing for the client. They may lead the client to end their therapy or return to the therapist but be particularly defensive.

Effective 'window-centred therapy' can be achieved by attending to three aspects of therapy that lie on a continuum between support and growth. These aspects are continua from: a) consolidation to exploration, b) low to high intensity control and c) self-work to focus on the trauma. When in doubt the therapist should err on the side of caution and stay close to the support end of each continuum (Briere, 1996a, 2002).

a) Consolidation or exploration – Consolidation involves helping the client anchor themselves in the present, through actions such as 'grounding' and bringing the client's

attention to the 'here and now'. Exploration is the invitation to the client to focus on some of their traumatic history that has not been fully explored. The aim is to assist the client to safely explore something new.

b) Intensity Control – Clients need guidance to only deal with small manageable pieces of their traumatic past and then feel sufficiently de-aroused and calm to re-enter their present world. Intensity control is the responsibility of the therapist (Briere, 1992a, 1996a, 2002). A session that is divided into manageable 'thirds' is designed to help the client to gain confidence in therapy as a predictable and controlled process (Briere, 1996a, 2002; Herman, 1992b; Meiselman, 1990). An effective session should assist the client to begin at a relatively low level of emotional intensity, build to reach a peak just before mid session and then level off, to near or lower where the session began (Briere, 1996a, 2002).

c) Goal Sequence: Self before Trauma – Clients need to be aware that the "intense re-experiencing of traumatic events can reduce self-function temporarily" (Briere, 1996a, p. 148). Because of the interaction between the client's self-regulation capacities and the amount of affect the traumatic material can unleash, a client's readiness to work with trauma cannot be assumed to be static at one point (Briere, 1996a). At some points in the therapy a therapist may find that the client's capacity to cope with distress proves to be insufficient for further exploration of their traumatic material. If this is the case, the exploration of trauma should cease, and the focus should return to self-work.

5) Three Stages of Abuse-focused Therapy

Several authors have described the idea that healing from CSA proceeds in recognisable stages (Courtois, 1991, 1997; Herman, 1992b; Meiselman, 1990, 1994). Yet, some theorists, notably Briere (1992a; 1996a; 1996b; 2002) and Salter (1995) do not divide therapy into stages. These latter theorists have been included in the three stages of therapy however because even those who favour staged-therapy acknowledge that stages of therapy are abstract concepts that should be regarded as 'fluid and dynamic' (Courtois, 1997; Herman, 1992b).

Stage One – Safety and self-work

At the beginning of therapy the therapist should attend to any life-threatening crises and work with clients to help them establish as much safety and stability in their lives as

possible (Courtois, 1997). Therapy work needs to focus on building self-regulation skills (affect tolerance and affect modulation) and improving day-to-day functioning (Briere, 1992a, 1996b, 2002). This work may involve learning about and labelling feelings as well as beginning to reduce the effects the most debilitating trauma-related impacts such as: symptoms of PTSD; self-harming behaviours; suicidality; depression; chronic low self esteem; difficult thoughts or moods; dissociation; eating disorders; and/or volatile, enmeshed or fearful interpersonal relationships.

Prior to therapy, due to their need for vigilance and/or the need to avoid thinking about their traumatic material, clients may have grown up without the "relative luxury of introspection" (Briere, 2002, p. 189). Survivors of chronic CSA often have very little self-awareness of their internal processes (such as knowledge of their feelings) or their identity, (such as their boundaries, what they like, dislike, or are entitled to). To assist a survivor to build self-awareness, Briere (2002) recommends a Socratic model of questioning such as gentle inquiries about the survivor's perceptions and views.

In Stage One, the therapist should aim to build a therapeutic relationship that provides safety and caring (Herman, 1992b). The rationale for creating a safe, predictable, trustworthy therapeutic environment is so that the client can experience the disparity between the re-experiencing of the traumatic material (danger/violation) and the current (safe/supportive) environment (Briere, 2002). Given the establishment of such a safe and trusting therapy relationship the emotions conditioned to the memories gradually become extinguished because they are not reinforced.

Although it is not linear, the first stage is considered fairly complete once clients have: gained some safety and stability in their lives; increased their self-confidence and ability to protect themselves from abusive people; gained some control over the most disturbing symptoms (including self-harming and suicidality); increased their self-regulation skills and firmed their self-identity; increased their self-competence and self-esteem; decreased self-blaming; demonstrated they are able to have somewhat more bounded and balanced interpersonal relationships; and begun to believe they deserve to be treated with respect and consideration. Some survivors who were chronically abused may take years to reach this point and may not wish to go any further (Herman, 1992b). Others will reach this point more quickly and will wish to move on to Stage Two.

Stage Two – Exploration and integration

> The painful memories of the sexually abused can come into the open only gradually, against much resistance and at the price of renewed suffering. (Frenken & Van Stolk, 1990, p. 262)

A goal of abuse-focused therapy is the integration of traumatic material through testimony. The therapist's role is ally and witness to events that may have felt unspeakable (Herman, 1992b). The rationale for focusing on the traumatic material is to desensitize the material so it can be integrated. Although abuse-related issues may have been lightly discussed at the beginning of therapy, in this stage the therapy work may focus more closely on the traumatic material so that it can be desensitized and integrated into the survivor's life – rather than being suppressed, dissociated or avoided.

In this stage the therapist will continue to monitor the client's safety and stability and continue to consult the client about the pace and focus of the therapy (Briere, 1996a). The aim is to support the client as she explores the CSA at a pace that does not cause her to resort to self-harming or damaging tension reducing behaviours. It is expected that some abusive material may be incorporated into the survivor's "generalized working models of self, others, deep cognitive structures, or distorted relational schema" a lot of which may not be within the survivor's "conscious awareness, let alone describable/explicit memory" – (especially if the abuse occurred in the first two or three years of life) (Briere, 2002, p. 193). This material may not be processed cognitively however and may "appear in the therapy session without the client or therapist ever having a detailed narrative of the material" (Briere, 2002, p. 193). This latter point is a source of controversy, with some individuals claiming that psychological amnesia for childhood abuse is virtually impossible. On this issue, however, Briere (2002) comments that the last three editions of the American Psychiatric Association's Diagnostic manual (DSMIII; DSM III-R; DSM IV) have suggested that some level of dissociation or amnesia for traumatic events are "not especially rare" (Briere, 2002, p. 200).

In Stage Two the therapist's role includes supporting the client as she: vents her emotions associated with the trauma; finds her own meaning about the abuse; and re-evaluates, processes and integrates the impact the CSA has had on her life (Herman, 1992b).

By the end of this stage, having had the courage to face what may have seemed to be terrifying traumatic material, clients are likely to have made many gains including that: while the CSA may not be forgotten, the effects of the CSA will have been integrated into their lives and will hold less affect; they will have shed much of the burden of guilt, hurt, grief, shame, humiliation, and/or anger that was sapping their energies; and their focus should now able to be redirected to other areas of their lives.

> *Stage Three – Empowerment and reconnection*
>
> Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery (Herman, 1992b, p. 197).

Goals of this stage include: consolidating gains; completing a deeper exploration of any issues that continue to require attention; orienting to 'normal' life; reconnecting with others; and preparing to end therapy (Herman, 1992b). The client should have increased control over her own life and be able to tolerate reasonable levels of everyday distress without having to resort to negative tension reducing activities (such as alcohol, increased sexual activity, or self-harming) (Briere, 1996a). Clients should have more direction over their future. At this stage clients should be able to acknowledge the abuse they experienced and the effects on their lives. Looking back, some survivors may find positive aspects of themselves that arose out of the trauma. Guilt and shame may be replaced by a new sense of pride and self-esteem. Some may develop a 'survivor mission' such as wanting to educate others about CSA (Herman, 1992b). Clients who have required long-term therapy may need three to six months of preparation for ending therapy during which time the therapy contact is gradually reduced over months. Many may return to therapy briefly if new issues arise or are triggered in the future (Courtois, 1997).

6) Boundary Issues and Potential Therapy Errors

Working with the effects of interpersonal violence

Therapy with an "interpersonally victimized" person has been described as a "daunting challenge" (Courtois, 1997, p. 481). Therefore, while a core requirement of effective abuse-focused therapy is "the development of a consistent, reliable and stable therapeutic relationship" (Courtois, 1991, p. 54) there is an on-going tension given that:

> Survivors often have great disillusionment and mistrust of authority figures: Therapists are no exception and are tested throughout the course of treatment. They must expect this and try to provide the conditions within which to develop trust right from the start (Courtois, 1991, p. 54).

Herein lies a tension within abuse-focused therapy. The therapy relationship is unique because its sole existence is to assist the client to heal (Herman, 1992b). It is also special because by the survivor acknowledging that they need help and support, they are consciously or subconsciously submitting to an unequal power relationship (Briere, 1992a, 1996b). This inequality inevitably engenders feelings of dependence. This inequality of power, also in a very real sense, leaves the client vulnerable to further violations and exploitations. For example, although therapists need to feel they are doing a good job, they must to be careful not to seek any form of solace or comfort from their clients because this may parallel the offender's behaviour (van der Kolk, 1994). It is imperative that the therapist uses the power and trust conferred onto them responsibly (Meiselman, 1994). This may become difficult if the therapist is perceived as a:

> …stand-in for other untrustworthy and abusive authority figures to be feared, challenged, tested, distanced from, raged against, sexualized etc, or may be perceived as a stand-in for the longed for good parent or rescuer to be clung to, deferred to, and nurtured by (Courtois, 1997, p. 481).

Expect minor therapy errors

It is important that the therapist acknowledges from the beginning of therapy that it is more or less inevitable that they will commit at least some minor therapeutic errors along a continuum from intrusion to withdrawal (Dalenberg, 1998a) (described in more detail later in this section). If a client is provided with this knowledge at the beginning of therapy, then, when errors occur they may be openly discussed between therapist and client. For example, the survivor is likely to be acutely aware of any signals of abandonment or mini betrayals which may occur through moments of therapist's inattention, insensitive communication or demeanour. Because of this, it is essential that the therapist be attuned to the client (Elliott & Briere, 1995). It seems however that many times it is "…impossible to avoid wounding the client", because of the way that "ordinary limits and boundaries that must be maintained in therapy" are interpreted as coercion (Meiselman, 1994, p. 96).

To lessen the distress that these inevitable minor therapy errors may cause, several authors (Dalenberg, 2003; Elliott & Briere, 1995; Pearlman & Saakvitne, 1995) recommend educating the client about the therapy process such as the limitation of the therapist's availability and how the client and therapist will deal with the possibility of the client feeling an acute need to talk to the therapist in between sessions.

Dealing with anger in therapy – The literature frequently gives examples of clients feeling angry towards a therapist and suppressing their anger for fear that the relationship may end if they express it (Dale, Allen, & Measor, 1998; Dalenberg, 1998b; Salter, 1995; van der Kolk, McFarlane et al., 1996). As early as possible a therapist needs to educate the client about the expression of anger in close relationships, (for example, that it can be constructive when expressed early, and with care for the other person). Clients need reassurances that, within limits (such as physical threats or refusal to pay for sessions), the relationship will not end if the client is angry or is testing of the therapist (Meiselman, 1990). Sometimes therapists are tempted to return a client's anger and, for example, will use destructive labels on their clients and refer to them as: 'resistant'; 'narcissistic'; or borderline personality disordered (Dalenberg, 2003).

Common therapy boundary issues

No matter how 'manipulative' a client may be, it is the therapist who bears the ultimate responsibility for maintaining therapeutic boundaries (Meiselman, 1994, p. 95).

Therapists' self-disclosures – Therapists need practice and training to be able to sensitively decline invitations from clients that violate a therapeutic boundary such as talking about their personal problems (Dalenberg, 1998a). It is important therefore that therapists do not over-disclose their own issues in therapy. Yet Salter (1995) comments that: "It is not unusual for a client to mention in therapy that a previous therapist spent much of the hour discussing her own issues" (1995, p. 254). Instead, once the therapist's door is shut the therapist must be completely focused on the client's issues (Salter, 1995).

Issues of touch – Not all abuse-focused theorists comment directly on touching between the client and therapist. A cautious therapist may have a 'No touch' rule (Meiselman, 1990). Some authors suggest that touch within such an intimate setting as therapy:

> ...raises the possibility that the client will feel that the relationship has been sexualized, or set the therapist on the 'slippery slope' to exploitation, and thus most forms of touching should be avoided. (Gutheil & Gabbard, 1993, p. 2)

Others support the considered use of touch when clients ask "for comfort or supportive contact" and argue that honoring such requests within reason "may alleviate shame and allow deeper processing of traumatic material" (Dalenberg, Dunkerly, & Collopy, 1998, p. 2). Meiselman (1990) recommends rules that the therapist only touch the client if: 1) the client initiates the touch; 2) the client gives permission; 3) the touch (or hug) is not routinized and; 4) the touch is not sexual.

Distancing and intrusion errors

Dalenberg (1998a) refers to potential therapy errors along a continuum from 'Distancing' to 'Intrusion' distinguishing between therapists at one end or the other as a Type I and Type II therapist. Type I therapists, she described as having a policy of trying to withhold any expression of their own emotion, (often because they are worried that they will negatively affect the client with the expression of emotion). Type II therapists frequently share their emotions too readily with clients (thinking that therapy must be genuine and honest).

In her study of clients' responses to therapy, clients mentioned that their therapists' distancing errors included therapists': 1) refusals to acknowledge their countertransferential feelings such as fear, disgust, or anger; 2) using exaggerated objectivity; and/or 3) unexplained refusals to do minor positive social acts such as shaking hands (Dalenberg, 1998a). Intrusion errors included inappropriate influence or control over the client's self-perception, behaviour, or memory. Subtle sexual intrusion errors included voyeurism or sexual innuendo. More obvious sexual intrusion errors included those that were blatant, such as sexual contact. Dalenberg (1998a) commented that although therapists' intrusion errors have found their way into recent ethical debates, distancing errors might be more frequent in the treatment of abuse survivors. Distancing errors, such as emotional withdrawal, can cause the client a great deal of pain and conflict. With a distancing error, the client may feel that the therapist has

abandoned them at a time when they were most needing support. In a survey of clients, Dalenberg (1998a) found that, of those clients who regarded therapy as unsuccessful, 76% cited a distancing error that preceded termination of the therapy (p.17). Clients who reported being satisfied by the therapy said that their therapists made mistakes of both types (intrusion and withdrawal errors) (Dalenberg (1998a). Clients seemed to be more able to forgive minor intrusion errors than withdrawal errors. Minor intrusive errors included having countertransferential reasons for intervening to end a client's negative affective reaction (such as being too fast to offer advice). When discussed later, these clients were able to derive a non-malicious reason for the therapist's error. For example, some of the clients considered that, although the therapist should have allowed them extra time to work out an issue on their own, they believed that the therapist was just trying to be helpful by intervening too early.

Clients surveyed by Dalenberg (1998a) reported the most helpful response from a therapist to their stated wish or request for a boundary change (such as a request to meet as a friend) was a statement from the therapist that included both self-disclosure and a role statement. Dalenberg's guidelines for therapists dealing with such situations included: 1) be honest about reasons for refusals; 2) respect the complexity of the issues; 3) allow time to be agonized with the client about the inherent unfairness of any refusal – seeing that the therapist cares can reduce the client's distress; and 4) when a therapist decides she has been wrong, never underestimate the power of a sincere apology (Dalenberg, 1998b, 2003).

Summary

Clinical guidelines suggest that most survivors of CSA require courage to enter therapy. Many may begin therapy due to a crisis in their lives. Some may want to talk about their current difficulties and arrive in therapy feeling fearful and tentative about the prospect of facing traumatic material that they may have tried to suppress or ignore for many years. Many may enter therapy with little knowledge of how their current difficulties are related to their history of CSA. Finding a match with an appropriately skilled therapist that they feel comfortable with in terms of gender, ethnicity and in other aspects of compatibility may be complex.

At the beginning of therapy, therapists should educate their clients about: the process of therapy; client and therapist rights and responsibilities; the possibility of strong reactions in therapy; and of some of the difficulties that may occur in therapy. Therapists need to conduct a thorough assessment at the beginning of therapy and should continue to assess their clients' physical safety and self-capacities to undertake the work throughout the therapy process. Abuse-focused therapists aim to create a safe, equal, open and resilient therapeutic relationship so that survivors can explore, process and make sense of the effects of trauma in their lives.

Therapists suitable to work with survivors of CSA are those who are able to: work collaborately with clients; be warm and affectively available; be open as well as bounded; and assess and attend to the client's needs and difficulties. Therapists need to be knowledgeable about the functionality of the effects of CSA and aware of second and third generation abuse-focused therapy guidelines that focus on stabilizing and strengthening the survivor's self and functioning prior to focusing on traumatic material at depth. An awareness of the therapy window can assist therapists to carefully titrate the amount of traumatic material that the client is exposed to. Consultation with the client over pace, focus, and modality are important.

CSA by definition involves boundary violations and it is imperative that therapists who work with this population do not cause the client further harm. It should be anticipated that many survivors of CSA would have little awareness of their own or of other's boundaries. It is the therapist's responsibility to deal with any boundary challenges in a sensitive way that normalizes and educates the survivor and does not add to any existing feelings of shame or difference. Therapists should work to build a therapy relationship that is based on open and honest dialogue about the process and progress of the therapy.

Section Three – Clients' Evaluations of Therapy for CSA

Literature searches discovered only five evaluation studies similar to the present study. Aspects of the five studies that most relate to the present study will be emphasized. The studies are presented in chronological order. The Dale et al, (1998) study is presented at a greater depth because Dale (1999) provided additional qualitative findings of the same study.

Armsworth (1989)

A postal questionnaire was used to gather the self-reports of 30 women incest survivors' experiences of the professional help they received for incest-related problems. Armsworth advertized through women's groups, community groups and private therapy practitioners. Participants' mean age was 31.2 years. Seventy-seven percent of participants reported some form of genital contact, 40% reported attempted intercourse and 40% reported experiencing intercourse. The mean age of incest onset was 7.8 years (SD 3.68), the mean duration was six years (SD, 4.07), and the mean age of incest ending was 13.9 years (SD, 4.52). Forty-seven percent of participants reported being sexually abused by their fathers; 30% by their brothers; 27% by their grandfathers; 40% by other males in the family and 3% by female cousins. In addition, 83% of participants reported child physical, verbal or emotional abuse.

Participants rated the helpfulness of services received from 12 categories of professionals. The 30 participants saw a total of 113 professionals (53 male and 60 female), ranging from one to nine with the mode being four. The length of time spent in therapy ranged from one session to five years, (240 sessions), making an average of (36 sessions) nine months. The scale of helpfulness was: 5=Very helpful, 3=Helpful, 1=Not much help, 0=More harm than good. Participants mean rating was 3.02 (SD, 1.93). (See: Table 1 Armsworth (1989): Mean Helpfulness Ratings)

Male helpers were seen longer but rated as less helpful than females. The mean rating for female professionals was 3.93 (SD, 1.47) and for male professionals was 1.98 (SD, 1.91). Eighteen of the 113 professionals were rated as 'doing more harm than good'; sixteen of these were males, six of whom received this rating due to sexual involvement. The remainder who were rated 'doing more harm than good' were for reasons that included that the participant was blamed for the incest, the incest was not believed and the over-use of medication.

Helpful interventions were described by participants as when: 1) the client felt believed; 2) the professional was supportive, compassionate, empathetic, and caring; 3) the client did not feel blamed for the incest; 4) the professional was not shocked or disgusted at

the incest disclosure; 5) the client did not feel odd or alone; and/or 6) the professional helped to stop the incest.

The most frequent reason for rating a professional as harmful was because of sexual exploitation by the professional. Seven participants (23%) reported eight cases of sexual harassment or sexual involvement with a male professional; (six were Ministers or pastoral counsellors, one was a support group leader, and one was a psychiatrist).

Armsworth reported that in addition to the 23% that reported sexual exploitation, a further seven participants (23%) reported what Armsworth described as 'victimization' that included professionals: not believing the disclosure of incest, telling the client she fantasized it; ignoring or dismissing the incest as not important (because no intercourse had taken place); over-prescribing medication; telling the participant she must have enjoyed the incest experiences because she stayed; and being shocked or disgusted at the disclosure of incest.

Table 1. Armsworth (1989): Mean Helpfulness Ratings.

Profession	Male	SD	Female	SD
Agency counsellor	2.25	2.22	3.50	1.91
Minister/priest	1.25	1.60	---	---
Pastoral counsellor	1.75	2.22	---	---
Peer counsellor	---	---	2.50	3.54
Psychiatrist	1.33	1.72	4.33	1.16
Psychoanalyst	---	---	1.50	2.12
Psychologist	3.17	2.29	4.46	0.93
School counsellor	2.00	1.41	4.00	1.67
Social worker	3.00	0.00	3.57	1.51
Support group	0.00	0.00	4.43	0.93
Therapy group	1.00	0.00	3.00	0.00
Other	3.00	0.00	2.33	1.61
Total	1.98	1.91	3.93	1.47

Scale: 5=Very helpful, 3=Helpful, 1=Not much help, 0=More harm than good
Mean 3.02 (SD, 1.93).

Armsworth's helpfulness rating scale appeared to be focused on measuring 'helpfulness' given that three points of the rating scale included some aspect of

‘helpfulness’ (Very helpful, Helpful, Not much help) and only one point was clearly ‘unhelpful’ (More harm than good). On the other hand, her finding that almost half (46%) of her participants reported ‘some form’ of ‘exploitation’ or ‘victimization’ by a helping profession, needs to be viewed in relation to a wide definition of ‘victimization’ (including that the incest disclosure was not believed or was ignored). In addition, when the eight incidents of sexual exploitation were compared to the total of 113 professionals, sexual exploitation by a professional became six percent; a proportion much more in line with other studies (Carr et al., 1990; Russell, 1993).

Feinauer (1989)

From a newspaper interview with the author, Feinauer gathered a sample of 57 women survivors of CSA. Of these, 36 had received therapy and 21 had no therapy. All 57 completed a questionnaire, and a sub-sample of 25 was interviewed. The mean age of the women when they initiated therapy was 31 years. The participants’ mean age at the time of the abuse was seven years old. A number of psychometric tools were used to measure current adjustment, abuse experiences and feelings about therapy.

Feinauer’s helpfulness scale was: Very helpful; Quite helpful; Somewhat helpful; Not very helpful; and Not helpful. Table 2 shows that, of those who had therapy, (29) 81% of participants reported some degree of satisfaction with therapy.

The length of time in therapy and the type of therapy was reported to have no significant relationship to the participants’ perception of adjustment post-therapy. Feinauer suggested that this finding was not surprising given that most respondents had participated in brief therapy with 60% having twenty sessions or less (See Table 3).

When therapy was initiated, 87% of the women described their psychological distress as ‘extreme’ or ‘severe’ (Table 4). At the end of therapy these categories dropped to 25%, and at the time of the study these levels had dropped to 17% (Table 4).

She went on to suggest that it was “highly probable” that women sought therapy during a crisis (p. 332) and, even though their level of distress was extremely high when they entered therapy, 22% remained in therapy for less than four sessions (Table 3). Feinauer suggested that continuation in therapy for sexually abused women seemed to be

"difficult" as they explored "conflicting feelings", went on to "reexperience the abuse", and " again have a sense of being out of control" (p. 332). When discussing the number of women who dropped out of therapy before their issues were resolved, Feinauer's recommendations included:

> It is important to support the survivors of abuse as they attempt to decide whether or not to pursue therapy. They must believe that therapy is a safe environment and the therapist is committed to going through the process with them until it is over. Unless they trust their therapist to be sensitive to their fears, pace, and individual issues, the clients will become resistant. These clients require more time for therapy than many others (Feinauer, 1989, p. 333).

Unfortunately Feinauer provided very little detail of the types of therapies the participants experienced apart from reporting that marital, family and/or individual therapies were equally effective. When discussing the limitations of the study, Feinauer acknowledged: 1) that her sampling procedure was likely to have excluded the more seriously damaged or disturbed clients, because "it would seem probable" (p. 331) that those who were severely harmed "would be less likely to respond" (p. 331); and 2) the evaluations were retrospective self-reports. In addition to these limitations Feinauer's rating scale, like Armsworth's (1989), was biased towards 'helpfulness' by offering four points on the rating scale that included some aspect of helpfulness (Very helpful, Quite helpful, Somewhat helpful and Not very helpful) and only one point clearly offered an unhelpful option (Not helpful).

Table 2. Feinauer (1989) Therapy Ratings

Responses N=36	N	%
Effectiveness of therapy:		
Very helpful	10	28
Quite helpful	13	36
Somewhat helpful	6	17
Not very helpful	2	6
Not helpful	5	14

Table 3. Feinauer (1989) Number Of Sessions Attended

	N	%
Number of sessions attended:		
1-4	9	22
5-8	3	8
9-12	7	19
13-20	4	11
21-100	11	25
101-520	6	17

Table 4. Feinauer (1989) Levels Of Distress When Therapy Was Initiated, Terminated, And At Time Of Study

Responses N=36	**N**	**%**		**N**	**%**		**N**	**%**
Levels of distress when therapy initiated:			**Levels of distress when therapy terminated:**			**Level of distress today:**		
None	2	6	None	6	17	None	7	19
Mild	0	0	Mild	16	44	Mild	16	44
Moderate	3	8	Moderate	5	14	Moderate	7	19
Severe	11	31	Severe	7	19	Severe	5	14
Extreme	20	56	Extreme	2	6	Extreme	1	3

Frenken and Van Stolk (1990)

A study by Frenken and Van Stolk (1990) differed from the previous two studies in that it focused on contact with the 'helping professions' in general (including child protection workers) rather than on abuse-focused therapy. Participants saw from one to nine professionals, with an average of 3.5 each.

Fifty incest survivors (49 were female) were recruited via articles in two Dutch national newspapers. The survivors were interviewed using open and closed ended questions on subjects such as: the nature and duration of the incest experience; the psychological and psychosomatic complaints that the respondents considered related to the abuse; and their evaluations of the contact they had with all professionals they had consulted.

The age range of the respondents was 19-62 years with a mean of 33 years. Incest experiences began between the ages of six and nine, with a mean duration of four years. The largest group of incest perpetrators was biological fathers (50%) followed by stepfathers and foster-fathers (25%). According to Russell's (1986) definition, 74%

experienced “very severe sexual abuse” (including genital contact, oral sex and penetration).

Frenken and Van Stolk (1990) developed three categories of psychological and psychosomatic complaints from the respondents’ self-reports: ‘very serious complaints’; ‘serious complaints’; and ‘less serious’ complaints. Before therapy, 46% of the respondents reported ‘very serious complaints’, including chronic depression, attempted suicide and incapacitating phobias as well as psychosomatic disorders and 24% reported ‘serious complaints’, including psychosocial problems in relationships, sexual and psychosomatic complaints, and persistent feelings of isolation, guilt, shame and disgust.

Although Frenken and Van Stolk provided participants’ satisfaction ratings (see Table 5) they provided few qualitative descriptions of what aspects of interventions participants found satisfying. Furthermore their rating scale was biased towards dissatisfied, given that they provided three dissatisfied rating options (Partly dissatisfied, Dissatisfied and Very dissatisfied) and only two clearly satisfied rating options (Very satisfied, Satisfied). Frenken and Van Stolk’s described participants as experiencing a “long march through the consultation rooms” trying to find the help they needed (p. 253) and that, in the end, finding a helpful therapeutic relationship usually depended on the participants’ perseverance. Nevertheless, they found that “in the long run just over 50% of the women found a lasting and probably satisfactory therapeutic contact” (p. 259).

Participants complained that when incest was mentioned 61% of the first professionals they saw did not delve further; the same was true for 59% of second professionals and half of the third professionals ignored the matter. Frenken and van Stolk were struck by the inability of the professionals to 1) detect sexual abuse, 2) explicitly diagnose it and 3) keep it as a subject of discussion. Participants were dissatisfied when helpers did not assist them to ‘work through’ issues to do with incest, and valued highly those who did show interest and understanding of their experiences of incest. However, of the professionals who did discuss the incest incidents in some way: 30% met their story with disbelief; 38% belittled it; 38% put the blame on the survivor; and 34% made light of the perpetrator’s deeds. Thirty-eight percent expressed ‘astonishment’ that the women had remained silent about the abuse for years. Some women heard these latter

statements as a lack of understanding on the part of the professional and others took the statements to mean they were responsible for the incest.

Table 5. Client Evaluation Of The First Four Contact With Professionals

(n=134)	N	%
Very satisfied	41	31%
Satisfied	12	9%
Partly dissatisfied	22	16%
Dissatisfied	14	10%
Very dissatisfied	45	34%

Most of the first consulted professionals were male. Five participants (10%) spontaneously complained of sexual abuse by a professional. Only four gave descriptions of the sexually abusing professionals: two were psychiatrists, one a male psychologist, and one a male general practitioner. Two-thirds of the participants stated that they would have preferred to see a female professional. The gender of the professional mattered less later on in the process of working through their experiences.

On the whole, participants tended to give nonmedical professions more positive evaluations. For example, 54% of psychiatrists, and 52% of general practitioners (GPs) were evaluated as “very unsatisfactory”, whereas 35% of psychotherapists were described as being “scored negatively”, and 25% of contacts with women’s self-help incest groups were “judged negatively”. (p. 261) Counter to this trend was the 50% negative evaluations of community social workers. Overall, two specific practice errors were noted. The first error, predominantly found with GPs, social workers and residential psychiatrists was that these professionals tended to avoid talking about the incest and focused on the present. Participants soon became tired of this avoidance and “stayed away without explanation or pretended that the problem they had worked on had been solved” (p. 262). The second error was less commonly found, and was associated mostly with volunteer workers and some psychotherapists. This error was of allowing the helpers' emotions to affect the therapy relationship, an error that hindered the participants’ progress in therapy.

Dale, Allen and Measor (1998) and Dale (1999)

Of particular relevance to this thesis was the part of Dale, Allen and Measor's (1998) study that focused on the interviews about the therapy experiences of forty male and female clients. Key qualitative findings from Dale (1999) (an expansion of the Dale et al. (1998) study) are also included.

Participants had survived a range of child abuse including: sexual abuse (77%); emotional abuse (74%); physical abuse (49%); and/or neglect (32%). They described the effects of child abuse as impacting on their daily lives in the form of lack of self-worth, great loneliness, self-destructive thoughts and behaviours, suicidality, addictions, repetitive destructive relationships, revictimization, aggression and the abuse of others, including their own children.

For some, the benefits of therapy were experienced as life saving. Benefits to participants were found predominantly in four areas: improvement in general day-to-day coping with life; the ability to express and deal with feelings; a re-ordering of relationships – with their own children, partners and families of origin; and developing an understanding and meaning of their abuse experiences.

The group had a total of 130 counselling experiences. Ninety percent of the sample had more than one experience of counselling, with a range of between one and ten experiences (mean 3.25). The Dale et al. (1998) rating scale was: Yes – a great deal; Yes – to some extent; Uncertain; No did not really help; No seemed to make things worse/was harmful. When asked "has the counselling/therapy you have received helped you to deal more effectively with the problems that led you to seek counselling/therapy?", of the 130 counselling experiences, 69% of all therapy experiences were rated as helpful to some degree, and 23% reported therapy did not help or made things worse (see Table 6).

Similar to the Armsworth (1989) and Feinauer (1989) studies, the Dale et al. (1998) rating scale was biased towards the positive and only contained one clearly negative point on the scale (No seemed to make things worse/was harmful).

After therapy: 17% of participants reported experiencing 'Major problems' associated with CSA; most (75%) still had 'Some problems'; 4% reported 'Hardly any problems'; and no participant reported 'No problems'. However, Dale et al. (1998) reported that "many" participants stated that therapy had helped them to "overcome substantial problems" and helped "to ameliorate the effect of remaining problems" (p. 146).

Table 6. Dale et al. (1998) Clients' Overall Rating Of Counselling Experiences

Has the counselling/therapy you have received helped you to deal more effectively with the problems that led you to seek counselling/therapy?

Rating of helpfulness of therapy (N=130)	**N**	**%**
Yes – a great deal	48	37
Yes – to some extent	42	32
Uncertain	10	8
No – did not really help	17	13
No – seemed to make things worse/was harmful	13	10
Total	130	100

Dale (1999) concluded that therapy for child abuse was both similar and different to other therapies. Similarities included the need for a safe context that included an accepting relationship in which the client could feel understood, could talk honestly and create meaning for their experiences. However, therapy for child abuse was different because of added difficulties including: 1) overcoming a lack of trust or over-trusting tendencies (in order to establish a therapy relationship); 2) inhibitions in communication (especially those of dissatisfaction with counselling and shameful experiences); 3) deciding if, when and how to talk about the abuse; 4) searching for understanding of why the abuse occurred and about responsibility for the abuse; 5) questions about current and future relationships with offenders and other family members (including their children); and 6) concerns regarding their memories.

Participants' Processes Entering Therapy

Dale's (1999) participants described their processes of entering therapy as a combination of factors including: recognizing their difficulties; motivating themselves to invest emotion, time and often money in the therapy process; and/or a crisis or a precipitating event had occurred (often referred to as a 'breakdown'). However, a

number of participants identified deterrents to help-seeking including: a denial of their difficulties; negative beliefs systems (such as not believing they deserved help), expecting not to be believed; the lingering pressure not to report the abuse to anyone; practicalities such as lack of local services, absence of child-care facilities, inability to travel (flashbacks when driving to and from therapy); and previous negative experiences with professionals (particularly psychiatrists and psychiatric hospital personnel).

Participants described finding a therapist to work with as a complex and difficult task. First time clients described feeling bewildered about the "rules of the game" of therapy (p. 73). Because so many participants experienced huge amounts of fear when approaching therapy, Dale (1999) suggested that initial rapport was necessary to avoid clients fleeing therapy or dismissing therapy as being of no assistance. Dale (1999) criticized many therapists for paying "insufficient attention to the impact of their behaviour" (such as careful listening, communicated understanding, empathy and a non-judgemental attitude) and not paying enough attention to the "therapeutic environment" (such as considering the participant's physical comforts and needs) (p. 76). Participants reported these issues as influential in their early assessments of therapy.

Dale (1999) was concerned that a number of participants did not experience careful listening, understanding, empathy, respect and a non-judgemental attitude from therapists. Some therapists sat behind desks and answered the phone during a session and some blamed the participant for their failures. Some participants concealed their negative reactions to poor therapy practices. Lack of feed-back from participants not only deprived therapists of criticisms but sometimes left the participant blaming themselves for poor therapy outcomes. In addition, some participants were deterred from future help seeking.

The direct, initial checking-out of therapists was difficult for participants who were new to therapy, were not assertive and/or who did not know what sort of questions to ask at the beginning of therapy (such as questions about theoretical orientation, levels of experience, attitudes to abuse, and therapy structures and boundaries). The indirect checking of therapists such as whether the therapist seemed trustworthy and safe to work with however occurred at the intuitive level however. Dale's (1999) study found that some clients were watching the therapist closely especially in the beginning stages,

and tested therapists throughout the therapy to check if the therapist was strong enough, aware enough, and safe enough to help them. Participants decided after initial sessions whether to continue or not. Crucial to their decision was the degree of rapport that had been established. Some participants opted out of therapy after early negative experiences; others persisted and sometimes found the therapy to be beneficial.

Dale (1999) stated that his study deliberately focused in great detail on the negative effects of therapy because this topic had been under-researched and this population did not report dissatisfaction to their therapists. When discussing participants' dissatisfaction Dale (1999) pointed out that: just as satisfaction with therapy did not necessarily mean that therapy was efficacious, dissatisfaction with therapy did not necessarily imply that the therapy was of no benefit. Dale (1999) emphasized that therapy was multidimensional and was difficult to evaluate using a single process or outcome measure. Participants in his study did not expect that therapy would be "pain-free", "pleasant" or a magical cure" (p. 85). They anticipated that effective therapy would include challenges and setbacks as well as progress. However, some participants who experienced dissatisfaction that they could not attribute to the process of therapy turned the responsibility for their negative experiences on to the therapist's characteristics, attitude or behaviours, or onto themselves.

Difficulties Leaving Unhelpful Therapists

A few participants gave examples of therapists using bizarre and abusive therapy practices. In addition, some participants complained that therapists punitively labelled them as psychotic and a number of therapists led participants into areas beyond the therapist's competence. Participants with little experience of therapy found it difficult to evaluate such practices as negative and leave the therapy. Factors that left a number of participants susceptible to poor and abusive therapy practices were: 1) a lack of knowledge of the therapy process; 2) deference to the authority status of the therapist; 3) lack of confidence in their own perceptions and judgements; and 4) the impact of child abuse having undermined their self-protective responses. Other participants stayed in therapy relationships that they were not sure were good for them for a range of reasons including: they liked the therapist; they did not want to have to find a new therapist; and some hoped that the therapy would improve. Extracting themselves from therapy was often difficult for reasons such as: they did not want to hurt the therapist's

feelings; they felt dependent on the therapist; or felt frightened of the therapist's reactions. Many participants did not voice their dissatisfactions with therapy and similar to the Frenken and Van Stolk (1990) study some pretended to get better in order to leave.

Unhelpful Therapy

Participants reported disliking a number of aspects of therapy including when: 1) therapy conversations were similar to conversations they could have with their friends; 2) therapists were over-loaded and preoccupied and could not provide them with regular appointments; 3) therapists did not focus on them throughout the therapy session; 4) therapists seemed emotionally fragile, became tearful and appeared to have unresolved issues; 5) therapists were over-zealous and saw their clients abuse experiences as the explanation for every problem; 6) therapists who used therapy to satisfy their own needs (such as for income or status as a therapist working with difficult clients or the therapist could feel needed); 7) the therapy relationship mirrored other difficult relationships without the therapist being aware of this dynamic

Talking About Abuse

There seemed to be no consensus from participants regarding the extent to which it was necessary to talk about the abuse in detail for therapy to be beneficial. Some participants felt talking about the abuse was vital, others less so. Some felt active emotional expression was necessary while others did not. Some preferred to talk about the present and how the abuse may have affected them. Some reported that feeling pressured to go over the "gory" details was "extremely destructive" (p. 105). Several participants reported that talking about the abuse was very difficult because they not only had to face their reactions such as fear, embarrassment, guilt and nausea but also they anticipated the professional's disgust, disbelief, rejection and/or voyeurism. Talking about abuse was reported to be a delicate and sensitive part of the therapeutic process with great positive gains when this was achieved successfully (albeit commonly associated with fear, emotional pain and distress). In addition several participants reported that they valued therapists who helped them work through the issues of responsibility for the abuse.

Therapists who discussed with the participant the benefits and disadvantages of talking about abuse were found to assist participants make informed decisions about this process. Participants criticized therapists who made assumptions that they 'should' talk about abuse or who pressured them to talk too much or to quickly about it. Yet other participants felt frustrated at therapists being over-cautious and avoiding the topic of the abuse. Some participants acknowledged that they felt the need to talk about the abuse and feared their own emotional responses. Some of these wished their therapists would 'push' them to focus on the abuse, but not too much (p. 109). A few participants wished that therapists had asked them directly if they had been abused, adding that a therapist's tentative enquiries about a non-disclosed but suspected abuse history was unlikely to do harm and could have assisted them to begin to talk about their abuse experiences. They added, however, that such tentative enquiries should not escalate to repeated enquiries or suggestions that an abuse history may be a fact.

None of the participants suggested that an impassive reaction to an abuse disclosure was appropriate. Key features of what was regarded as helpful with abuse disclosures were rapport and real human involvement. Any strong responses from a therapist (such as anger that the participant had been abused or anger towards the offender) often inhibited clients talking about the abuse and sometimes caused them to leave the therapy. Participants acknowledged that gauging their needs with sufficient sensitivity was difficult for therapists but that when therapists found the optimum balance, the benefits for the participant could be great.

Therapists' Self-Disclosures

In general, analytical and behavioural forms of psychotherapy have discouraged therapist self-disclosure. However, most humanistic therapies include some self-disclosure as part of the therapy relationship. Dale (1999) identified three areas of therapist self-disclosures: 1) sharing thoughts and feelings about the client; 2) sharing personal aspects of their lives; and 3) sharing their own experiences of child abuse. Benefits for participants from therapists' self disclosure included: 1) learning about the effect they had on others; 2) developing trust and rapport in the therapy relationship; 3) promoting a feeling of being understood; 4) experiencing a role model of someone who has coped with similar issues and 5) experiencing a sense of equality. Aspects of therapists' disclosures that were unhelpful were when participants felt: 1) burdened by

unwanted information; 2) overwhelmed; 3) compliant; 4) that they were rivals; 5) the roles were reversed and they needed to care for the therapist; and/or 6) frightened by the therapists' vulnerabilities. A key distinction for participants of whether the therapist's self-disclosure was helpful or unhelpful was the degree to which the disclosure stemmed from a "healed" or an "unhealed" position (p. 120). Despite these difficulties many participants reported very positive outcomes from knowing if their therapist was a survivor of child abuse and paid "tribute to the special skills and sensitivity" of many survivor-therapists (p 93).

Help Working Through Emotions

Participants valued therapy for helping them to learn about and control their feelings. Feeling able to acknowledge and work through the anger they felt towards family and others who abused them, allowed some in Dale's (1999) study to move on to accept or forgive. However criticisms were levelled at therapists who pushed participants to forgive before they were ready. Although many participants gained great benefit from action methods and these methods assisted some to express emotions, some participants criticized "action hungry" therapists who seemed to view the expression of anger and catharsis as a desired end point of therapeutic resolution (Dale, 1999, p. 131). Some participants felt pressurized to express anger and felt they had to act angry to satisfy their therapists' expectations. It seemed that some therapists did not recognize that anger was not relevant for all survivors of child abuse and that pressuring participants to express emotions was potentially harmful and re-traumatizing.

Dale et al. (1998) concluded that there was such diversity within the group of adults abused as children that they could not be considered a unitary group with predictable difficulties or needs. As a group they experienced a mix of therapy outcomes. However, the data suggested that when counselling was effective for adults abused as children, it often had profound benefits. While many of the skills learned from generic types of counselling may work well with this group, there were also many specific challenges. The inability of some clients to express their dissatisfaction with counselling made this population particularly vulnerable to bad practice. Many counsellors seemed unaware of the negative impact of some of their practices. Dale et al. (1998) concluded there was:

> 1)...a pressing need for training, accreditation/registration and commissioning bodies to insist on sufficient levels of theoretical knowledge, and acceptance of

> good practice principles, by practitioners who offer counselling to adults who were abused as children; and
>
> 2) …a compelling need for public education to directly alert this particularly vulnerable client group to issues of good and bad practice, so that they are better prepared to monitor and evaluate the counselling which they receive, from a more informed perspective (p. 155).

Palmer, Brown, Rae-Grant and Loughlin (2001)

A recent Canadian study of 384 adults (86% female) who experienced physical, sexual or emotional abuse by family members in childhood, asked participants about: 1) their abuse experiences; 2) the helpfulness of the service providers; and 3) their present functioning. All respondents were recruited through advertisements and reports in newspapers, radio and church bulletins during 1993-1994. Of 500 questionnaires mailed out, 384 were completed. Fifty follow-up interviews were conducted. A number of standardized instruments for depression, self-esteem, and family functioning were used.

Almost half (45%) participants experienced all three types of child abuse (physical, emotional and sexual abuse). The average ages when CSA began and ended was 6.3 years and 16.3 years. Participants' ages ranged from 19-80 years with a mean of 38.7 years (SD=9.4). The rating scale used to measure the helpfulness of therapy was Very helpful; Somewhat helpful; No help and; Made it worse. Similar to Armsworth (1989); Feinauer (1989) and Dale et al. (1998) this scale is biased towards the positive by including more positive points (Very helpful and Somewhat helpful) on the scale than negative (Made it worse).

Of the 384 participants, 311 sought help "for problems related to the abuse". Of the respondents who sought help, 218 (70%) found at least one professional whom they rated as helpful. The authors found a link between perceived helpfulness and good outcomes on self-esteem and family functioning and stated that, although they could not infer causality, the associations were in the expected direction and therefore supported "the possible value of a helpful experience with professionals" (Palmer, Brown, Rae-Grant, & Loughlin, 2001, p. 141).

The 311 participants typically went to more than one source for help (mean number of helping sources 3.2). (See Table 7 for ratings of helpfulness for each profession). The authors considered the reasons that participants may have moved on to other helpers was because they may have: 1) "shopped around" because they were "not satisfied"; 2) sought interim help while on a waiting list or; 3) experienced rationed services (p. 139). Most participants sought professional help for extended periods of time (more than ten sessions). Similar to Frenken and Van Stolk (1990), this study included a number of professionals who seemed to have provided interventions other than talk therapy.

From their qualitative data Palmer et al. (2001) found 15 themes of helpfulness. The top seven (according to the number of respondents) were: 1) listening/being empathetic; 2) dealing with feelings; 3) being non-judgemental/understanding; 4) empowering; 5) providing connections with other survivors; 6) building self-esteem and; 7) validating the survivor's experience.

Table 7. Respondents' Ratings On "Helpfulness For Each Professional Or Service".

Type of Profession or service	M	SD	Type of Profession or service	M	SD
*Other	3.4	0.8	Family physician	2.9	0.9
Psychologist	3.2	0.8	Psychiatrist	2.7	1.0
Group treatment	3.2	0.8	Minister or priest	2.5	1.0
Community agency	3.1	0.9	School personnel	2.3	0.9
Social worker	3.0	1.0			

(N=311) Rating scale: 4 Very helpful; 3 Somewhat helpful; 2 No help; 1 Made it worse.

(*Other – specialized therapies; therapists; counsellors; psychiatric hospitalisation; addiction treatment programme; crisis lines)

When asked: "what other kind of (professional) help would you have liked?" the respondents reported: 1) group therapy; 2) helpers who had specialized knowledge and skills in treating the effects of child abuse; 3) free or affordable services; 4) acceptance (helpers believing/not judging); 5) availability (shorter waiting periods); 6) continuity of help; and 7) long-term/uninterrupted help.

Overall this study identified two significant gaps in services for adult survivors of child abuse. The first was a lack of professionals who had sufficient knowledge and/or sensitivity to work with this population. The second was a paucity of accessible, long-term help. Given that many participants mentioned the importance of having long-term help, Palmer et al. (2001) expressed concerns regarding the trend towards managed care and rationed services and stated that it was "unrealistic to expect a quick healing of psychological wounds that were created in early childhood in relationships with major attachment figures" (p. 143). Palmer et al. (2001) recommended: "at a minimum providers should acknowledge the rationing of services to help survivors plan their treatment and should help them co-ordinate the available help in a continuum of treatment" (p.143).

Summary

Each of the studies differed slightly in their focus. Armsworth (1989) and Frenken and Van Stolk (1990) focused on help for incest experiences only, whereas Feinauer (1989) focused on all CSA (including incest). Dale et al. (1998) focused on help for adult survivors of all types of child abuses and Palmer et al, (2001) focused on all types of child abuses perpetrated by family members. Two studies (Armsworth, 1989; Feinauer 1989) only included female participants (although the majority of participants in all of the studies were women). Furthermore, the Frenken and Van Stolk (1990) and Palmer et al. (2001) studies seemed to focus on a wider range of helping interventions, without the focus on individual talk therapy that Armsworth, (1989), Feinauer (1989) and Dale et al. (1998) had. The number of professionals seen by participants varied little in each of the four studies that provided this information, (Feinauer did not). The mean number of professionals seen by participants ranged from 3.2-4.0 professionals: Armsworth (1989) reported a mode of four; Frenken and Van Stolk (1990) an average of 3.5; Dale et al. (1998), 3.25 and Palmer (2001) 3.2.

All five studies demonstrated that many survivors of CSA experienced a mix of helpful and less than helpful contacts with professionals in their attempts to deal with the effects of their childhood abuses. Complaints from participants about professionals ranged from therapeutic errors (such as pressuring participants to express anger) to gross violations such as sexual contact. However, the majority of participants in all five

studies found some satisfaction in therapy: Armsworth (1989) reported an overall rating of helpfulness as 3.02 (SD 1.93) (based on her scale where 3= Helpful); Feinauer (1989) reported that 81% of her participants found therapy to be of some help; Frenken and Van Stolk (1990) reported over 50% found some satisfaction in therapy; Dale et al. (1998) reported 69% of all therapy experiences were helpful to some degree; and Palmer et al. (2001) reported 70% of participants reported finding at least one professional whom they rated as very helpful. However these findings need to be viewed in relation to the different rating scales. Four studies (Armsworth, 1989; Feinauer, 1989; Dale et al. 1998; Palmer et al. 2001) seemed to provide more positive options to participants in their rating scales and Frenken and Van Stolk seemed to provide more negative options.

Although most studies in this section gave participants' satisfaction ratings of the help they received, not all studies identified which aspects of therapy were specifically helpful. Of those that did, more than one study found that participants reported that helpful interventions included professionals who: were female (Armsworth, 1989; Frenken & Van Stolk, 1990) and; listened, had empathy, were understanding, non-judgemental and acknowledged and/or believed their disclosures of childhood abuses (Armsworth, 1989; Frenken & Van Stolk, 1990; Palmer et al, 2001). Unhelpful interventions included: not being believed; the incest being minimized; being regarded as somehow complicit in the incest; and abuse by a professional (Armsworth, 1989; Frenken & Van Stolk, 1990).

A composite picture of an overall helpful professional from all of these studies might be a professional who: was safe (would not abuse the client); was able to hear disclosures of child abuse without shock or disgust; was empathetic, understanding, and non-judgemental; had specialized knowledge of therapy for childhood abuse to help the client work through their issues surrounding their abuse; and was available for continued, affordable care. This composite picture does not differ from the template of best practice therapy in Section One and Two of this Chapter.

Aims Of This Study

Although this present study in part replicates the aims of these five studies (asking consumers about their therapy experience), it does not focus on what 'types' of professionals (for example psychologists or psychiatrists) were rated in contrast to others. The present study set out to gather specific details from consumers of therapy about what aspects of therapy were helpful and unhelpful in dealing with the effects of CSA. It was hoped that gathering such data would enable a comparison of client therapy experiences with abuse-focused guidelines about 'best practice', and provide information for current and future clients, providers of therapy, professional bodies, policy makers and funders – with the objective of improving the delivery of therapy to survivors of CSA.

CHAPTER THREE – METHODOLOGY

Overview – Two main data gathering methods were used in this study, a postal questionnaire of 191 participants and follow-up face-to-face interviews with a sub-sample of 20. Ethical approval from the University of Auckland Human Subjects Ethics Committee was granted in April 1999 and, following analysis of the pilot study a new approval was granted in Feb 2001 and was valid for 3 years.

Section One describes the consultation process that led to the pilot study. Section Two focuses on: the postal questionnaire and provides a description of the sample (participants who completed the postal questionnaire); data gathering methods (discussion of the content of the postal questionnaire and strategies for collecting the data); procedures (piloting of the postal questionnaire, recruitment of participants and how the postal questionnaire was administered); and analysis of the data. Section Three focuses on the sub-sample of face-to-face interviews that were conducted following the postal questionnaire including descriptions of the sample, data gathering methods, procedures, and data analysis.

Section One – Consultation Process

The initial consultation process about the design and focus of this study involved five audio-taped interviews (that were transcribed and sent back to the consultants for verification) with experts from a range of areas including: a psychiatrist who had already conducted research with child survivors of CSA; a Maori women academic with extensive experience of conducting research with Maori; and three clinicians (a family therapist, a clinical psychologist and a counsellor), all of whom had worked with survivors of CSA for over a decade. Design decisions from this consultation process included:

- *involving women survivors of CSA only* (mainly for safety reasons – to avoid me having to interview men alone in their homes);
- *keeping the research independent of any particular agency* to avoid the positive bias associated with in-house studies, (such as Jehu's (1988) study);

- *involving clients who were not currently in therapy* - to avoid interrupting the therapy relationship and to avoid the potential for positive bias by therapists, (for example, advertising the study only to clients they worked well with);
- *involving adults only* - a study had already been undertaken in this country with child survivors of CSA (Merry & Andrews, 1994);
- *a minimum number of therapy sessions* as a criteria for participating in the study – (so that participants would have some therapy experience to comment on).

Once the main parameters of the study had been established, a steering group involving eight specialist therapists was drawn together to fine tune the design of the pilot study. All eight therapists (including two Maori therapists and one Pacific therapist) had extensive experience working with survivors of CSA. Decisions from the steering group included:

- *not restricting therapy experiences to therapy with ACC therapists* because some participants may not have known if their therapy was funded by ACC, and anecdotal evidence suggested that a number of CSA survivors elected not to apply for ACC funded therapy (for example, to avoid the restrictions put on therapy that was subsidized by ACC and concerns about ACC gaining their personal information);
- *to ask participants to focus on 'all' of their therapy experiences*, over time, (rather than their best or worst experiences) to gain overall pictures of 'therapy journeys' including referral processes and interactions with a wide range of therapists (ACC registered therapists, student counsellors, crisis counsellors, church counsellors, and therapists only seen once or twice);
- *to ask survivors of CSA about their CSA experiences* so that comparisons about the levels of severity of the CSA could be made in relation to other studies and in relation to participants' levels of satisfaction with therapy. (This issue was strongly debated given that the focus of the study was 'therapy experiences' and that including questions about CSA could reduce participation - especially for those who still felt distressed about their CSA experiences);
- *to involve survivors of both CSA and incest* (not incest survivors only);
- *to encourage participants to only answer questions they felt comfortable answering*;
- *to include two or three simple emotional well-being assessments* (such as Likert scales) but not to use lengthy psychometric measurements;

- *that all advertising include a description of the study and criteria* for participating so that potential participants could easily assess whether they wanted to participate and;
- *advertising as widely as possible within different cultural groups and agencies* (including Te Whareruruhau: a therapy centre for Maori and non-Maori; Fale Lalaga: a Pacific Island Women's Counselling and Education Centre; and the Shakti Asian Women's Centre) and involving an interpreter and/or a support person if necessary.

During this study design process, in addition to my three supervisors, I was in contact with a number of overseas experts including (in chronological order of my meetings with them): Dr Margaret Wetherall (UK); Dr Michelle Fine (USA); Dr Constance Dalenberg (USA); and Dr Peter Dale (UK).

Section Two – Postal Questionnaire

Sample Characteristics

Age and Ethnicity

Criteria for participating in this study were women survivors of CSA who were: over the age of 20 years; had at least five therapy sessions for the effects of CSA; and were not currently in a therapy relationship. One hundred and ninety one women ranging in age from 20 to 74 years completed a postal questionnaire about their therapy and child sexual abuse experiences. The average age was 42.5 years. The majority of participants (78.0%) reported they were New Zealand European, 13.1% were Maori, 1.0% were Pacific people, and 7.3% were of 'Other' ethnic origins.

Education

Of the 189 participants who answered the question about their education: 68.3% had studied at either Polytechnic or University level; 31.2% were educated to high school level and one (0.5%) reported that her highest level of education was to the level of primary school.

Personal and Household Income

Personal income: Of the 169 participants who answered the question on personal income (in the last 12 months): 58.0% reported a personal income of less than $20,000; 27.2% reported between $20,001-$40,000; 14.8% reported between $40,001-$70,000.

Household incomes: Of the 150 participants who answered the question on household income: almost a quarter (23.3%) reported household incomes of less than $20,000;

26.0% reported incomes between $20,001-$40,000; 30.0% reported incomes between $40,001-$70,000; and 20.7% had incomes above $70,000.

Data Gathering

Pilot Study

A pilot study of five, face-to-face audio-taped interviews (that included all topics that were later included in the postal questionnaire and follow-up interviews) was conducted. The five pilot study participants were recruited from students and colleagues who had heard about the study and who fitted the criteria. The pilot interviews were transcribed and taken through to the data analysis stage. A review of the pilot study concluded that a one-off interview of one to three hours was not by itself the best design to gather data about past therapy experiences. Participants spent much of the interview time trying to remember the chronological order in which they saw their therapists. The interviews were long and seemed emotionally taxing to the participants because of the wide range of questions that included: their well-being assessments; their CSA and disclosure experiences; their range of therapy experiences; costs of therapy; messages they wanted to give to others; and the impact therapy had on their lives. Data from the pilot study of five participants resulted in 200 pages of transcripts and seemed potentially unwieldy should the study be based on 50 face-to-face interviews (as had been an initial plan). Through the pilot study it also became clear that some components (quantitative and qualitative) of the study could be researched using a postal questionnaire format.

Development of the Postal Questionnaire

There were a number of advantages and limitations in dividing the study into two-phases (postal questionnaire and interviews). Using a questionnaire in the first phase of the main study may have meant a loss of ‘thick’ descriptions (Miles & Huberman, 1994). However this design had the advantage of being able to gather information from a larger, nation-wide sample – as opposed a smaller number of face-to-face interviews restricted to the greater Auckland area. Furthermore, including a number of follow-up face-to-face interviews would provide ‘thick’ descriptions of the therapy experiences unencumbered by numerous other areas of questioning.

There were a number of concerns about using a questionnaire format. Questionnaires are difficult for people with literacy problems (McLeod, 1994) and this seemed to be a particular concern for some survivors of CSA – especially those who had their school years disrupted by abuse (Russell, 1986). With a face-to-face interview the client could ask for clarification of questions, but with a questionnaire the participant could only respond to what was on the page. An advantage of using a questionnaire format however was that anonymity would be enhanced.

As with all questionnaires there is a trade-off between brevity (to encourage the participant to complete the questionnaire) and gathering sufficient information (McLeod, 1994, p. 70). Armsworth (1989) (Chapter Two) used a 19-page questionnaire and commented that a number of participants did not return it due to the length. To maximize the return rate it was decided to use a relatively short questionnaire. The second phase of the study would consist of face-to-face interviews that could explore and expand some of the material at a greater depth.

Planned Care for Participants

The main concern when contemplating postal questionnaires was that participants would be completing the questionnaire without an interviewer present. Although I was able to travel to support any participant in the greater Auckland area, I was unable to provide support nation-wide. Given the concern that recalling CSA and therapy experiences may be upsetting, the brochure accompanying the questionnaire had a number of support-line phone numbers, both within Auckland and nationwide support lines (Appendix 2). Ten therapy agencies were contacted to provide support for participants of this study and six of these, plus two clinical psychologists from the Psychology Department at the University of Auckland, agreed to provide support and to be listed on the brochure (Appendix 2). Of the support agencies four agencies provided support to women survivors of CSA within the Auckland area, (of these, two provided support for Maori, and Pacific women and another agency provided a 24 hour support number for all survivors of sexual assault) and the other two agencies provided nation-wide generic counselling support (not specialized support for sexual assaults).

Postal Questionnaire Content

The postal questionnaire (Appendix 3) included five sections:

- demographic details;

- assessments of therapy experiences;
- CSA and disclosure experiences;
- payment for therapy; and
- messages from participants.

The postal questionnaire followed McLeod's (1994) recommendations that a questionnaire begin with factual items (age/gender) to engage the respondent before moving to more difficult questions. The flow of the postal questionnaire began with relatively emotionally easy questions (such as demographic questions and ratings of therapy experiences), and then moved on to exploring potentially more difficult questions (such as CSA experiences) in the middle of the questionnaire. The postal questionnaire ended with less emotionally taxing questions such as questions about the costs of therapy and messages the participants would like to pass on to others. In an attempt to have the postal questionnaire be and appear 'manageable' it was formatted as one folded sheet with one page of instructions and definitions and three pages of questions. The more difficult questions (child sexual abuse experiences) were deliberately placed on the inside of the booklet. This design left the back of the questionnaire (that was exposed when turned over) with less emotionally difficult questions (payment issues and messages).

To remind participants that the study was about their therapy experiences *and* their CSA experiences, the title "Experiences of Therapy and Childhood Sexual Abuse" was chosen. On the initial page there was a reminder that there was no requirement for the participant to complete all questions and that any information identifying any person would be removed. The initial page also included the aim of the study 'to evaluate therapy'; and a definition of the type of therapy this study focused on – 'one-on-one, talk therapy with a therapist face-to-face' rather than group therapy, body therapy, or telephone counselling.
Inside the booklet the following five sections were included:

Section 1) Demographics

This section included questions about age, ethnicity, education and income (based on the 1996 New Zealand Census form).

Section 2) Experiences of therapy

This section was the main focus of the study and contained the largest number of questions (14). The first was designed to locate the participant at the beginning of their 'therapy journey' by asking "what first led you to see a therapist for the effects of CSA". The wording "for the effects of CSA" was designed to allow survivors of CSA determine what they considered were effects of CSA. Many may have seen therapists for effects of CSA (such as depression, drug and alcohol dependence and relationship and parenting difficulties) but may not have connected these 'effects' to their CSA histories until they had the benefit of hindsight. (See Chapter Eight for further discussion). Other questions asked them to rate (on a Likert scale 1-7) 'How did you feel prior to the first time you had therapy for the effects of CSA', 'How did you feel at the end of all therapy for the effects of CSA' and 'Please indicate how you feel now in general'.

Participants were then asked to rate, overall, how therapy impacted on their ability to deal with CSA. To avoid the positive bias of the client evaluation studies described in Chapter Two, equal opportunity was given to respond positively and negatively. For this present study the scale used was: 1) Very helpful; 2) Somewhat helpful; 3) Made no difference; 4) Somewhat unhelpful; 5) Very unhelpful. Participants were also asked to rate each therapist they saw on the same rating scale.

Respondents were also given a small amount of space to answer three key open-ended questions about what they found helpful and unhelpful in therapy and what they thought was missing from therapy. Participants were asked about the numbers of therapy sessions they had, and what were the main reasons therapy ended.

Section 3) Child abuse experiences, disclosure and support

Child sexual abuse experiences: In the pilot study one of the five women did not wish to answer any questions about her child abuse experiences. To avoid putting participants off completing the whole questionnaire by including too many questions on the topic of CSA, only some of the key variables for assessing the severity of CSA were included. One variable included, for example, was their ages when the CSA began and ended. It was acknowledged that asking when the CSA began and ended would only give an approximate idea of the *duration* of CSA. It was anticipated that for some the CSA

would include multiple episodes of abuse, with the abuse stopping and starting within this age range and that sometimes multiple offenders might overlap in their abuse of the child.

Disclosure experiences: Only minimal questions were asked about disclosure experiences due to space considerations and because this question was only one of the variables that was related to effects of CSA.

Section 4) Payment for therapy

The usefulness of questions about payment of therapy was confirmed through the pilot study. Cost was reported as an obstacle to participants being able to access on-going therapy. Cost also affected the participants' choice of therapists and sometimes was an issue related to dissatisfaction with therapy.

Section 5) Messages

One of the main aims of this study was to gather the advice clients wanted to pass on to others. This section asked what advice participants wanted to give to other survivors, therapists, and funders.

Final comments/Questions sheet

Dale (1999) was concerned his group of self-selected participants could represent an 'elite' group of clients who were articulate and well educated therefore he asked his participants why they wanted to contribute to the study. To address a similar question a final comments sheet was added that asked respondents about for their main reason for participating (Appendix 4).

Procedures

Pilot of Questionnaire

The postal questionnaire was piloted by having three colleagues who fitted the study criteria complete the questionnaire. The pilot was undertaken to evaluate: the order of the questions; their comprehensibility; the length of time required to complete the questions and; the level of emotional responses elicited by the questions. Results from the three pilot interviews suggested that the postal questionnaire was understandable and not overly emotionally taxing.

Advertising

Finding women survivors of CSA who were not currently in a therapy relationship necessitated advertising to the general public. To reach potential participants a national media campaign was planned. Several months before the launch of the study, 2000 brochures; 3000 flyers; 300 postal questionnaires; 20 semi-structured interview schedules; 300 consent forms for postal questionnaire; 20 consent forms for interviews; and 300 participant information forms, were developed and printed.

In January 2001 an embargoed press release (Appendix 5) about the study was sent out to twenty media contacts. A week after sending the press release, I phoned each media contact to check they had sufficient information. Advance interviews were given to local newspapers and radio stations (these interviews were embargoed until the launch date). A number of newsletters including the ACC newsletter and the Auckland Women's Health Council Newsletter publicized the launch of the study and one agency (the Auckland's Women Centre) advertized the study on their web-site.

Implementation of Postal Questionnaire

On the day of the launch of the study I gave one live national TV interview to "Breakfast TV" – a morning news and issues programme. (A few weeks later, the Producer of another TV show "Good Morning" – a mid-morning show known to attract a large female audience – heard about the "Breakfast TV" interview and invited me to give a second live TV interview). On the day of the launch various radio stations carried the release of the study from 6am and repeated the information almost hourly through most of the day. Several local newspapers including Aotearoa/New Zealand's most widely read paper 'The New Zealand Herald', carried information about the study.

There were 25 phone messages within 20 minutes of the first TV interview. At the end of the first day there had been 50 phone calls about the study and at the end of the first week there had been a total of 120 phone calls. After two weeks 150 postal questionnaires had been sent out and the first 50 had been returned. Postal questionnaires were not sent when the criteria were not fulfilled – such as when the callers: 1) were male; 2) were female but the rapes they experienced were over the age of 16 years (therefore were not classified as CSA); 3) had not had any therapy following the CSA; or 4) were in therapy at the time.

Most potential participant/callers responded with enthusiasm towards the study. They were pleased the study was being implemented and wanted to tell their story. Some required more information before deciding whether to take part. One woman reported that when she saw me interviewed on the first TV programme she was undecided about whether to participate in the study. After seeing me on the second TV programme however, she decided that I seemed sufficiently trustworthy for her to participate. Several other participants commented that they carried the advert about the study with them for months before making their decision to participate. One woman rang me 18 months after she had read about the study in the paper. She had finally decided to participate but unfortunately the study was closed.

Each participant who met the criteria was posted six items: 1) a covering letter; 2) a brochure; 3) a consent form; 4) a questionnaire; 5) a final comments/questions sheet and 6) a return stamped addressed envelope.

The time between January – May 2001 involved responding to over 300 initial phone calls, 30 emails and 32 letters, and the co-ordination of 232 questionnaires being sent out. If the questionnaire was not returned, a follow-up reminder letter was sent three or four weeks later. In total 88 reminders were sent. If there was no response to the reminder, a follow-up phone call was made two or three weeks later. Fourteen participants requested a second questionnaire because they had lost the first, of these nine returned the second questionnaire.

Of the 232 questionnaires sent out, 41 were not returned. In 17 cases contact was lost (the phone was disconnected or there was only an address and the phone number could not be located). Twelve people promised to return the questionnaire at each follow-up phone call, but did not. Four said they were struggling emotionally with the questionnaire and would try to send it in but did not. Three excluded themselves (one had not had any therapy, one was not sure if she had been abused or not, and one was a hypnotherapist who just wanted a copy of the questionnaire). One participant chose not to return the questionnaire because it had a code number on it and the participant did not feel that her confidentiality would be kept safe. Another chose not to participate because the questionnaire included a question about income. Two others were unable to complete the questionnaire for physical reasons. One person said she would prefer to

send a letter instead. I was requested to visit one woman aged in her sixties to fill in her questionnaire as she dictated. Of the 232 questionnaires that were posted out, 191 were returned (a return rate of 82.3%). In addition to the questionnaires, the study attracted a number of moving letters sometimes from people who did not fulfil the criteria for the study but wanted their voices to be heard by the researcher at least.

Data Analysis

Analysis of Quantitative Data

All quantitative data were entered into EpiInfo version 6 and then analysed using SAS version 8.0. Associations between categorical variables were analysed using chi-squares. Due to small numbers in some categories for some variables it was necessary to collapse the number of categories for analysis purposes. Non-parametric methods were used to test for differences between means, as none of the data met the assumptions for parametric analysis. The Kruskal-Wallis test was used for these analyses. Corrrelations between continuous dimensional variables were tested using Spearman's rank-order correlations option. Results were considered significant at the 5% level of significance.

Analysis of Qualitative Data

> Qualitative inquiry is particularly oriented toward exploration, discovery, and inductive logic. Inductive analysis begins with specific observations and builds towards general patterns (Patton, 2002, pp 55-56).

An inductive approach was used to analyse the qualitative data within the questionnaire. Immersion into the details and specifics of the data assisted the exploration of emergent patterns, themes and interrelationships (Patton, 2002). There was an acknowledgement that any findings would be located within a specific social, cultural and historical context and would not necessarily be generalisable across time and space.

Description of open and axial coding methodology

Coding the eight open ended questions (such as 'what first led you to see a therapist for the effects of CSA') was a highly time consuming task, as each question generated many hundreds of units of meanings. Developing categories from the five semi-open ended questions (for example 'who was the offender') was much less time consuming.

Open and axial coding processes used by grounded theorists were used to develop categories for all open-ended questions in the postal questionnaire. Open coding analysis followed processes described by Strauss and Corbin (1990):

> During open coding the data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena as reflected in the data (p.62).

Each "discrete" unit of meaning is examined and placed into a category with a label (Strauss & Corbin, 1990, p. 63). A category is developed by comparing concepts against each other and grouping together those that appear to present a similar phenomenon (Strauss & Corbin, 1990).

Axial coding is a set of procedures used by grounded theorists to describe how: "data are put back together in new ways after open coding, by making connections between the categories" (Strauss & Corbin, 1990, p. 96). The lines between open coding and axial coding are blurred however. The different types of coding do not necessarily take place in stages. In a single coding session the analyst may move between one form of coding and another.

Responses to the open ended questions were transcribed verbatim and the study number was included next to each response. Responses were coded into specific categories, and the frequencies were calculated and data analysed using the statistical package EpiInfo6.

Open coding – process of developing categories: The researcher began with close, multiple readings of the verbatim text. Some participants gave one or two word answers and some gave paragraphs that contained multiple meanings. Each participant response was read for the meanings within the response. Text segments that contained a unit of meaning were identified by the researcher and given a category label. Text segments with similar meanings were allocated to the same category with the same label. By this method, categories emerged and were developed from the data. Through this process, each category developed a description of meaning based on the text units allocated to that category – the description served to set out the scope and the limitation of the

category. The constant comparative method (Glaser & Strauss, 1967) was used to revise and refine the categories.

- *Example of coding and categorizing processes:* The first open-ended question, in the questionnaire (Qn 5) was "What first led you to see a therapist for the effects of childhood sexual abuse?" Rather than count the number of participants who answered this question, the number of text segments (units of meaning) were counted. Three hundred and fifteen text segments emerged from multiple readings of the responses to Qn 5. These 315 text segments (meanings) were grouped into 22 categories. The following examples describe how two participants' (A & B) responses to Qn 5 were categorized, coded and counted. The first three of the 22 categories developed from multiple text segments were: 1) Depression; 2) Symptoms of PTSD; 3) Suicidality. To the question "What first led you to see a therapist for the effects of childhood sexual abuse?" Participant A gave a two-word answer *"Suicide attempt"*. This response was assigned to the category labelled 'Suicidality' (the category 'Suicidality' had a code number 3) and was entered into EpiInfo6 as one text unit in code number 3.

  Participant B gave the response: *"My partner took me because he felt that the effects of my CSA were affecting our relationship."* This response was considered to contain two different meaning units and therefore was counted as two units of meaning, and was assigned two different code numbers that related to two different categories. The first text segment of meaning *"my partner took me"* fitted into the category "Referred by family" (code number 15). The second text unit of meaning was determined to be: *"because he felt that the effects of my CSA were affecting our relationship"* – this text segment was considered to fit into the category "Relationship difficulties" (code number 5). Thus these two text unit meanings were counted as two units of the total 315 text units that emerged from Qn 5.

- *Axial coding:* The 22 categories that emerged from Qn 5 were later reduced to 15 categories, with some of the smaller categories being merged with similar allied categories. For example, three of the 22 different categories that emerged from the text units in Qn 5 were labelled 'Depression', 'Breakdown' (this term was derived from several text units), and 'Suicidality'. However it became difficult to fit some

text units neatly into only one of these categories. These three categories appeared to be on a continuum of despair. The boundaries between each of these categories seemed to be blurred, and a more meaningful category (that reflected the meaning from the data) seemed to be a merger of these three categories. The amalgamated category retained the 'feel' of the continuum of despair by merging the three labels into one: 'Depression/Breakdown/Suicidality'.

The main focus of this study were responses to the open-ended questions Qn 12 (what was helpful in therapy), and Qn 13 (what was unhelpful in therapy), and to a lesser extent Qn 14 (what was missing from therapy). As a consistency check the researcher re-coded all of the data (over a thousand text units) from questions 12, 13 and 14 to check for any 'procedural errors' (Thomas, 2000). This meant that I took a 'clean' print-out of a) the verbatim text of responses to questions 12, 13 and 14, and b) the list of category labels that had been developed and went through the entire verbatim text placing code numbers for the categories beside each text unit. I then compared my first coding categorisations with my second coding categorisations. Where there was not a match between the first and second categorisations, I reviewed the text units allocation and/or the category headings and descriptions. Necessary amendments were made to improve the match before giving these categories to others for a reliability check.

Inter-rater reliability tests

Before entering the code numbers into EpiInfo 6, an inter-rater reliability test was conducted using two different raters (see Table 8). Each rater (one male (Rater 2), one female (Rater 3), both with lengthy counselling experience) was given a 'clean' (no code numbers written on the sheet) verbatim list of participant responses to the open-ended question. The raters were also given a list of the labelled categories (with the code number beside each labelled category) that had been developed from participant responses to the open-ended questions. Each rater was asked to place the category code number(s) that they considered best fitted the participant response. The researcher then compared the category code numbers each rater had given each participant response, with the category code numbers the researcher had given.

Table 8. Inter-Rater Reliability Scores For Questions 12, 13 and 14

Question 12	Rater 2	90%	Rater 3	89%
Question 13	Rater 2	83%	Rater 3	81%
Question 14	Rater 2	88%	Rater 3	91%

The formula used for reliability estimates was agreements divided by agreements plus disagreements x 100/1. Differences in ratings (code numbers assigned to the participant response) were discussed. Agreement was reached by:

- collapsing redundant categories
- discussion of the meaning of the text unit and an alteration to the code allocation
- eliminating coding errors (for example, raters had accidentally written down an incorrect code number instead of the code number that they had intended to record).

Triangulation and consistency checks to improve content and clinical validity

All of the coded text units from all open-ended questions in the postal questionnaire were entered into EpiInfo 6. The frequencies and categories from question twelve (what clients found helpful in therapy) were written into a chapter for this thesis and were also presented to an Australasian Society for the Study of Traumatic Stress Conference (as preliminary findings). Around this time one of my supervisors considered that: a) some of the category labels did not fit the data sufficiently well to easily convey the meaning of the categories to clinicians and; b) some category descriptions would not be easily recognisable and applicable by clinicians from a wide range of disciplines.

The lack of clarity when assigning category headings (that could be understood by a variety of clinicians) may have come about because I had not been able to sufficiently ‘bracket-off’ my everyday clinical knowledge and instead may have imposed my clinical assumptions on the category labels. Having raters from a similar clinical background as myself (counselling) meant that they were also viewing the material from a similar perspective. Having a fresh pair of eyes from a different perspective assisted in triangulating the data.

The approximately one thousand text units in question 12 and 13 were re-categorized and re-labelled (process described below) using the software package NVivo. The revised categoriees were re-submitted to the supervisor to check for improved content and clinical validity. This process was repeated a number of times with the supervisor giving suggestions to improve the fit between the category label and the text units within the category. Throughout this process the supervisor regularly carried out an inter-rater check by testing the fit between the text unit and the category allocation. After re-coding these two main questions, there was sufficient agreement between myself, and all three supervisors about the 'fit' between the text units and the labels and categories. The final categorisation of the data had many similar categories to the first version. The final version had increased in content and clinical validity and had been improved by applying the supervisor's critical perspective.

Example of coding using NVivo – Similar to the open-coding procedure, described earlier, text segments that were sufficiently different were placed into different categories. Qn 12 'what was helpful in therapy' asked participants for up to three points: One participant responded:

Point One: "*Therapist offered a safe place to talk"*

Point Two:"*I got an hour of quality time. To be heard."*

Point Three: "*Someone I could turn to"*.

These three points were categorized into four units of meanings and categorized into three different categories (two meanings fitted into the same category).

Coding decisions

Point One was deemed to have two units of meaning: for example:

- the first part of Point One: "Therapist offered a *safe place* – fitted into the category "Rapport and Safety"
- the second part of Point One "to *talk*" was categorized as "Talking and Listening"

Point Two: "*I got an hour of quality time. To be heard*" was also placed in the category of "Talking and Listening".

Point Three: "*Someone I could turn to*" was placed in the category of "Care and Support".

An example of text uncategorized: Some text was not categorized at all. For example, to the question 'what was helpful in therapy' one response was: *"I am a survivor of CSA"*. Because such a response did not include a description of what was helpful in therapy, this text unit was not placed in a category.

Section Three – Interviews

Sample

The sub-sample of 20 participants who took part in face-to-face interviews ranged in age from 26 –57 years (mean age 40.5 years). Thirteen reported they were New Zealand Europeans, six were Maori, and one was a Pacific person.

Selection of sub-sample of interviewees: Criteria sampling was used in the selection of interviewees. Although the selection process was designed to gather a sub-sample that was similar to the overall sample, the selection process was also designed to ensure diversity of experiences (especially to ensure the inclusion of Maori and Pacific people and participants who had negative therapy experiences). The selection process was carried out at two points (one month apart) during the receipt of questionnaires. The first sample of 12 was selected using the following criteria. An initial pool was created by including all participants who: a) answered "Yes" to the question *"If you live in the Auckland area would you be willing to take part in a face-to-face interview to discuss more fully what you found helpful and unhelpful in therapy?"*; b) reported themselves to be Maori or Pacific people; and c) whose therapy ended after 1990.

Those selected into this pool of potential interviewees using criteria a), b) and c) were then divided into three groups. The groups were based on those who answered (in the postal questionnaire) that overall therapy was: 1) Very helpful (n=18); 2) Somewhat helpful (n=10); and 3) the three ratings 'Made no difference', 'Somewhat unhelpful' and 'Very unhelpful' (these three were combined together because there were so few within each group), (n=5). Four interviewees were selected from each of these three groups. Further criteria were used to sample for diversity within Group One and Two because these were the largest of the three groups. All those in Groups One and Two who rated any therapist *individually* (in Qn 17) as 'Somewhat unhelpful' or 'Very unhelpful' were selected into the potential pool of interviewees. Other criteria considered in the selection of potential interviewees were: a range of numbers of

therapists seen (high/low); a range of therapy hours (high/low); a range of CSA severity levels; and a range of participant ages.

A month later when the first twelve interviews were completed and a selection of transcripts had been reviewed by my thesis supervisors, and Dr Dalenberg (who was visiting Aotearoa/New Zealand at the time), a similar (but slightly modified) set of criteria were used to select the final eight interviewees. The first twelve interviews were assessed as having been slightly over-sampled from those with negative therapy ratings of individual therapists (in Qn 17). The second selection criterion was adjusted to focus less on those with a number of negative therapy ratings of individual therapists (in Qn 17). (For final selection see Table 9).

Table 9. Profile Of Interview Sub-sample

Overall therapy rating	Age	Ethnicity	CSA severity	Number of therapists	Therapy hours
1	43	NZ	Genital contact/threats	1	11-20
1	47	NZ	Penetration	2	51-100
1	53	NZ	Penetration	3	21-50
1	36	NZ/Maori	Penetration	3	51-100
1	41	NZ	Penetration	4	51-100
1	54	NZ European	Penetration	4	301-400
1	34	NZ	Penetration	4	401-500
1	28	NZ/Maori	Penetration	7	401-500
2	30	Maori	Penetration	3	101-200
2	42	NZ/Maori	Non genital contact/ violent assaults and threats	4	51-100
2	29	NZ/Maori	Penetration	5	101-200
2	37	NZ	Genital contact	6	51-100
2	38	Samoan	Penetration	15	51-100
2	56	NZ	Genital contact/ emotional blackmail	21	501+
3	39	NZ	Genital contact/verbal	3	51-100
3	36	NZ	Penetration/dirty talk	4	21-50
3	35	NZ	Penetration	9	51-100
4	57	NZ	Penetration	2	11-20
4	43	NZ	Genital contact	5	51-100
5	32	NZ/Maori	-	7	101-200

To test the representativeness of the interviewed sample in relation to the larger sample statistical tests were employed on several key variables. The Fishers Exact Test was used to compare the distributions of the categorical variables, and the Kruskal-Wallis Test was used to compare the medians of the numerical variables. Variables compared on their medians included: age; the participants' Emotional Well-being (EWB) ratings before therapy; their EWB after therapy; their EWB ratings at the time of the study; their overall ratings of therapy; the number of therapists they saw; if the number of therapy sessions covered by ACC was adequate; and how much they paid for their therapy. Variables compared on their distribution included: ethnicity; the participants' EWB ratings before therapy; their EWB ratings after therapy; their EWB ratings at the time of the study; the severity of the CSA; whether they experienced other forms of child abuse; whether they had any contact with mental health services; how their therapy was paid for and whether they were ever unable to have therapy due to cost. The only significant differences found were that the participants in the Interview sub-sample had seen more therapists (mean = 5.35) than those in the whole sample (mean =3.36). (Wilcoxon Two Sample Test $p<0.01$).

Data Gathering

Design/rationale of semi-structured interview schedule

The semi-structured interview format was designed to allow the interview to follow the participant's particular experiences (Patton, 2002). Dale (1999) discussed how structured interviews run the risk of leaving the participant feeling as though they had the research 'done to them'. In semi-structured interviews participants are less likely to feel exploited and manipulated by the researcher because each interview is uniquely paced, focused and can be a collaborate venture. The participant can feel as though they have given a personal contribution.

The semi-structured interview (Appendix 6) was designed to focus on helpful and unhelpful therapy experiences. Similar to Dale's (1999) face-to-face interviews, the interview was to start with a 'grand-tour' question asking the participant to describe their initial process of finding or being referred to a therapist for the effects of CSA. Questions then addressed the helpful and unhelpful aspects of each therapy experience. There was a range of prompts in the semi-structured interview schedule, some of which were based on a partial replication of Dr Dalenberg's (2000) questions and personal

communications with Dr Dalenberg during the design phase. These questions were to prompt participants who had difficulty describing specific helpful or unhelpful aspects of therapy. Questions included: trust building (what helped or did not help); whether they felt the therapist was over or under-involved; and the therapist's approach (warm/cold). The interview schedule ended by asking consolidating and/or empowering questions such as about their strengths and learnings.

Planned safety for participants

When contacted, participants who agreed to a follow-up interview were to be given a choice of venues – the University, the Auckland Women's Centre or their home. Participants were informed that the face-to-face interview would not focus on questions surrounding their CSA or disclosure experiences.

At the beginning of the interview, participants were to be reminded that they: did not have to answer any question put to them; could ask for a break in the interview at any time; and could end the interview at any time. After the interview participants were left with another brochure so that they had counselling phone numbers at hand should they need support.

Planned safety for the researcher

Before going to interview in a participant's home there was an attempt to establish who would be present and if any offender was likely to be present. A cell phone was to be taken to every interview. As the only interviewer I estimated how long I was to be out of the office for each interview and was to ring the office to confirm when each interview was over.

Procedures

Pilot of interview schedule

Two colleagues who had participated in the pilot of the postal questionnaire agreed to participate in the pilot of a brief version of the semi-structured interview schedule. Responses from the pilot participants confirmed that the flow of questions was understandable and the content was not too emotionally taxing.

Conducting the interviews

The 20 interviews were conducted between February – April 2001. Fifteen were conducted in the women's homes, two at the University and three at the Women's Centre. Each interview lasted between one and two hours.

The semi-structured interview began with the 'grand-tour' question of asking how they first found a therapist (Dale, 1999). Then each participant was encouraged to describe, their helpful and unhelpful experiences with each therapist they encountered. My role was to clarify, explore and probe the participant's therapy experiences. For example, when a participant mentioned a particularly unhelpful aspect of therapy, I would ask "what would you have preferred the therapist to do instead?".

In some cases, a disclosure from a participant appeared to leave them feeling embarrassed or isolated. For example one woman looked embarrassed after describing the way she was "dumped" by a number of therapists. Each therapist had told her that there was nothing more they could do for her or that she was "all right" and did not need further therapy (even though she knew she was suffering from a wide range of effects following CSA). I was able to tell her that: "A number of other participants had described similar experiences of therapists ending therapy before completing the therapy work". The effect of normalizing her 'unhelpful' therapy experiences seemed to provide her with significant relief and had the effect of allowing her to move on to expand on the circumstances surrounding each therapist's lack of knowledge of the effects of CSA and how to help her.

Before each interview ended I reviewed the list of questions, to ensure most of the areas of questions about therapy and the therapeutic relationship had been covered.

Emotional well-being of interviewee

On the phone before the interview, each woman was encouraged to pre-arrange her time after the interview so that she had adequate support to process whatever feelings or memories the interview left her with. Several women cried during the interviews and several expressed anger and frustration, often in response to remembering particularly difficult times when they did not have access to adequate therapy and other supports. One of the final questions of the interview was how their life was *now*, compared with

what it was like *before* seeking therapy. This question was designed to assist the participants to re-connect them to their strengths, and focus on how much they had achieved. Even those who had mostly negative experiences of therapy were able to report some strengths or learnings they had achieved. Before leaving, I left each participant with a plain sheet of paper with the heading "After thoughts" and a stamped, addressed envelope so that they could write to me if there was anything they had forgotten, or they wanted to say about the interview. (Three women sent "After thoughts" to me). Each interview participant was sent a "Thank you" card.

Interviewer wellbeing

Dale (1999) commented on the exhausting nature of the interviewing process, with the interviewer having to concentrate for up to two hours on at least nine levels simultaneously. The interviewer had to: develop rapport; understand what was being said and not said; reflect on significant content and developing analysis; consider interview technique options such as which issue to probe; explore unusual cases; monitor and help to regulate the participants' emotional well-being; be alert to the psychodynamics of the interview; keep an eye on the time and; worry about the microphone working. In addition, I felt the need to take care before, during and after the interview, to avoid adding to a list of people and professionals who had let a number of the participants down in some way. Furthermore, it was emotionally taxing hearing 25 (including the pilot study) participants' accounts of abuse, betrayal in childhood as well as about some experiences of being let down by mental health professionals. After some interviews I was left feeling sad and angry at the inadequacy of some mental health services. I was careful to deal with my reactions in supervision rather than express them in the interview.

Interviewer safety issues

There was only one interview where there was a slight risk of some sort of violence occurring during the interview. One participant told me that a man who had raped her was still stalking her. A male friend[1] of hers (who was recently out of prison) regularly called to check she was all right and to try to catch the rapist/stalker. Although her male friend was due to call while I was conducting the interview, he did not.

[1] Relationship altered to reduce the chance of recognition.

Data Analysis

Role of the researcher

> …analysts have an obligation to monitor and report their own analytical procedures and processes as fully and truthfully as possible (Patton, 2002, p. 434).

All research is value laden (Du Bois, 1983). In qualitative research in particular the effect of the researcher is central to the research process. Similar to Dale (1996), as a therapist-researcher I would acknowledge the advantage of having been trained in a therapeutic milieu that was predominantly person-centred in focus and philosophy. Such training was valuable in the research context because of the potential to promote rapport and trust between researcher and participant. Due to my clinical background I was able to import into the research context attributes of: empathy; acceptance; equality; ability to listen; respect; and congruence.

While having a therapist's background had its advantages in a research context, there were also potential disadvantages. In particular, Dale (1996) warned that although prior theoretical knowledge and clinical experience can be helpful to sensitize the researcher to the participants' experiences, meanings and themes; they can also:

> act as a blinker whereby such phenomena become more likely to be elicited and interpreted in accordance with the therapist-researcher's existing 'world-view' (p. 81).

For this reason researcher reflexivity was particularly important. As the qualitative analyst, my aim was to be aware of my own perspective and to be as self-analytical, and reflexive as possible, in an attempt to provide a credible, authentic and trustworthy analysis (Patton, 2002). Training as a therapist assisted me to be self-aware, self-reflective and to constantly check-in at a meta-level during interviews with participants. Meta-level awareness of transference and counter-transference processes can be helpful to monitor the interactions within an interview. One of the objectives of the study was to gain a deep empathetic understanding (Verstehen) of the perceptions of the participants (Miles & Huberman, 1994). Therefore it was important that throughout the interviews I made a conscious attempt to 'bracket-off' (suspend) my preconceptions of my views of 'helpful' and 'unhelpful' therapy processes when necessary and consciously focus on listening to, following and exploring what the participants described as helpful and unhelpful. For example, I was forced to bracket-off my

preconceptions when a participant's view of therapy were the opposite of the abuse-focused therapy guidelines, my therapy experiences, or the views of the majority of the participants in the study. An example of my need to bracket-off these preconceptions was when one participant said that although she did not feel that her therapist was warm towards her, she cared about her or liked her, she did not believe that these aspects were necessary in a therapy relationship.

Analysis of interview data

The interviews were transcribed. In addition to being present in each interview, I listened to each tape (approximately 40 hours of interviews) twice before beginning to analyse the 693 pages of transcripts. Each transcript was also read at least twice before conducting a thematic analysis with the assistance of the software data management tool NVivo. Themes were developed and revised in a similar way to the open and axial coding processes described in Section Two.

Finally, three women's stories (Chapter Nine) were selected to help illustrate examples of helpful, unhelpful and mixed therapy experiences. Analysis of the Case Studies followed several of Emden's (1998) guidelines to creating a core story including: reading the full interview text several times; deleting all interviewer questions and comments; deleting all words that detract from the key idea of each sentence; reading the remaining texts; and moving fragments of themes together to create one coherent core story. In contrast to Emden's core stories, which were a quarter of the length of the full-length stories, the three women's stories were, (due to spatial constraints) only ten percent of the full-length stories.

Tests of validity

Audit-trail – for a critical evaluation

In much quantitative research, design and testing criteria are established before data collection commences. Testing validity in qualitative data is different. Because it would be very difficult to replicate most qualitative studies exactly, validity in qualitative research is achieved by providing detail of the way the research was developed and conducted, so that decisions made during the research process can be critically examined. For this reason, descriptions in this Chapter are intended to provide what Lincoln and Guba (1985) described as an "audit trail". Validity of qualitative research is

based on credibility of the description, analysis and theoretical discussion to establish if the research is trustworthy (Lincoln & Guba, 1985).

Triangulation

One of the aims of triangulation is to "find agreement" about "core meanings or themes" (McLeod, 1994, p. 91). A task of triangulation is to find which meanings are most valid, accurate or important by sifting through meanings and looking for convergences between the data produced, (from a diverse number of methods, sources, or investigators), to check the validity of a conclusion. Dale (1999) and Miles and Huberman (1994) have commented however, that with qualitative data, the way one person approaches the data and attempts to make sense of it is not the only way to analyse the data. Other researchers approaching this same data set may have analysed these data in a different way. Despite the openness to interpretation however, McLeod (1994) states that it is possible to make judgements about the adequacy of any interpretation. Triangulation, in this study, was achieved in several different ways:

a) *Within methods*: comparing findings from different methods of data collection within the sample: such as from questionnaires and interviews; by comparing the pilot study to the main study; by adopting a pluralist approach of using both qualitative and quantitative methods; by using inter-rater reliability and consistency checks on categories developed from open-ended questions; and from comparing findings within each interview.

b) *Theoretical reflection on the data* – my supervisors provided different theoretical perspectives and consistency checks to this research process, as did my peers (from their comments each time I presented pilot or preliminary findings to them). Furthermore, given my own multiple roles and experiences, I could also view the data from a number of different perspectives, not only as a researcher but also as a clinician, consumer advocate, and an ex-client.

Participant validation

One form of triangulation, 'testimonial validity' (Stiles, 1993) (sending the transcript back to the participant to check for accuracy – a validity check I used in the first consultation process) was considered for use with interviewees. The negative aspects of this process for the participant however were: a) taking up a lot of the participant's time; b) the interview transcript being a potentially unwelcome reminder of a subject that the

participant may have considered complete; c) the potential for others to read the transcript and d) the time-consuming nature of this process. These issues seemed to out-weigh the benefits of using this process. A second form of participant validation was used instead. Similar to Dale (1999) I was able to explore, with each interviewee, similar and different issues raised in previous interviews, as well as in the literature and in the questionnaires. This process provided a constant opportunity to check respondent validation, and to explore negative cases and exceptional cases. An example of this was when an interviewee stated that it was unhelpful in therapy when her therapist had avoided the topic of CSA. One or two previous interviewees had complained that they had the opposite experience – the therapist would 'only' talk about the CSA. When I put this to the interviewee she stated that she had also had the opposite experience and this comparison enabled her to articulate an ideal that was somewhere in between the two extremes– where the therapist did not avoid but did not over-focus on the CSA.

Replication

To check for validity, this study included partial replication of Dale (1999) and Dalenberg's (2000) research questions – these findings will be compared in the Discussion chapter. Furthermore, to promote the ability for this present research study to be replicated, I have attempted to provide clear and comprehensive descriptions of the research procedures employed in this study.

Catalytic validity

This is achieved when participants gain something from the research (Stiles, 1993). As a criterion for judging qualitative research, this present research study appeared to achieve highly in catalytic validity based on: 1) the vast majority of participants in the postal questionnaire who were enthusiastic that this study was going ahead and made comments such as "at last someone is doing something" in this field; and 2) a number of interview participants who, often to their surprise, found the interview process beneficial. For example, similar to Dale's (1999) study several participants used the study to measure their progress and one interviewee commented that she was able to "detoxify" her negative experiences by participating in the interview.

Plausibility of the analysis

"Ultimately, the validity of qualitative research rests on transparent method and the plausibility of the analysis" (Dale, 1999, p 58). The aim of this research was not to

develop a new theory, but to give voice to a group that has been under-researched and that has often been unable to express their views. A key aim of this research was to provide an accurate description of the participants' experiences that would be useful to both clients and therapists. The plausibility of this research will continue to be tested as the findings of this study are disseminated.

Summary

Through an extensive consultation and piloting process a two-phased study was designed, given the support of a number of therapy agencies and launched using media advertising in the general public. An overwhelming response from women survivors of CSA resulted in: over 300 phone calls; the return of 191 postal questionnaires; and twenty in-depth interviews. The quantitative data were analysed using EpiInfo Version 6 and the qualitative data were analysed using both EpiInfo Version 6 and the soft-ware data management tool NVivo. Analyses of these data are described as fully as possible (within the realms of the spatial constraints of this thesis) to assist with validity concerns and the possibility of the study being replicated.

CHAPTER FOUR - CHILD SEXUAL ABUSE AND DISCLOSURE EXPERIENCES

This is the first of six chapters presenting the findings of the study. In this and the following three chapters, analysis and discussion of the postal questionnaire are presented. (Findings from the interview sub-sample are in Chapter Eight and Nine.) Section One of the current chapter presents the participants' experiences of child sexual. Section Two presents their experiences of disclosure. Section Three provides a summary of key points.

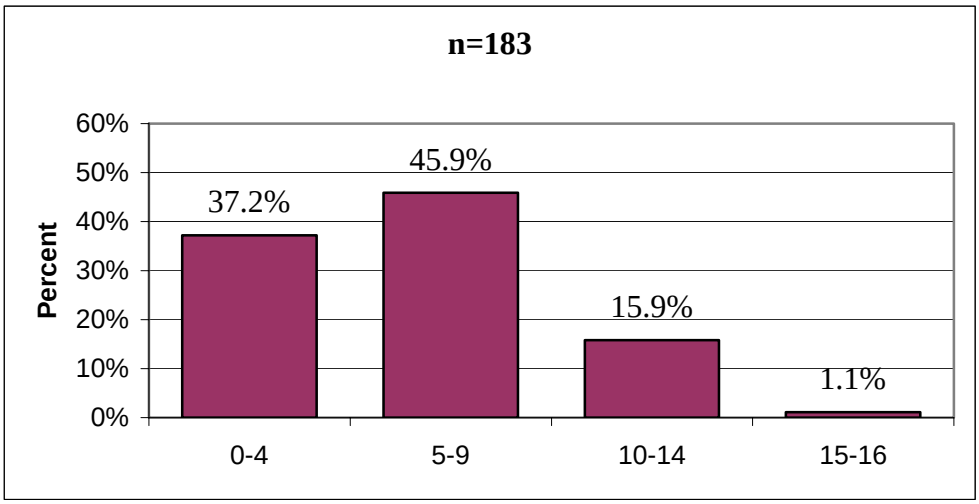
Section One– Child Sexual Abuse Experiences

This section includes: the age when the CSA began; the age when the CSA ended; the duration of the CSA; the number of offenders involved; the gender and relationship of the offender to the participant; the nature of the CSA experienced; and forms of child abuse the participants experienced other than CSA.

Age When The CSA Started

Figure 1 shows that for 84 participants (45.9%), the CSA began between the ages of five and nine. For 152 participants (83.1%), the CSA began before the age of 10. The mean age that CSA began was 6.3 years.

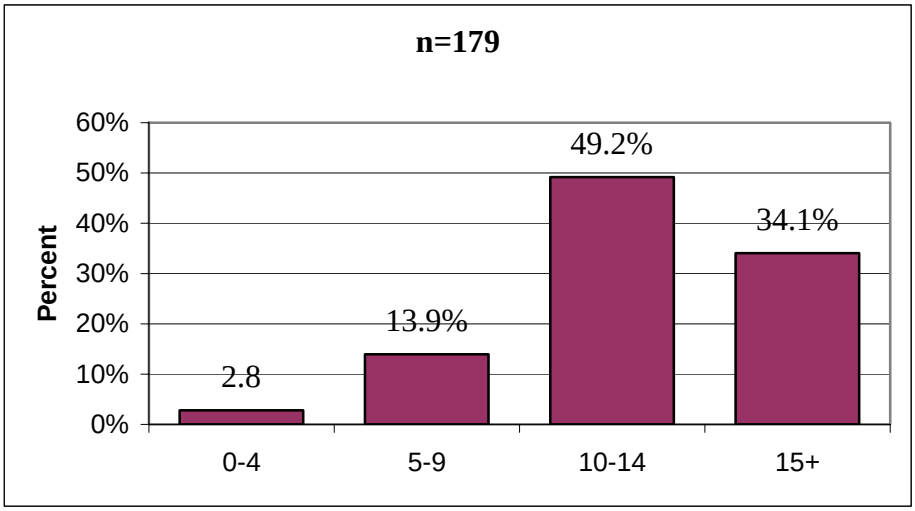
Figure 1. Age When CSA Started.



Age When The CSA Ended

Figure 2 shows that for 88 participants (49.2%) the CSA ended when they were between 10 and 14 years old. For one hundred and forty nine, (83.2%), of the participants the CSA had ended by age 16 years. By 18 years old the CSA had ended for one hundred and ninety one (95.5%) of the participants. The mean was 12.9 years old.

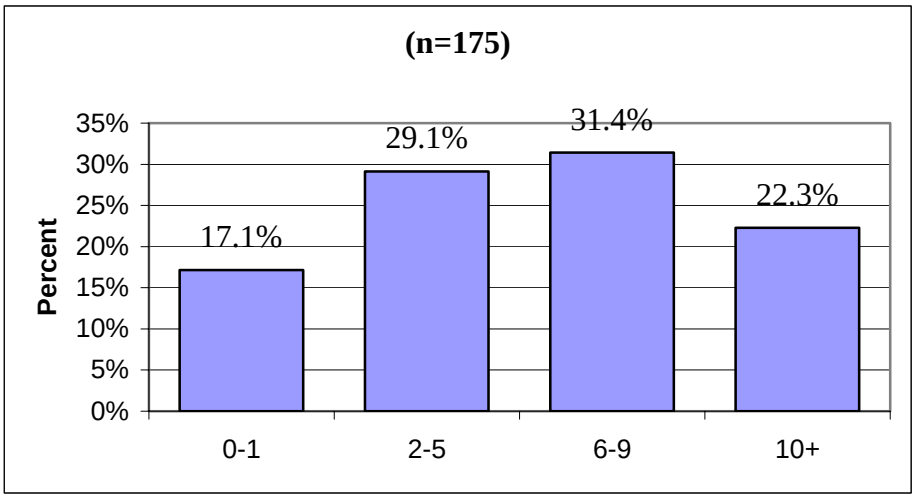
Figure 2. Age When CSA Ended.



Duration Of CSA

Figure 3 shows that for ninety-four participants (53.7%) the CSA continued for more than six years. On average the participants were sexually abused over a period of 6.1 years (range 0-15 years). More than one person could have abused them during this time. Furthermore, for participants who experienced CSA to the most severe level (attempted penetration or penetration) the duration of the CSA was longer (mean=6.7 years) than for those who experienced CSA to the level of genital contact only (mean=5.2 years) (Wilcoxon Rank Sum Test, 4900.5, $p<0.05$).

Figure 3. Duration Of The CSA



The Number Of Offenders Involved.

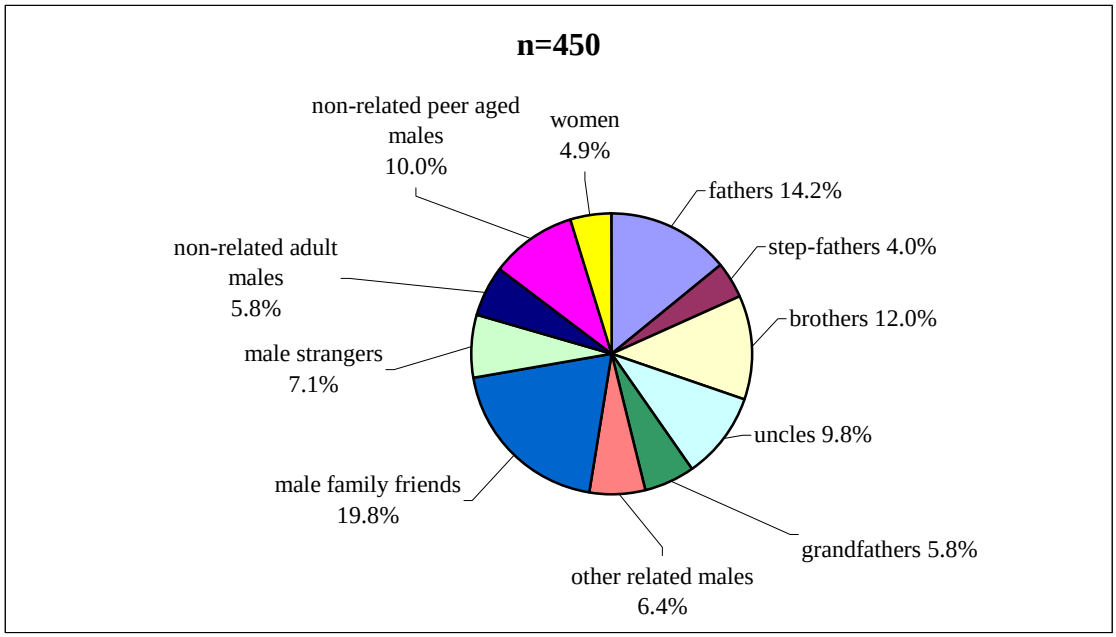
One hundred and ninety participants reported that they had been sexually abused by a total of 450 offenders. The number of offenders per participant ranged from one to ten, with the average being 2.4. Seventy-eight participants (41.1%) experienced CSA by a single offender. Fifty (26.3%) were sexually abused by two offenders. Twenty-six (13.7%) were sexually abused by three offenders. Sixteen (8.4%) were sexually abused by four offenders and twenty (10.5%) were sexually abused by between five and ten offenders.

The Gender and Relationship of the Offenders

Of the 450 offenders: 427 (94.9%) were male. (See Figure 4). (The gender and relationship of one offender was unknown).

The largest group of offenders, accounting for over half (52.2%) of the total number of offenders, was males who were related in some way to the participant. The group of related males (235) was made up of: 82 fathers (18.2%), including 64 biological fathers (14.2%) and 18 step-fathers or foster fathers (4.0%); 54 brothers (12.0%), including step-brothers and foster-brothers; 44 uncles (9.8%); and 29 other related males (6.4%) including brothers-in-law and cousins; and 26 grandfathers (5.8%).

Figure 4. Type Of Offenders



The group of one hundred and ninety two non-related males (42.7%) was made up of: 89 male friends of the family (19.8%), such as neighbours, mothers' friends and fathers' friends; 45 non-related peer aged males (10.0%), such as neighbourhood boys, brothers' friends, girlfriends' brothers and male students; 32 strangers (7.1%); and 26 non-related adult males (5.8%), including those who were not strangers or family friends but were mostly older males in positions of power over the child such as the school bus driver, teacher, priest, church minister, Guru, boarder, babysitter's husband, or swimming instructor.

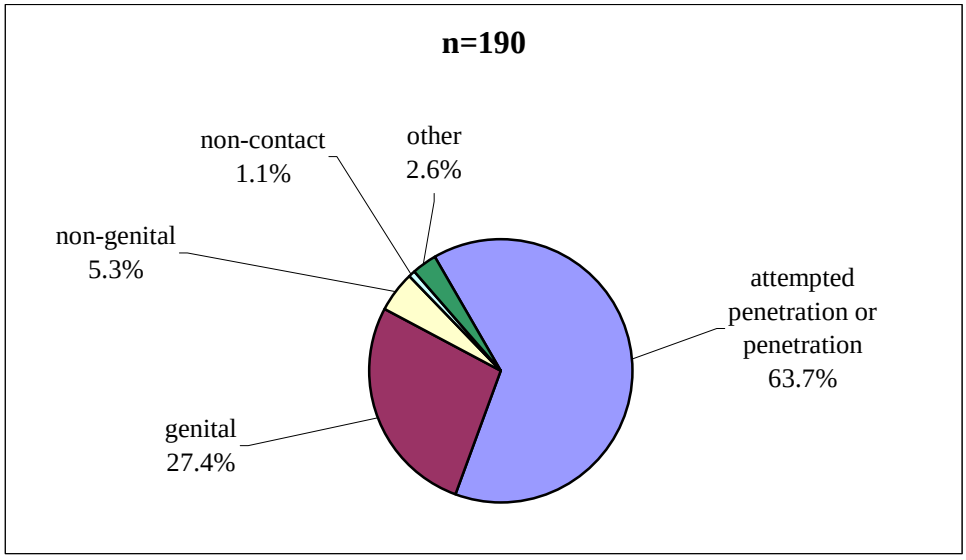
Of the total number of offenders (450), 22 (4.9%) were female offenders. The group of women offenders was made up of: three mothers (0.7%); three sisters (0.7%); and 16 'other females' (3.6%) including: female cousins; fathers' women friends; babysitters; and an older female child. None were strangers.

Nature of CSA Experienced

Most participants experienced several levels of CSA. Figure 5 portrays the frequencies of the most severe level experienced by each participant. When describing the nature of CSA, of the 190 participants, 91.1% experienced CSA to the level of genital contact (that included genital fondling or oral sex) or attempted or completed penetration.

Ten participants (5.3%) reported that their most severe CSA experience was to the level of non-genital contact (such as kissing or touching breasts). Two (1.1%) participants reported that their most severe experience of CSA was to the level of non-contact (such as peeking or flashing). Five (2.6%) reported that their most severe experience of CSA was to the level of 'other' types of CSA.

Figure 5. Most Severe Level Of CSA



Although only five participants reported 'other' types of CSA as the most severe level of CSA, a further 62 participants also reported 'other' types of CSA in addition to the different levels of their CSA experiences. Of the 67 participants, examples of 'other' types of CSA included: physical force (spanking); violent assaults; threats; gang rape; stalking; "filthy language"; "unpleasant sexual talk"; sodomy; being ejaculated upon; forced to assist with urination; pornography (photos taken during the CSA or forced to watch and take photos of others being sexually abused); blackmail; sadism and masochism practices; money given after rape; forced sex with an animal; and the CSA resulting in pregnancy and the offender performing an abortion.

Other Forms Of Child Abuse

Participants were asked to answer yes or no to the question: ‘In addition to CSA, did you experience any other type of abuse as a child’. If their answer was ‘Yes’ they were then asked to tick all boxes that applied: physical abuse; emotional/psychological abuse; neglect; or other (please specify).

One hundred and fifty participants (79.9%) reported that they experienced other forms of child abuse. One hundred and thirty four participants, (70.2%) reported emotional/psychological child abuse; 80 (41.9%) reported some form of physical child abuse; and 48 (25.1%) reported neglect. A further, twenty-one participants (11.0%) reported ‘other forms’ of child abuse. Of these, descriptions of ‘other forms’ of child abuse ranged from emotional abuse such as parents’ overly high expectations to attempted murder. Examples included:

- parents with high expectations - "emotional abuse from my mother for not performing as well as I knew I should and she expected me to”;
- manipulations to increase sibling rivalry and scapegoating;
- verbal abuse, sex-talk, and “sexism” within the family of origin;
- over-worked – such as "slavery" and "had to mother younger siblings";
- parents with unresolved issues – such as "mother child sexual abuse victim unresolved… split personality, behaviour, nice and nasty”;
- mind-games such as "he learned in the army control… he could get you at any time";
- being force to lie – such as “forced to lie that it was an accident not a rape”;
- threats, intimidation – such as "my father had a violent temper";
- witnessing violence in the family – such as "witnessing multiple beatings of mother and siblings";
- attempted murder - “attempts on my life eg attempted strangulation, drowning”.

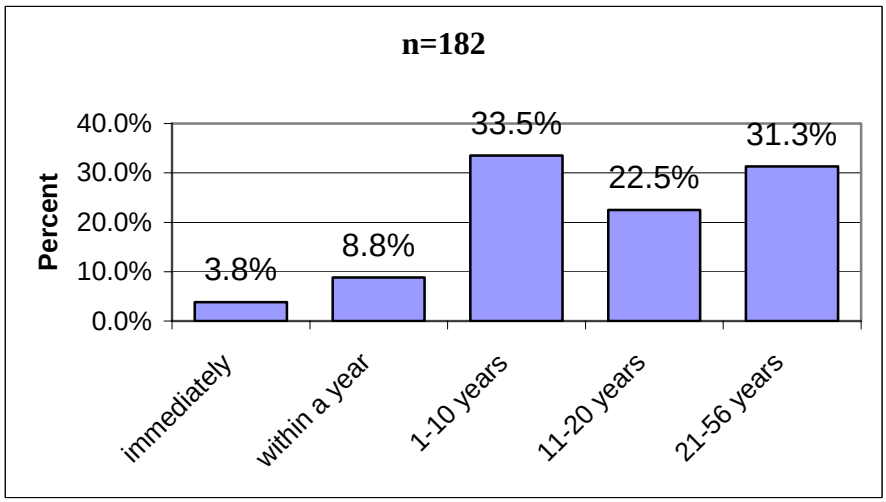
Section Two - Disclosure Experiences

This section includes findings of participants' experiences of disclosure such as the time it took them to disclose the CSA; who they told about the CSA; whether they were believed; what the people disclosed to did; whether they reported the CSA to any authorities and whether they were in contact with mental health services (MHS) prior to the therapy they had for CSA.

Time Taken To Disclose The CSA

Participants were asked how long after the first experience of CSA did they tell someone about the CSA (See Figure 6). The range was from immediately to 56 years. Only seven participants (3.8%) told about the CSA immediately and after a year only a total of 23 (12.6%) had told. More than half 53.8% took over ten years to tell and nearly a third (31.3%) took over twenty years. The average time was 16.3 years.

Figure 6. Time Taken Between CSA And Disclosure Of CSA



Who Was First Told About The CSA?

Of the 185 participants that answered the question about who they told first about their experience of CSA, some participants told more than one person. The 185 participants told 207 people. (Of those who told more than one person it is unclear whether they told them at the same time or at another time.) (See Table 10).

Table 10. Who Was First Told About The CSA?

People told about the CSA	No. of people told (n=207)	Percentage
Female family member	79	38.2
Friend	38	18.4
Counsellor/mental health profs	31	14.9
Partner/spouse	31	14.9
Male family member	10	4.8
Doctor/health professionals	8	3.9
Social worker and *other profs	7	3.4
Was discovered	3	1.5
Total	207	100

* Such as teachers and priests.

Of the 207 people told about the CSA, the largest group, seventy-nine (38.2%,) were female family members such as mothers, sisters, stepmothers, grandmothers, aunts or cousins. The second largest group told about the CSA was thirty-eight (18.4%) female and male friends (including childhood and adult friends, student friends, members of a group or flatmates).

The group of thirty-one counsellors (14.9%) told about the CSA included: school counsellors; therapists; mental health workers; or those in crisis teams. Three (1.5%) CSA experiences that were not disclosed by the participant but were discovered by others. Examples included: "(my) mother read it in my diary" and "my sister saw (the CSA) and told".

Were Participants Believed?

The participants were asked if the person/s they first told about the CSA believed them. Of the 189 participants who answered this question, 138 (73.0%,) reported being believed. Only 23 (12.2%) reported not being believed and 28 participants (14.8%) were unsure. Those who were believed waited significantly longer on average (18.3 years) to report the CSA, compared to those who were not believed (9.7 years) (Kruskal-Wallis x^2 = 7.59, *df* = 1, p<0.01). Participants who reported the CSA when they were adults

(over 16 years) were significantly more likely to be believed (95%) than if they reported the CSA when they were children (74%) (x^2 = 13.41, *df* = 1, p<0.001).

What Did The People Disclosed To Do?

People responded to the participants' disclosures in different ways and some people responded in more than one way. One hundred and eighty-five participant reported 218 responses to their disclosures of CSA (See Table 11).

Fifty-seven responses (26.2%) to participants, when they disclosed CSA, were of being 'believed, listened to or made safe'. Examples included:

- caregivers stopped all unsupervised access;
- mother "got rid of her boyfriend" (the offender);
- gave suggestions to stay away from offender;
- gave sympathy and help to address self-blame;
- witnesses to the abuse confirmed that the abuse happened;
- found safe family members for the participant to talk to; and
- a husband became more considerate during sexual intimacies.

Table 11. Responses To Disclosures Of CSA

Responses to disclosure of CSA	**n**	**%**
Believed / listened/made safe	57	26.2
Therapy suggested	39	17.9
Did nothing	31	14.2
Angry response / assault	21	9.6
Minimized/ disbelieved	19	8.7
Confronted offender	14	6.4
Contacted parents	13	6.0
Disclosed own abuse	9	4.1
Contacted police	8	3.7
Medication/refer to MHS	4	1.8
Negative impact on therapy	2	0.9
Don't remember	1	0.5
Total	218	100

Thirty-nine responses (17.9%) were to suggest therapy or those in therapy for another matter were referred on to a specialist therapist to deal with CSA. In addition, some participants who were already in therapy when they disclosed the CSA reported being offered new techniques in therapy to deal with the abuse.

Thirty-one responses (14.2%) were to do “nothing” or not help the participant in any way. Reasons for not responding or supporting the participant included:

- those disclosed to were children themselves and too young to do anything effective to help;
- those disclosed to did not understand, “couldn’t cope” hearing about the CSA; or appeared uncomfortable or overwhelmed with the disclosure;
- made comments indicating it was "too late to do anything"; and
- made comments indicating that the person disclosed to had known about the CSA at the time but had not said anything.

Twenty-one responses (9.6%) were angry responses including: verbal abuse; physical abuse; withdrawing; punishing; or blaming the participant for the CSA. There were three reports of the participant being physically assaulted. Other responses included verbal abuse such as: being told that they were "lying”; “evil"; that the CSA was their “fault”; or that “everyone would hate” them if they knew about the CSA. One response was to tell a participant that she could not "become a Nun" because of the CSA. Some participants (as children) were blamed or were sent to their room. Some people who learned about the CSA withdrew from the participant or terminated their relationship. A few participants were forced to disclose the CSA to others in the family after they had told a member of the family.

Nineteen responses (8.7%) included minimizing, disbelieving or silencing. Minimizing comments included “kids experiment". Disbelieving responses included: accusations that the participant must have taken “too many drugs”, or it was suggested that the participant had "dreamed” the CSA. Silencing responses included being laughed at, told not to tell anyone about the CSA again, or told not to speak about it again. Another response was to “sweep” the disclosure “under the carpet”.

Fourteen responses (6.4%) were to confront the offender. When some partners or family members learned of the CSA they responded with anger towards the offender or support for the participant or others to confront the offender. A few went further and attacked the offender. Others confronted those who could perhaps have stopped the CSA, (for example one person talked to an aunt who was the wife of an offender). A further thirteen responses (6.0%) were to contact others such as: the participant's parent(s); the school; or a doctor. Eight responses (3.7%) were to contact the Police or a child protection agency**.**

Nine responses (4.1%) were to disclose their own abuse. Four responses (1.8%) were to recommend the participant be given medication or have referred them to a mental health unit. Two responses (0.9%) indicated that a therapy relationship was negatively impacted after the participants disclosed the CSA to their therapists. Of these, one response was that of a therapist abruptly ending the therapy relationship. The other response was that the therapy became "harder" following the disclosure of CSA.

Was The CSA Reported To An Authority?

Participants were asked if the CSA was reported to the Police or to a child protection worker such as a social worker. Of the 188 participants who answered this question, twenty-eight (14.9%) said that the CSA was reported to the Police or a child protection worker. One hundred and fifty five (82.4%) participants said that the CSA was not reported and five (2.7%) were unsure.

Contact with Mental Health Services Prior To Therapy.

Of the 186 participants who answered the question "Did you have any contact with mental health services prior to the first therapist you saw?", 61 (32.8%) participants reported that they had.

Reasons for contact with mental health services.

The 61 participants gave 77 reasons for their contact with mental health services (MHS). (See Table 12). Thirty-five (45.4%) were due to symptoms of depression. These symptoms were reported as: feeling "unstable"; had a "mental breakdown" and; was "crying uncontrollably". Twelve reasons (15.6%) for contact with MHS were due to

suicidal thoughts or attempts. Nine reasons (11.7%) were due to relationship or parenting difficulties.

Further reasons for being in contact with MHS included: postnatal depression; problems with alcohol or drugs; being hospitalised, (one participant was diagnosed with schizophrenia, another with manic depression and spent 24 years in contact with MHS and one participant was hospitalised in a mental health unit for two years); being referred by family (because they were “concerned I was lesbian”) and other reasons such as “being involved with a cult group in the 1970s” and “the doctors didn’t know what was wrong with me”; referrals to MHS following the disclosure of CSA; eating disorders; problems at school including concerns about behaviour; discovery that their own child had been sexually abused; and physical and sexual abuse by a partner.

Table 12. Reasons For Contact With Mental Health Services

Reasons for contact with MHS prior to therapy for CSA	No. of reasons given	%
Depression	35	45.4
Suicidality	12	15.6
Relationship/ parenting difficulties	9	11.7
Child birth	4	5.2
Alcohol/ drug	3	3.9
Psychiatric hospitalisation	3	3.9
Referrals and other	3	3.9
Disclosed CSA	2	2.6
Eating disorder	2	2.6
Problems in school	2	2.6
Own child was sexually abused	1	1.3
Revictimization as adult	1	1.3
Total	77	100.0

Time with mental health services

Participants were asked how much time in total they were in contact with MHS. They were asked to give their answer in one of four categories: hours; weeks; months; or years. Of the 55 participants who answered this question, nineteen (34.5%) were in contact with MHS for 'years'; ten (18.2%) for 'months'. fourteen (25.5%) for 'weeks' and; twelve (21.8%) for ‘hours’.

Did Mental Health Staff Ask About CSA Experiences?

Participants were asked: "During this time did any mental health staff ask you if you had experienced CSA?" Of the 60 participants who answered this question, 38 (63.3%) had not been asked, 13 (21.7%) were asked and; nine (15.0%) were unsure.

Section Three - Summary Of Key Points

Age when CSA began – For 83.1% of participants the CSA began before they were 10 years. Mean age was 6.3 years.

Age when CSA ended – For 83% of participants the CSA ended when they were over 10 years old. Mean age was 12.9 years.

Duration of the CSA – For more than half (53.7%) the CSA continued for more than six years. Average duration was 6.1 years.

Number of offenders – Ranged from 1-10, with an average of 2.4.

Gender of offender – 94.9% of offenders were male.

Relationship of offender - The largest group of offenders (52.2%) were males related to the participant. Of those: fathers, step-fathers and foster-fathers were the largest sub-group (18.2%).

Nature of the CSA – 91.1% experienced CSA to the level of genital contact, attempted or completed penetration.

Other forms of child abuse – 79.9% of participants also reported some other form of child abuse: 70.2% reported emotional/psychological abuse; 41.9% reported physical abuse; and 25.1% reported neglect.

Time taken to disclose the CSA – Participants disclosed the CSA from immediately to 56 years later. The average time taken was 16.3 years. Only 3.8% disclosed the CSA immediately and 87.4% disclosed the CSA over a year after the CSA began.

Who was told about the CSA? – 76.3% of those told about the CSA for the first time were family, friends or partners; 14.9% were counsellors; and 7.3% were doctors, social workers or other professionals such as teachers and priests.

Were participants believed? – 73.0% reported being believed; and 12.2% were not believed. Those who were believed waited longer on average to report the CSA. Those who were adults were more likely to be believed than if they reported the CSA when they were children.

What did the people disclosed to do? – 44.1% of responses included being believed, listened to, made safe and therapy being recommended; and 32.6% of responses

included not helping the participant in anyway; becoming verbally or physically abusive and attempting to minimize the abuse or silence the participant.

Was the CSA reported to an authority? – 14.9% of the CSA was reported to the Police or a child protection worker; 82.4% of the CSA was not reported.

Contact with mental health services (MHS) – A third (32.8%) reported that they had contact with MHS prior to therapy for CSA.

Reasons for contact with MHS – 61.0% of the reasons for being in contact with MHS was symptoms of depression or suicidality.

Time with MHS - Over a third (34.5%) reported being in contact with MHS for years.

Did MHS ask about CSA? – Two thirds (63.3%) of those in contact with MHS reported that MHS staff did not ask them if they had experienced CSA. Less than a quarter (21.7%) was asked.

CHAPTER FIVE – ASSESSMENT OF THERAPY EXPERIENCES

This is the second of the four findings chapters based on the postal questionnaire. Findings in this chapter include: the reasons the participants gave for entering therapy; the years when therapy took place; the number of therapists the participants saw; the number of therapy sessions the participants had; participants' Emotional Well-Being ratings before therapy, after therapy and at the time of the study; participants' overall assessment of therapy; their ratings of individual therapists; as well as issues surrounding payment and the allocation of therapy hours.

Reasons For Entering Therapy

The postal questionnaire asked what first led participants to see a therapist for the effects of CSA. Many gave more than one reason producing a total of 315 responses. These responses were coded into two groups: 'Effects of CSA' and 'External Triggers' (See Table 13). Examples of responses from participants are included in each category outlined below. (Rather than provide only the segment of the response that relates to the category, many examples contain meanings that overlap into more than one category).

Effects of CSA

While a history of CSA may have been the fundamental reason for seeking therapy, and participants may have sought therapy for effects resulting from CSA, many may not have connected the effects with their CSA histories at the time they sought therapy. Nevertheless, possibly with the use of hindsight, when answering the postal questionnaire, 240 responses (76.2%) identified one or more effects of CSA that led the participant to begin therapy. 'Effects of CSA' included ten categories. (See Table 13).

Depression / Breakdown / Suicidality

Three sub-categories, on a continuum of despair: depression, 'breakdown', and suicidality, were merged into one category and represented the most frequently reported reasons (22.9%) for entering therapy. The sub-category "depression" was developed from the participants labelling their affective states as: "depression"; "uncontrollable crying"; "mood swings"; "I was very depressed and withdrawn", and "feeling emotionally unstable". The sub-category "breakdown" was developed from descriptions of affective symptoms that contained a more intense tone than those included in the sub-category "depression". The responses included descriptions of

strong affect such as: a “breakdown”; “crisis”; or feeling “out of control”. The subcategory “suicidality” was developed from responses that described suicidal thoughts or attempts such as: “repeated periods of severe, suicidal depression.”

Table 13. What First Led To Therapy For CSA?

Effects of CSA	**n**	**%**
Depression/Breakdown/Suicidality	72	22.9
Relationship difficulties	44	14.0
Post-traumatic stress	31	9.8
Physical problems and difficulties with childbirth	21	6.7
Prior therapy for a range of effects	16	5.1
Parenting issues	15	4.6
Sexual difficulties	12	3.8
Problems with anger	10	3.2
Revictimisation	10	3.2
Problems with alcohol and drugs	9	2.9
Sub-total	*240*	*76.2*
External Triggers	**n**	**%**
Hearing or reading about CSA	18	5.7
Wanting to talk about CSA	18	5.7
Referred by professionals or work place	15	4.6
Other	14	4.4
Referred by family	10	3.2
Sub-total	*75*	*23.6*
Grand-total	***315***	***99.8***

Relationship difficulties

The second most frequent reason (14.0%) for seeking therapy was “relationship difficulties” such as marriage difficulties, relationship break-ups, or difficulties with trust, intimacy, relationship boundaries, or with males. Examples included:

> “Wasn’t coping with marriage break-up and flashes of childhood memories.”
>
> “The effects of my childhood began to manifest themselves in a …lack of trust.”
>
> “Fear of intimacy.”
>
> “Boundary problems in relationships.”

Posttraumatic Stress

Another frequently given reason (9.8%,) for entering therapy was the experiencing of symptoms of posttraumatic stress such as flashbacks, terrors or chronic anxieties. Participants’ descriptions included:

> “Was having flashbacks which affected my relationship with my partner and my daughter.”
>
> “Non-stop flashbacks, emotional mess.”

Physical Problems and Difficulties with Childbirth

Twenty-one responses (6.7%) referred to therapy for physical problems. Responses included: vaginal pain; sleeping difficulties; migraines; eating difficulties; eczema; or medical procedures that triggered thoughts of CSA. Other examples included:

> “Panic attack during a throat examination by an ENT (ear nose and throat) specialist whom I had chosen because I knew and trusted him.”
>
> “Fear after having children. Need to tell somebody.”

Of the 21 responses, nine (2.9%) reported difficulties with reproductive health including: difficulties with pregnancy; postnatal psychosis; or miscarriage.

Prior therapy for a range of effects

Sixteen responses (5.1%) referred to therapy beginning for a range of issues including therapy in childhood for: “fears”; "tantrums"; "struggling at school"; "running away" from home, or therapy in later life for: drug use; alcohol use; rape; sexual harassment; domestic violence; grief; depression; or eating disorders. It seems that therapy for this wide range of issues at some point led on to therapy for CSA. (Because there were no direct questions in the postal questionnaire that asked about the pathways from one set of therapy to the other however, data tracing these pathways are largely unavailable – although sometimes participants have described these pathways).

> “Initially I saw a counselor for depression. By session three I said that I might as well mention I’d been abused. At that stage I didn’t see a link, but after a while I did.”

"I felt I was different from other children. I was frightened of everything eg men, school, the night, birds, I lived in a state of fear – so I decided when I was 12 to get help."

Parenting Issues

Fifteen responses (4.6%) referred to parenting or grand-parenting issues leading to therapy. These included descriptions of: when a participant's child reached the age when their CSA began and other issues such as:

"My daughter was being affected by my abuse, because of my behaviour."

"The feeling that I was just not right. Not emotionally connected enough to my kids (but) I didn't acknowledge it was the CSA."

Sexual difficulties

Twelve responses (3.8%) referred to therapy beginning due to experiencing sexual difficulties. Some of the difficulties were along a continuum from being unhappy with (what was described as) "promiscuous behaviour" to the opposite, (what was described as) "frigid". Other difficulties were related to experiencing anxiety or flashbacks during sexual intimacies. Participant's descriptions included:

"Flashbacks and sexual problems."

"Sexual problems. Problems with trust."

"Difficulties experienced relating to husband sexually."

"Not being able to commit sexually or in any way to a man."

Problems with anger

Ten responses (3.2%) described problems with anger including:

"I felt angry most of the time."

"Worried about my anger towards my children."

Revictimisation

Ten responses (3.2%) referred to therapy beginning due to experiences of revictimization that occurred after the CSA, including adult rape, sexual harassment or other experiences of violence including:

"I was gang raped twice in my home and I had a breakdown."

Problems with alcohol or drugs

Ten responses (2.9%) referred to difficulties with alcohol and drugs leading to therapy. Substance abuse was often included with several other issues such as depression and symptoms of posttraumatic stress.

> "Unable to have long term relationships, alcohol abuse, low self esteem etc thoughts of suicide."
>
> "Alcohol and drug abuse which affected my relationships with family and friends."

External Triggers

Almost a quarter of responses (23.6%) referred to external triggers or goals for therapy rather than to actual effects of CSA. This second group of issues 'External Triggers' included five categories. (See Table 13).

Hearing or reading about CSA

Eighteen responses (5.7%) referred to participants seeking therapy having being triggered to seek help hearing or reading about CSA from a variety of sources such as: a conversation; the media; an education course; issues at work; or discussions in a group. An example:

> "The huge burst of publicity in the early 90's led to <u>not</u> recovered memories but the inability to ignore them."

To talk about CSA

Eighteen responses (5.7%) referred to seeking therapy to talk to a therapist about CSA. Some responses referred to the need to tell after years of staying silent, others wanted support because they were about to disclose the CSA to their family. A few needed support following their disclosure of CSA. Some had thoughts about their CSA experiences and wanted to discuss their thoughts with a therapist. A few reasons given for beginning therapy were to discuss issues about confronting a CSA offender. Examples included:

> "After 10 years of keeping it a secret, I finally decided to tell someone, and after telling – I realized I needed some help."
>
> "The need to tell someone."
>
> "My boyfriend threatened to tell my mother who didn't know about it at the time."
>
> "I wanted to confront the person and needed support."

> "An overwhelming need to sort out my confusion and pain surrounding the issue."

Referred by Professionals or Workplace

Fifteen responses (4.7%) mentioned being referred to therapy for CSA by a GP, another professional or by people from their workplace. Examples included:

> "After visiting doctor with panic attacks and depression and explaining to doctor things of my childhood."
>
> "Work made me."

Other Responses

Fourteen responses (4.4%) referred to beginning therapy for a variety of other reasons. Of these: five responses (1.6%) referred to entering therapy because there were new opportunities of being able to see a therapist (such as a new funding source became available) or because they needed assistance to process compensation claims for CSA; four responses (1.3%) suggested they were unsure or could not remember how or why they began therapy; three reported reasons (1.0%) for attending therapy were because their own child had also experienced CSA; two reasons (0.6%) were wanting therapy support to deal with a Police complaint or a legal case:

> "Pressing charges against my offender and needing help due to this."
>
> "On divulging the info, Police intervened and organized a therapist."

Referred by family

Ten responses (3.2%) referred to beginning therapy because their partner, family or friends either referred them or encouraged them to go to therapy.

> "Confiding in my sister … and her advice to go to my GP and ask if I could get counselling from ACC."
>
> "My partner took me because he felt that the effects of my CSA were affecting our relationship."

Years When Therapy Took Place

When did the participants first see a therapist about the effects of CSA?

Of the 187 participants who answered this question, the range of years of when therapy began was 1957- 2000. However, 174 (93.0%) of the respondents began therapy from 1980 onwards. Only one participant (0.5%) began therapy in 1957, one (0.5%) began therapy in the 1960s, and eleven (6.0%) began therapy in the 1970s.

When did the participants last see a therapist about the effects of CSA?

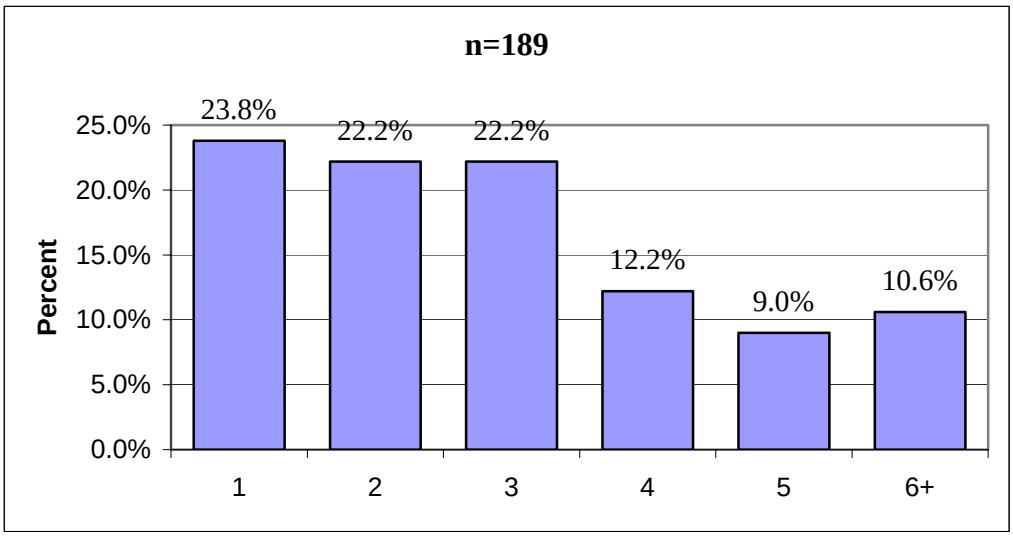
Of the 188 participants who answered this question, the time of their therapy ending ranged from 1981-2001. However, only 9.6% of the sample last saw a therapist in or before 1991; therefore most of the sample, 170 (90.4%), had some therapy in the last 10 years. As over half the sample (51.1%) last saw a therapist between 1998 and 2001, the experiences of this sample largely relates to recent therapy practice.

Number Of Therapists Seen

How many therapists did the participants see about the effects of CSA?

The 189 participants who answered this question saw a total of 633 therapists (See Figure 7). The average number of therapists seen was 3.4. The range was between one and twenty-five therapists. Almost a quarter (23.8%) of the 189 participants saw only one therapist. Eighty-seven (46.0%) saw one or two therapists. Sixty (31.8%) saw four or more.

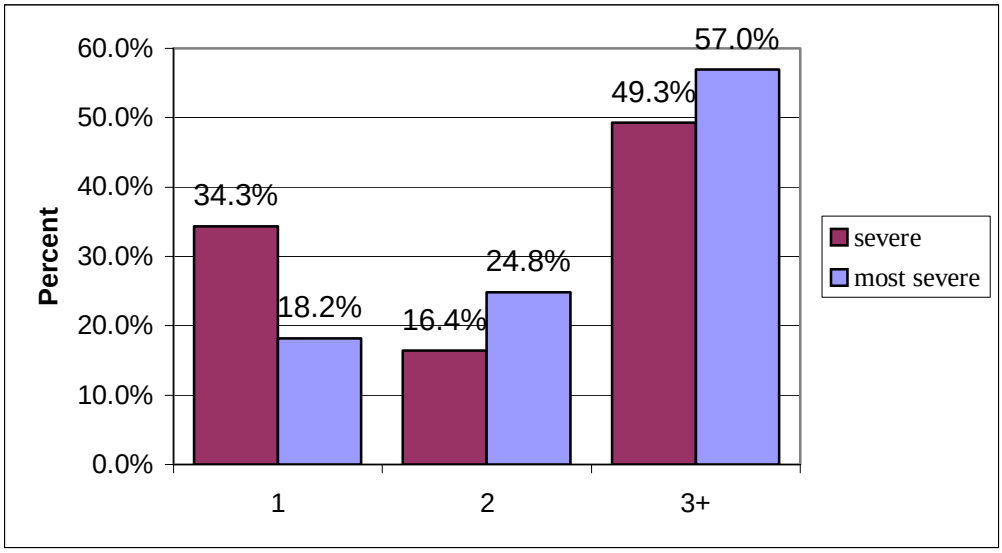
Figure 7. Number Of Therapists Seen By Participants



Number of therapists seen based on the severity of CSA

The question of whether those who experienced more severe CSA saw more therapists was considered. The CSA was regarded as 'severe' if the abuse was to the level of genital contact; and 'most severe' if the CSA was to the level of any attempted penetration or penetration. The number of therapists seen was grouped into three categories, of one, two, and three or more. A chi-squared test, relating the three categories of numbers of therapists to the two categories of CSA severity was significant (see Figure 8). ($x^2 = 7.1550$ $df=2$ $p< 0.05$)

Figure 8. Number Of Therapists Seen By Severity Of CSA



Number of Therapy Sessions

Participants were asked to estimate how many sessions of therapy they had by selecting from one of nine ranges of numbers of sessions (see Table 14). Ninety-four (49.5%) of the 190 participants who answered this question had 50 therapy sessions or less. Fifty-seven (30%) had more than 100 sessions.

Table 14. Number Of Therapy Sessions Per Participant

Number of therapy sessions	n	%
5-10	18	9.5
11-20	35	18.4
21-50	41	21.6
51-100	39	20.5
101-200	25	13.1
201-300	14	7.4
301-400	6	3.1
401-500	3	1.6
501+	9	4.8
Total	190	100.0

Emotional Well-Being Ratings Before And After Therapy

How did participants feel prior to therapy for CSA?

Participants were asked to rate their Emotional Well-Being prior to the first time they had therapy for the effects of CSA on a Likert scale (1 represented feeling 'Emotionally Unwell' and 7 represented feeling 'Emotionally Well') (see Table 15). Of the 189 participants who answered this question, 84.7% rated themselves within the bottom three points (1 - 3) of the Emotional Well-Being scale. Only 4.8% rated themselves within the top three (5 to 7) of the Emotional Well-Being scale.

How did participants feel at the end of all therapy for CSA?

After all therapy for CSA, 63.2% of 190 participants rated themselves within the top three points (5 to 7) of the Emotional Wellness scale (See Table 15). Thirty-two (16.8%) rated themselves in the bottom three points (between 1 and 3) after all therapy for CSA.

Table 15. Participants' Ratings Of Their Emotional Well-Being Prior To Therapy, After Therapy And At The Time Of The Study.

Participants' ratings of emotional well-being	Likert scale	Prior to therapy		After therapy		Current ratings	
		N	%	N	%	N	%
Emotionally unwell	1	60	31.8	5	2.7	1	0.5
	2	70	37.0	8	4.2	3	1.6
	3	30	15.9	19	10.0	14	7.4
	4	20	10.6	38	20.0	28	14.7
	5	4	2.1	39	20.5	35	18.4
	6	4	2.1	58	30.5	71	37.4
Emotionally well	7	1	0.5	23	12.1	38	20.0
	Total	189	100.0	190	100.0	190	100.0

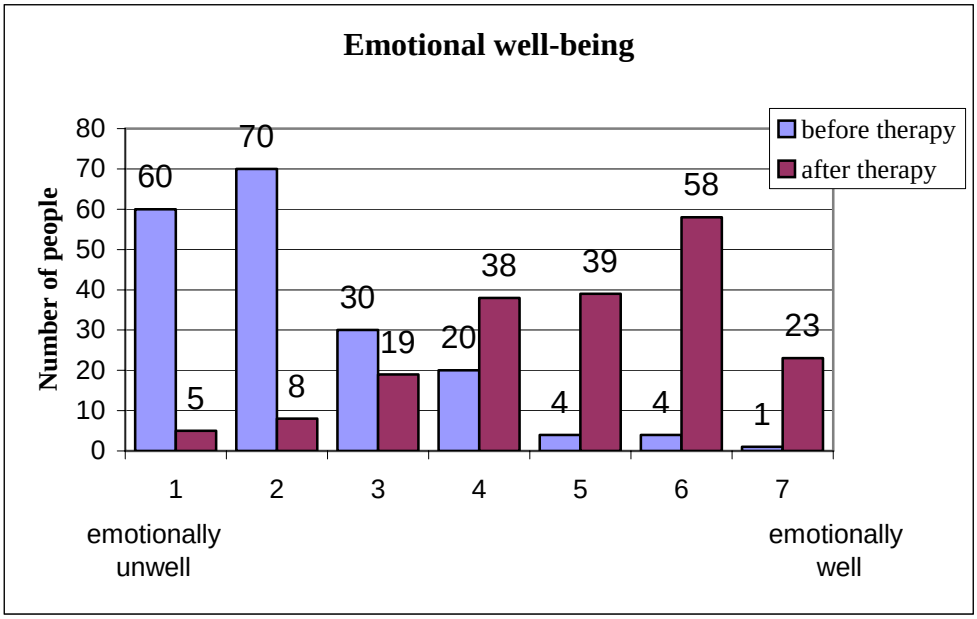
Comparison between emotional well-being before and after therapy.

There appears to have been a vast improvement in self-reported Emotional Well-Being before and after therapy, with 4.8% of participants in the top three points (5-7) prior to therapy compared with 63.2% after therapy (Figure 9). The distribution of scores was significantly different before therapy compared to after therapy (x^2 = 199.56, *df* = 6, p<0.001). When the before therapy ratings are compared with the after therapy ratings there was a positive movement of the means from 2.2 to 4.9. To reduce the inherent variability in the sample, a paired comparison was employed to examine the difference between participants' Emotional Well-Being at the end of therapy and at the beginning of therapy. Due to the non-normality of the shift in responses, a sign test was used. This was significant (M=76.5, p<0.0001).

Were there differences in the amount of change in Emotional Well-Being experienced by participants at either end of the Emotional Well-Being scale?

Those participants who rated themselves on the lower end of the Emotional Well-Being Likert scale before therapy improved more in their 'after' therapy assessments of Emotional Well-Being, than those who were higher up the Emotional Well-Being scale before therapy. (Spearman rho -0.56; p<.001).

Figure 9. Emotional Well-Being Before And After Therapy For CSA.



Was there a difference in outcomes for short and long-term therapy?

Participants who had long-term therapy (over 50 sessions) were significantly more likely to report a large positive change in their well-being (44%) compared to those who had 50 sessions or less (27%) (x^2 = 5.87, *df* = 1, p<0.05). A large postive change in this instance was defined as a positive change in Emotional Well-Being of four or more on the Likert scale.

Current Well-Being

When asked how the participants felt 'now' (at the time they completed the postal questionnaire), on the Emotional Well-Being scale, most (75.8%) of the 190 participants rated themselves in the top three points (5-7) on the Likert scale. (See Table 15). This is compared with the 63.2% who rated themselves in the top three points (5-7) of the Likert scale at the end of all therapy. The participants' current well-being at the

time of the questionnaire was distributed in a manner that was significantly different to the Emotional Well-Being at the end of therapy (x^2 = 12.43, df = 6, p<0.05). Participants' Emotional Well-Being at the time of the questionnaire was centred with a mean of 5.4 and a median of 6.0 on the emotional well-being scale. The sign test found that the median of 6.0 was significantly different to the Emotional Well-being at the end of all therapy for CSA for which the median rating was 5.0 (M=30.0, p<.0001). The time from ending therapy to 'now' (2001) ranged from 0-20 years.

Participants' Overall Assessment Of Therapy

Participants were asked: "Overall, how did therapy impact on your ability to deal with the effects of CSA?" a five point scale of 1='Very helpful', 2='Somewhat helpful', 3='Made no difference', 4='Somewhat unhelpful', or 5='Very unhelpful' (see Figure 10). When the two positive ratings (Very helpful and Somewhat helpful) were combined 161 (85.7%) rated therapy as being of help to them. Fifteen (8.0 %) reported therapy 'Made no difference'. When the two negative ratings (Somewhat unhelpful and Very unhelpful) were combined twelve participants (6.4%) reported therapy as being unhelpful to them.

Ratings For Individual Therapists

Participants were also asked to rate therapists on an *individual* basis rather than give an *overall* rating of all therapists they saw. When the participants were asked how many therapists they saw *overall*, they gave a combined total of 663. However, when they were asked to rate each therapist on an *individual* basis they only rated a total of 553 therapists (See Table 16). When the participants were asked to rate the therapists individually, the helpfulness ratings were lower than when the participants rated their *overall* therapy experiences.

Figure 10. Assessments Of Overall Effectiveness Of Therapy

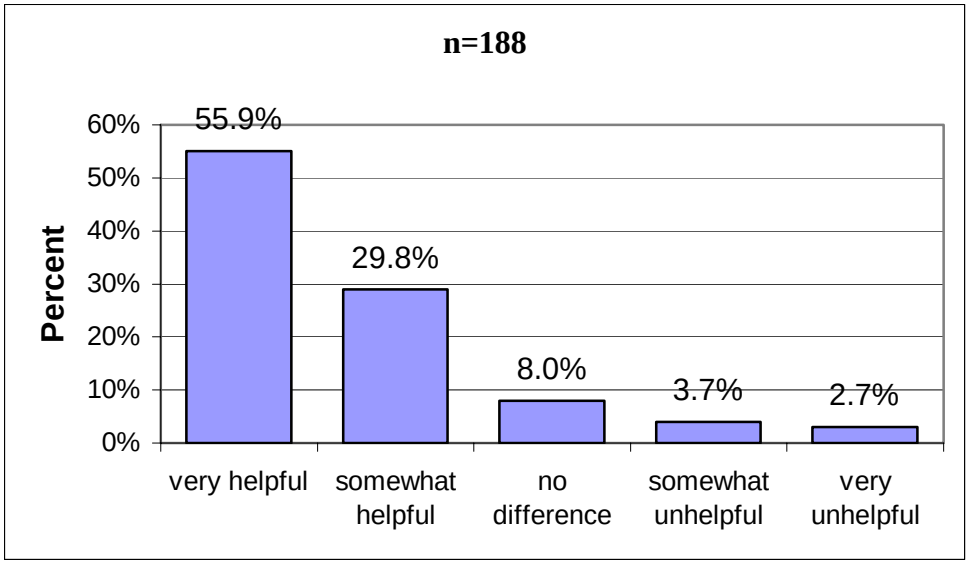


Table 16. How Participants Rated Individual Therapists

Individual therapist ratings	**n**	**%**
Very helpful	174	31.5
Somewhat helpful	166	30.0
Made no difference	78	14.1
Somewhat unhelpful	49	8.9
Very unhelpful	86	15.5
Total	553	100.0

For example when the participants were asked to rate the *therapy experiences overa*ll, 161 participants (85.6%) reported that, overall, therapy had either been 'Very helpful' or 'Somewhat helpful'. When the participants rated their *therapists individually*, the percentage of therapists rated in the two positive categories 'Very helpful' and 'Somewhat helpful' dropped to 61.5%. In the *overall* ratings of therapy only twelve participants (6.4%) rated therapy in the bottom two categories 'Somewhat unhelpful' and 'Very Unhelpful'. However, when the therapists were rated *individually* nearly a quarter (24.5%) of therapists were rated in the two bottom categories.

The mean rating of therapists increased (i.e. therapists were rated as less helpful) as the number of therapists seen increased (See Table 17).

Table 17. Participants' Mean Ratings Of Therapists

Number of therapists seen	Number of therapists rated (n=549)	Mean *ratings of individual therapists
1	46	1.78
2	83	2.25
3	120	2.36
4	92	2.53
5	77	2.48
6+	131	2.92

* Rating scale: 1=Very helpful, 2=Somewhat helpful, 3= Made no difference, 4=Somewhat unhelpful, 5=Very unhelpful.

Funding For Therapy

Participants were asked about some of the issues surrounding therapy such as: how therapy was funded; whether the number of sessions allocated by ACC were adequate; how much the participants paid for therapy; whether they were ever unable to have therapy due to costs and if so how did they cope.

How was therapy funded?

Therapy was funded in several ways (See Table 18). Many participants had more than one funding source. More than two thirds (71.6%) of the 190 participants who answered this question received some ACC funding and 60.5% paid themselves for some or all of the therapy.

Twenty-six responses (13.7%) reported finding 'other ways' of funding their therapy including: Employees Assistance Programmes, disability allowances, income support or

the therapist reduced or ended their charges when the client was unable to afford the therapy.

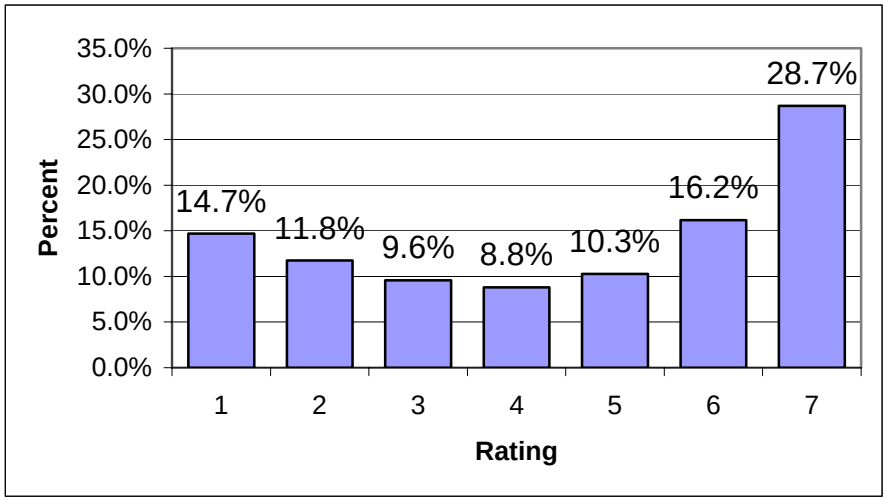
Table 18. Multiple Sources Of Funding

Funding source	Percentage of responses	Number of responses (n=334)
ACC	71.6	136
Self	60.5	115
Community centres	12.1	23
Hospitals	8.4	16
Student counselling	6.8	13
Private insurance	2.6	5
Other ways	13.7	26

Was the number of sessions covered by ACC adequate?

Of the 136 who had part or all of their therapy funded by ACC, 61 (44.8%) described the number of therapy sessions covered by ACC in the top two points (6-7) of the Likert scale when rating adequacy of sessions (1=Inadequate and 7=Adequate) (See Figure 11). Over a quarter (26.5%, n=36) described the number of sessions covered by ACC in the bottom two points (1-2) of the same adequacy scale.

Figure 11. Adequacy Of ACC Therapy Sessions



(Participants n=136) (Likert Scale: 1= Inadequate 7=Adequate)

How much did participants pay for therapy?

The 134 participants who answered this question personally paid a total of over a quarter of a million dollars for their therapy. This is an average cost of $1,939 per

participant. The amount paid ranged from zero to $17,500. Over a third (37.3%) paid $1,000 or more. A quarter (25.4%) paid between $1,000 and $5,000 and 11.9% paid between $5,000 and $17,500.

Were the participants ever unable to have therapy due to cost?

Of the 182 participants who answered this question, 96 (53.3%) reported they were at some point unable to have therapy due to cost.

How did participants cope if they could not afford therapy?

The 96 participants that reported not being able to have therapy due to cost were asked to explain the circumstances and how they coped. Some described more than one way of coping without therapy. The 118 responses were divided into ten categories (See Table 19). Examples that describe these categories are outlined.

The most frequent response (35.6%) was that of having "no choice, just coped". Participants reported coping by: trying to ignore the effects of CSA; trying to bury or suppress the effects; or focusing on other things such as work or family.

Table 19. How Participants Coped If They Could Not Afford Therapy.

	n	%
Just coped	42	35.6
Symptoms increased	18	15.3
Used self-help resources	12	10.1
Used free therapy services	10	8.5
Suffered hardship to pay	9	7.6
Found other ways to pay	9	6.8
Relied on partners/family	7	5.9
Took medication	7	5.9
Therapist dropped their fees	3	2.5
Stretched out therapy gaps	2	1.7
Total	118	100.0

The next most frequent response (15.3%) was that their symptoms of CSA, such as anger or depression, increased or "got worse". Coping without therapy by using self-help resources (such as books, physical exercise, spiritual practices, or creative activities including artwork), and safety plans and skills learned in therapy, accounted for 10.1% of responses. A further 8.5% of responses described coping by using free

therapy services such as: help-lines; alcohol and drug agencies; sexual abuse agency 24 hour telephone counselling/crisis support lines; group supports; the Police; or waiting on hospital waiting lists.

There were some reports (7.6%) of hardship suffered (such as going without food or other essentials) to afford therapy. Some responses including taking out a loan to afford therapy. A few indicated that in order to afford therapy savings were used, mortgage payments were delayed, or long hours were worked.

Some responses (6.8%) described finding other ways to get some therapy such as: asking a husband to pay for the therapy; bartering to pay for therapy; using a disability allowance; arranging email support from therapist or finding a cheaper therapist. Several (5.9%) responses indicated the need to rely on partners, friends or family for emotional support to cope without therapy. A few (5.9%) reports included taking medications such as antidepressants or self-medicating with illegal drugs to cope without therapy.

Three responses (2.5%) described therapists dropping their fees when the participant could not afford therapy. Two (1.7%) described stretching out the gaps between therapy by having less time in a therapy session or less frequent therapy sessions.

Summary Of Key Findings

- *Reasons for entering therapy*: The three leading reasons for entering therapy making up (46.7%) of responses were depression, relationship difficulties and posttraumatic stress.
- *When therapy took place*: 93.0% began therapy after 1980; 90% ended therapy after 1991; and 51.1% last saw a therapist between 1998 and 2001.
- *Number of therapists seen*: The average number of therapist seen was 3.4.
- *Number of therapists seen by severity of CSA:* Participants who experienced more severe CSA saw more therapists.
- *Number of therapy sessions:* Almost half of the participants had 50 therapy sessions or less and 30% had more than 100 sessions.

- *Emotional Well-Being:* Overall, participants Emotional Well-Being improved significantly from beginning of therapy to the end of therapy for CSA. Those at the lower end of the Emotional Well-Being scale improved significantly more than those at the higher end of the scale. Participants who had over 50 sessions were significantly more likely to report a positive change in Emotional Well-Being compared with those who had 50 sessions or less. Participants' Emotional Well-Being had improved significantly from the time they ended therapy to the time they completed the questionnaire for the study (a span of 20 years).
- *Overall impact of therapy:* 85.7% of participants rated therapy very helpful or somewhat helpful; and only 6.4% found therapy either somewhat or very unhelpful
- *Individual therapist ratings:* 61.5% of participants rated therapy 'Very helpful' or 'Somewhat helpful' when *individual therapists* were rated and 24.5% of participants rated therapy as 'Somewhat helpful' or 'Very unhelpful' when *therapists were rated individually*.
- *Seeing a higher number of therapists was related to lower ratings of helpfulness in therapy.*
- *Therapy funding sources:* 71.6% received some ACC funding and 60.5% paid for some or all of their therapy themselves.
- *Adequacy of ACC sessions:* 44.8% of participants described the number of therapy sessions they had as adequate; 26.5% described number of sessions as inadequate.
- *Amount paid by participants:* participants paid an average of about $2,000.00 each for therapy.
- *Ability to fund therapy:* 53.3% of the participants were unable to have therapy at some point due to the cost.
- *Coping without therapy:* 35.6% of responses were of having no choice but to 'cope' without therapy and 15.3% of responses were that symptoms increased.

CHAPTER SIX - HELPFUL THERAPY

This is the third of the four findings chapters based on the postal questionnaire. Findings in this chapter describe what participants reported as helpful in therapy.

What Was Helpful In Therapy

In the postal questionnaire, the 191 participants were asked the open-ended question: "Of all the therapy you had for the effects of CSA, what did you find most helpful?" They were asked to give up to three responses. Some gave only one-word responses while others gave several sentences. The 606 responses were divided into four major categories. (See Methodology chapter for description of development of categories). The order of these categories in Table 20 follows the process that a client would move through in therapy, that is: a client would first need to gain access to a therapist, and build a relationship with the therapist in order to do their work in therapy. The four major categories were: 1) access issues; 2) therapy relationship; 3) therapy models; 4) therapy work. The four major categories were divided into minor categories and subcategories. The minor categories and the subcategories were rank ordered by frequency. Examples of participants' responses are used to illustrate the meaning of each subcategory.

1 Access Issues

Thirty-six responses (5.9%) reported that what was helpful in therapy was gaining and maintaining access to therapy.

1.1 Compatibility and funding

To engage in therapy participants found it helpful to find therapists with whom they felt comfortable and who were knowledgeable about abuse-focused therapy. On-going access to therapy was assisted by therapists being affordable, reliable and available for regular therapy. Other issues that influenced on-going access to therapy were those of funding and the therapy environment.

Table 20. What Was Helpful

	Titles of Major, minor and categories and subcategories	Major category (n) (%)	Minor category (n) (%)	Sub-category (n) (%)
1	**ACCESS ISSUES**	**36 (5.9%)**		
1.1	Compatability and funding		36 (5.9%)	
1.1.1	Compatability/training			19 (3.1%)
1.1.2	Ongoing access and funding issues			17 (2.8%)
2	**THERAPY RELATIONSHIP**	**213 (35.1%)**		
2.1	Supportive relationship		91 (15.0%)	
2.1.1	Non-judgemental attitude, acceptance and understanding			35 (5.8%)
2.1.2	Rapport and safety			33 (5.4%)
2.1.3	Care and support			23 (3.8%)
2.2	Talking/listening		74 (12.2%)	
2.2.1	Talking and being listened to			61 (10.1%)
2.2.2	Non-directive talk therapy			13 (2.1%)
2.3	Inter-active therapist		48 (7.9%)	48 (7.9%)
3	**THERAPY MODELS**	**95 (15.7%)**		
3.1	Models and techniques		95 (15.7%)	
3.1.1	Various techniques, models or tools			45 (7.5%)
3.1.2	Creative techniques			36 (5.9%)
3.1.3	Group therapy			14 (2.3%)
4	**THERAPY WORK**	**262 (43.3%)**		
4.1	Work on effects and functioning		110 (18.2%)	
4.1.1	Dealing with effects, skill building and expressing emotions			64 (10.6%)
4.1.2	Dealing with relationship difficulties			25 (4.1%)
4.1.3	Self esteem and focus on strengths			21 (3.5%)
4.2	Abuse experience normalized		91 (15.0%)	
4.2.1	Not mad – understanding effects of CSA			48 (7.9%)
4.2.2	Not bad – undoing guilt and self-blame			43 (7.1%)
4.3	Able to disclose CSA		61 (10.1%)	
4.3.1	Sharing CSA experiences			37 (6.2%)
4.3.2	Feeling acknowledged and believed			24 (3.9%)
TOTAL		**606 (100%)**	**606 (100%)**	**606 (100%)**

1.1.1 Compatability and training

Nineteen responses (3.1%) related to the participants' selections of therapists that were based on therapists' characteristics, knowledge and experience. Thirteen of the nineteen responses referred to participants' choice of therapists or compatability based on their gender, ethnicity, survivor-status or world-view. Of the thirteen: four stated that having a female therapist was helpful: *"She was a woman";* three stated that having a survivor-therapist was helpful: *"Knowing my counsellor had experienced it too"*; two stated that finding a therapist with a similar world-view (feminism) or a similar spiritual background to them was important; two referred to being able to choose their own therapist was helpful; one reported having a Maori therapist was helpful; and one stated that having a combination of a female and a male therapist was helpful.

Six commented that accessing a therapist who was experienced and qualified was helpful: *"I felt the therapist knew her work - well trained"; "My therapist was very good (on to it) techniques, skills etc years of professional experience"; "Knowing that my therapist really understood her stuff"; "(A therapist) who was skilful but left me feeling in control"*.

1.1.2 On-going access and funding issues

Seventeen responses (2.8%) commented that access to regular on-going therapy and funding had an impact on the helpfulness of their therapy. Of the 17 responses, six referred to having easy regular access to therapy was helpful. *"Knowing that there was every week a time just for me"; "Having regular appointments"; "Having therapy available for a long period of time – the healing process is so slow"*.

Five of the 17 responses referred to on-going access to therapy was helpful in the form of inter-session support (such as a phone call to see if they were all right) and advocacy (help to deal with other agencies). Helpful inter-session support included links to extra services such as a crisis team or a 24-hour counselling phone line and sometimes the participant's therapist provided therapy outside of the usual session times. Examples included: *"My therapist was supportive and allowed me to phone her at home if I needed to"; "Being able to ring when panicking"*. Sometimes the therapist being an advocate helped: *"Accompanying self to a mediation meeting – ie therapist psychologist for moral support."*

Three responses stated that free or subsidised therapy helped them to access therapy: Examples included: *"(I) didn't have to pay- couldn't have afforded (therapy)"; "Having ACC pay for my therapy – I could not pay for therapy myself*".

The therapy environment was another important point influencing the initial or on-going access to therapy. Three responses mentioned that what was helpful was the environment, such as the therapy room: *"Held in a small informal room, felt very safe"*.

2 Therapy Relationship

Two hundred and thirteen responses (35.1%) referred to three broad areas of the therapy relationship. Participants found it helpful to have a supportive therapy relationship based on acceptance, understanding, rapport, safety and care. Being able to talk about anything and at their own pace and be listened to was reported as helpful; especially in the context of one to one therapy with someone who was outside the sphere of family or friends. Helpful therapists were interactive therapists, actively involved with participants and in anticipating and managing the work in therapy.

2.1 Supportive therapy relationship

Of the 213 responses, ninety-one (15.0%) referred to the therapy relationship as being supportive in three ways: 5.8% found therapy helpful when the therapist had a non-judgemental attitude and was accepting and understanding; 5.4% found it helpful when there was a basis of rapport and safety in the therapeutic relationship; and 3.8% found it helpful when they could rely on their therapists for care and support.

2.1.1 Non-judgemental attitude, acceptance, understanding

Thirty-five responses (5.8%) reported therapists as helpful when they were non-judgemental. Examples included: *"Not being judged or blamed"; "She never judged me"; "Having a therapist who was non-judgemental"; "Non judgemental, genuine therapist"*. Being able to feel accepted, understood and comfortable with the therapist was also appreciated: *"Someone who understood me"; "Acceptance of all my feelings, fantasies, thoughts"; "Her acceptance of my religious beliefs that at the time were important to me"; "Respect for my spirituality and total understanding"; "Acceptance";* and *"Understanding"*. Other responses included: *"Empathy";*

"Sensitive"; "One to one therapy with a sympathetic counsellor"; "Being shown… respect".

2.1.2 Rapport and safety

Thirty-three responses (5.4%) referred to the need to have safety and rapport with the therapist in order to build a therapeutic relationship. Examples included: *"Finding a therapist I got on well with"; "I related to the therapist"; "Being able to build a good rapport with the therapist".*

Examples where safety and trust were important included: *"Talking to someone I trusted"; "I felt safe talking about it"; "Therapist was approachable and trustworthy"; "having someone I felt I could trust with the essence of me"; "Knowing I could be safe talking"; "Therapist offered a safe place"; "Trust"; "Security".*

2.1.3 Care and support

Twenty-three responses (3.8%) reported that feeling cared about was an important aspect of the therapy relationship. Caring, supportive therapy included: *"Feeling as if someone cared"; "Knowing some-one cared about me (eg signing a non-suicide pledge)"; "Care and concern"; "Genuine caring/interest in me myself"; "That she cared"; "Support through very difficult decisions"; "Warmth, kindness, caring, sincere, patient."* Responses of what was helpful included: having *"Someone I could turn to"; "Realising I wasn't alone, and help and support was available"; "An on-going, long-term relationship with a therapist";* and the *"Counsellor made a personal commitment to walk this journey with me."*

2.2 Talking/listening

Seventy-four responses (12.2%) reported that talking and being listened to in regular one-to-one sessions, with a skilled person, outside their sphere of family or friends were helpful in therapy. The freedom to talk about any related issue, at the client's own pace in non-directive therapy was also described as helpful. (Some aspects of this category may appear to overlap with aspects of the 'work' carried out in therapy. However, in contrast to the work in therapy that focuses on achieving the goals of abuse-focused therapy, this category focuses on the 'process' that facilitates the work).

2.2.1 Talking and being listened to

Sixty-one responses (10.1%) referred to being able to talk and to be heard (sometimes for the first time), in one-to-one therapy, by an objective person. Examples included:

Talking – *"Being able to talk about it to someone"; "Being able to talk and talk and talk and talk…"; "Just talking"; "Talking with a counsellor"; "Talking it all through"; "A place to go an talk"; "Being able to just talk"*.

Being listened to - *"Someone not offering advice or pills but listening to me"; 1st time listened to"; "Someone who listened to me"; "I got an hour of quality time, to be heard"; "Active listening"; "Someone actually listening to me"; "Someone who heard me"; "Someone to listen to my thoughts and feelings"; "A good listener"*.

One-to-one therapy – Twelve of the sixty-one responses were all very similar and reported that it was helpful to have therapy on an individual basis: *"one to one"* or *"face-to-face"*.

Objectivity - *"Someone prepared to listen just to me without (their) own baggage"; "Just talking about it to someone skilled"; "Talking to a person who was not directly linked to me"; "Being able to talk openly to someone (a professional)"; "Speaking to someone detached from every situation in my life"*.

2.2.2 Non-directive talk therapy

Thirteen responses (2.1%) reported that helpful therapy was talk therapy not directed by the therapist. Participants valued being able to talk about what ever they wanted to talk about: *"Just being able to say <u>anything</u> to the therapist"; "A place were anything can be spoken about"*. The ability to set their own pace of therapy work was much valued, for example: *"Letting me set the pace of therapy"* and *"Working at my own pace."*

Respondents preferred being able to talk through difficulties and be allowed the time and space to come to a decision about how to deal with their difficulties - rather than have a therapist impose their solutions. Examples included: *"Options to consider, but not pushed into action, it was up to me to decide"; "Someone who didn't try to 'make it better' "* and when the therapist *"Doesn't force personal belief or opinion onto client"*.

2.3 Interactive therapists

Forty-eight responses (7.9%) suggested that therapy was helpful when the therapist was 'involved' in the therapy process by being:

- Encouraging: *"Encouragement to develop my native skills and gifts"; "Encourage me to work to the future"; "She encouraged me and supported me to continue to work outside of therapy sessions";*
- Active: *"Communicative"; "Dynamic therapist";*
- Affirming: *"Believes in client's ability";* and *"His (therapist's) constant belief and encouragement";* and
- Empowering: *"The therapist providing an alternative voice to my own inner voice and life script based on past destructive messages"*.

Therapists who were affectively open and able to share a little about themselves when appropriate were also seen to be helpful. Interactive therapists were affectively open therapists and were comfortable with emotions. Participants valued: *"Being allowed to cry";* and when *"The therapist was not afraid to share my tears"*. Interactive therapists were comfortable about being known to the respondents. Three responses referred to the helpfulness of therapists making self-disclosures: *"The therapist herself had endured suffering (cancer)"; "(My) therapist let me know she had been where I had"; "Sharing her own abuse when appropriate"*.

Interactive therapists were also described as:

- Guides: *"Someone to guide me through it";*
- Educators: *"Therapist taught me affirmations". "I didn't know what was happening to me (flashbacks), therapist helped";*
- Facilitators managing the therapy process: *"Continuous feedback to help summarise what had been said"; "Help to identify ongoing problems"; "Drawing out my feelings"; "Being asked specific questions"; "Challenging – exploring issues";*
- Working holistically with all the effects on the client's life: *"Therapist included marriage difficulties in the focus of therapy rather than solely focus on abuse";* and

- Moving the therapy forward: *"Someone who did not dwell on what had happened but worked on the effect now"; "Strategizing ways to get through things in new ways"*.

3 Therapy Models

Ninety-five responses (15.7%) identified specific therapy techniques, models or tools used within one-to-one therapy or as an adjunct to one-to-one therapy (such as group therapy and family therapy) were named as helpful.

3.1 Models and techniques

Of the 95 responses: 45 (7.5%) referred to various techniques, models or tools; 36 (5.9%) to creative techniques; and 14 (2.3%) to group therapy.

3.1.1 Various techniques, models or tools

Forty five responses (7.5%) referred to a variety of specific techniques or named particular models of therapy including: 'talk' therapies (such as *"Counselling", "Cognitive therapy", "Psychotherapy"*) were mentioned eight times; and being referred to appropriate literature was also mentioned eight times (of these *"Courage to Heal"* (Bass & Davis, 1990) was mentioned three times). Drug therapy was mentioned three times, as was including family in sessions. Jungian therapy, visualisation, and therapy that had a religious or spiritual approach were mentioned twice. Other therapies that were mentioned once included: Narrative therapy; Gestalt therapy; Neurolinguistic Programming (NLP); hypnotherapy; inner-child work; audio/video presentation; dream work; using metaphor; affirmations; rebirthing; bodywork; acupuncture; osteopathy and a specific 'personal growth' course.

3.1.2 Creative techniques

Thirty-six responses (5.9%) referred to some form of creative technique such as:

- Roleplay/Psychodrama (n=18): *"Role playing ways to do new things ie ask for help."*
- Writing (n=10): *"Expressing myself through writing down my thoughts, feelings."*
- Artwork (n=8):*"Drawing a picture about what happened and how I felt"*.

3.1.3 Group therapy

Fourteen responses (2.3%) stated that *"Group therapy"* such as incest or CSA survivor groups were helpful. For example one response stated that, through group therapy: *"I was able to listen to others and it gave me a window into myself."*

4 Therapy Work

Two hundred and sixty-two responses (43.3%) referred to helpful therapy work that included assistance to: deal with the effects of CSA; build the skills necessary to deal with everyday functioning; and express emotions. Assistance to deal with past and present relationships was also valued. Participants reported that helpful therapy: focused on their strengths; built their self-esteem; assisted them to understand the effects of CSA so that they felt 'normal' rather than 'mad'; and helped undo feelings of self blame about the CSA. Often participants had been silent about the abuse for decades, therefore, being able to disclose their experiences of CSA was reported as helpful.

4.1 Work on effects and functioning

One hundred and ten responses (18.2%) commented on the helpfulness of dealing with effects of CSA, expressing emotions, skill building, dealing with relationship difficulties, and building self-esteem.

4.1.1 Dealing with effects, skill building and expressing emotions

Sixty-four responses (10.6%) referred to dealing with a range of effects such as depression, symptoms of posttraumatic stress (such as flashbacks, nightmares), dissociation, and other effects such as feelings of isolation were reported as helpful. Building skills to deal with effects of CSA was an important way to assist the participant to be able to self-manage. Expressing emotions was reported as a helpful way to work through the impact of CSA.

Dealing with Effects - Respondents stated that they wanted to learn about the effects of CSA, such as posttraumatic stress, dissociation and depression, and be taught skills to manage them. Helpful information included: *"Flashbacks- how to distinguish the past from the present - how to <u>manage</u> them"; "Discovering techniques to reduce*

dissociation (eg body checks)"; "Learning, coping thought mechanisms to control the depression"; Dealing with phobias, dreams, etc"; and *"Learning and reading about posttraumatic stress"*.

Skill Building - Building skills to manage feelings and day-to-day functioning was reported as helpful. Examples included: *"Learning to feel"; "Learning how to deal with my emotions"; "Coping skills to help me function now as an adult"; "Learning to cope"; "Learning to feel 'not alone'"; "(Learning) self help strategies to cope (life skills)"; "Learning new coping mechanisms"; "Worked through … reactions with breathing exercises"; "Anger management"; "Learning how to deal with the abuse";* and *"Building inner resources to cope with fears."*

Expressing Emotions – Feeling able to express emotions, particularly anger and sadness, in therapy was reported as helpful. Respondents stated what was helpful was: *"The crying"; "Being able to finally let all the hurt out"; "Reducing some of the anger!"; "Letting my emotions out"; "Expressing my anger"; "Crying"; "Ridding myself of the anger I felt towards my father for what he'd done";* and *"For the anger to go"*.

As a result of dealing with effects, skill building and expressing emotions participants reported a number of gains: *"As I dealt with each grief or scar it faded"; "Putting actual CSA behind me"; "Hope for a more normal life"; "I could make good decisions now"; "Sense of control in life";* and *"My mind became unloaded and I was finally able to learn how to live"*.

4.1.2 Dealing with relationship difficulties

Twenty-five responses (4.1%) reported that what was helpful was: working on interpersonal difficulties with past and current relationships; learning about boundary issues; and learning ways to move on and build healthy new relationships. Responses included:

- Work on interpersonal difficulties: *"Forgiving my father and mother";* and *"My ex-husband blamed all our marital problems on CSA - therapy helped me realize this was not all my problem"*.

- Being taught about healthy boundary rights within relationships was helpful: *"Finally understanding that I have boundary rights"; "(Learning) to accept touch only when I am happy to receive it";* and *"Learning to say "No"*.
- Learning the skills necessary to build healthy relationships: *"(Learning) how to have an appropriate relationship with someone"; "Learning new relationship skills with all people"; "Being able to build trust with another person";* and *"Encouragement to create new relationships"*.

4.1.3 Self esteem and focus on strengths

Twenty-one responses (3.5%) reported that building a positive view of the 'self', self-esteem, and assertiveness was helpful. Examples included:

- Focus on strengths: *"Being affirmed and even praised for my courage"; "Realising a) all the effects on my life and b) how strong I am to have coped with them all"; "The clear message that I had done well with my life and was not a victim but a survivor"; "Looking at ways of putting less emphasis on "victim" and getting on with life"; "Finding my positive points";* and *"Realising I could heal"*.

- Building self esteem and confidence: *"Learning to like myself"; "Giving me back self confidence, assertiveness"; "Gaining self esteem as a right, not something to earn";* and *"Feeling better about myself"*.

4.2 Abuse experience normalised

Ninety-one responses (15.0%) reported that having a therapist explain that a respondent's thoughts, feelings, and behaviours experienced subsequent to the CSA were normal and predictable outcomes from such an experience, helped respondents to feel less 'mad' and helped them to reduce self-blame.

4.2.1 'Not mad' – understanding effects of CSA

Forty-eight responses (7.9%) related to participants appreciating help to understand how abuse in the past may have influenced their development, and how it could be having an impact on their current thoughts, feelings and behaviours: For example *"(Therapy) helped me understand why I react the way I do";* and *"(Therapy provided) an understanding of how CSA had affected my life both as a child and an adult"*.

It helped to hear from the therapist that they were normal: *"Realising how I reacted was normal"; "Telling me that my reactions are normal";* and *"Knowing how I felt and how I reacted to life was "normal" for CSA survivor"*.

Respondents expressed relief at finding out that their reactions to CSA were common and 'normal' reactions to CSA and did not mean that they were insane: *"She (therapist) could explain…that I wasn't nuts"; "Receiving reassurance that I was not mad"; "Having how I felt now normalised (I wasn't mad); "Realising I was normal"; "Reassure you are not crazy or mad";* and *"Reassurance that I was not crazy"*.

Information about the biopsychosocial effects of CSA was reported as helpful: *"Realising the effects"*. Reframing negative reactions to CSA as 'coping' or 'survival' strategies was also reported as helpful: *"Understanding what I thought were phobias were coping tools"*.

Learning of *"Others' experiences" (of CSA)* helped undo feelings of isolation so that: *"I didn't feel so alone with my feelings"*.

One response demonstrated the profoundly healing effect the process of normalisation could have: *"(Through) normalisation of my feelings, suicidality subsides"*.

4.2.2 'Not bad' – undoing guilt and self-blame

Forty-three responses (7.1%) made it clear that some participants had blamed themselves for the CSA and had carried the responsibility for much of their lives. Therefore, therapy that helped respondents to realize that they were children at the time of the CSA, lessened self-blame. Responses about what helped to lessen self-blame included: *"I brought a photo to a session (on the therapist's request) of myself at 6-8 years old to remind me that I was only a child and was not responsible for the sexual abuse"*.

Participants who learned that children could not consent to sexual encounters helped them feel less guilt and shame about the CSA. For example, what was helpful was: *"Being told a seven year old is not responsible for what happened";* and *"To realize it was very wrong for an adult to touch me sexually"***.**

Another helpful therapy strategy to deal with self-blame was when the therapist gave the name 'abuse' to their experience of CSA: *"Being told that what happened to me was not normal – it was abuse."*

Some participants commented that they felt "dirty", "disgusting" and "loathsome" for much of their lives. They found it helpful when therapists reassured them of their "goodness". Responses included: *"Reassurance that I am a good person";* and *""Truly believing it was not my fault."*

Participants reported that working through issues of responsibility helped to relieve guilt and shame. Examples included: *"To know it was not my fault and not feel guilty"; "The release of feelings of guilt and shame; "Not blaming myself anymore"* and to *"Forgive and stop blaming myself"*.

Being believed and reassured that they were not to blame for the CSA seemed to have a profound impact on some. For example, one comment stated that what was helpful in therapy was: *"Being relieved of guilt and fear carried for 28 years"*.

4.3 Able to disclose CSA

Sixty-one responses (10.1%) indicated that being able to share their experiences of CSA and feeling acknowledged and believed were important when disclosing the CSA.

4.3.1 Sharing CSA experiences

Of the sixty-one responses (10.1%), thirty-seven (6.2%) commented on the feelings of liberation involved with being able to talk about CSA; often after being silent about these issues for many years. What was helpful included:

- Being asked about it : *"When finally a therapist asked me if I had been sexually abused"*.
- Telling for the first time: *"Disclosure of my CSA after 47 years (of silence)"; "Just letting someone else know"; "Being able to say it out loud to someone…"; "One person (the therapist) knew of the CSA when no-one in… world did";* and *"To tell a stranger for the first time"*.
- Being able to talk about the details*: "Being able to bring it all out in the open"; "Being able to name my abuser"* and *"Talking about the abuse was great!"*

- Processing the CSA experience: *"Being helped to return to the past and relive and release the trauma"*.
- Talking about the impact: *"Being able to talk freely about what happened and how I felt"; "Being able to say how it affected me"*.
- Feeling free to talk without consequences: *"Able to talk about it and not be embarrassed"; "Free to talk about what happened with no guilt"; "Feeling safe to talk about it without being judged"; "Being able to talk honestly about what happened"; "The safe environment enabled me to acknowledge my abuse";* and*"To be able to talk freely about the rape"*.

Having shared the CSA in therapy assisted some (five responses) to take another step and share the experiences with their family. It was helpful: *"Finally telling my mother";* gaining the *"Strength and support to tell my family";* and *"Telling my spouse and children"*.

4.3.2 Feeling acknowledged and believed

Sometimes telling a therapist about the CSA was the first time a respondent had told anyone – many feared the therapist would not accept their disclosure or believe them. Twenty-four responses (3.9%) stated that what was helpful was to have the experience of CSA acknowledged and taken seriously: *"Having a therapist acknowledge that I was not making up a story"; "Acceptance of my truth"; "(The) therapist taking the abuse seriously"; "Acknowledgement of reality"; "Acknowledgement of my experience"*.

For some what was helpful was more than acknowledgement, it was feeling believed. A strong theme of what was helpful after disclosing CSA was feeling believed (the word "believed" was used in twelve separate responses): *"That my therapist believed me"; "Someone who believed me"; "The understanding and <u>BELIEVING</u>"; "Being believed"; "They believed me"; "I talked to people who believed me"; "Being validated and believed"*.

Having a therapist acknowledging how difficult it can be to disclose abuse was also helpful: *"That a counsellor understood the tremendous emotional impact of disclosure"*.

Summary Of What Was Helpful In Therapy

Access

Participants found therapy helpful when they had easy access to regular, affordable therapy with experienced therapists who were available and with whom they felt compatable.

Therapy relationship

To be helpful, the therapy relationship needed to be based on the therapist having a non-judgemental attitude, and being accepting and understanding. There also needed to be rapport, safety, care and support in the relationship. When respondents felt safe and supported by their therapists they felt able to talk about anything, at their own pace and they felt heard. Helpful therapists were interactive, communicating, encouraging, reassuring, affirming, empowering, affectively available and, involved with guiding, educating, managing, and, facilitating progress through the therapy.

Therapy Models

A variety of therapy models and specific techniques were named as helpful, for example: talk therapies; being provided with appropriate literature; and a range of other therapy tools and techniques. Creative expression such as role play/psychodrama, writing and art-work were also mentioned, as was group therapy.

Therapy Work

Participants found therapy helpful when they were assisted to deal with effects of CSA (including depression, suicidality, PTSD, and dissociation) and build the skills necessary to deal with everyday functioning (including learning to feel and deal with emotions). Helpful therapy also assisted participants: to deal with past and present relationships; focus on their strengths; and built self-esteem. Understanding the effects of CSA helped participants to feel ‘normal’ rather than ‘crazy’, and helped undo feelings of guilt and self-blame. Sharing details about their CSA experiences was reported as helpful when their experiences were acknowledged and believed.

CHAPTER SEVEN – UNHELPFUL THERAPY, MISSING THERAPY AND REASONS THERAPY ENDED

In this chapter findings from three questions asked of participants in the postal questionnaire are presented. They were: what was unhelpful in therapy; what was missing in therapy; and what the main reasons were for therapy ending.

What Was Unhelpful In Therapy

The 191 participants were asked the open-ended question: "Of all the therapy you had for the effects of CSA, what did you find most unhelpful?" Participants were asked to give up to three responses. Some gave only gave a word or two, others gave several sentences. The same methods used for analysing responses in Chapter Six were used in this Chapter (Methodology Chapter). The 364 responses were divided into four main categories approximating the process a client would progress through in therapy: 1) accessing therapy; 2) building a therapy relationship; 3) experiencing therapy models and techniques; 4) and doing work in therapy (Table 21). Examples of participants' responses are used to illustrate each subcategory.

Table 21. What Was Unhelpful

	Title of Major Categories, and Subcategories	**Major Categories (n) (%)**	**Sub-category (n) (%)**
1	**ACCESSING THERAPY**	**117 (32.1%)**	
1.1	Insufficient therapy available		28 (7.7%)
1.2	Emotional costs of therapy		27 (7.4%)
1.3	Funding issues		25 (6.9%)
1.4	Choice of therapist		25 (6.9%)
1.5	Practical issues		12 (3.2 %)
2	**THERAPY RELATIONSHIP**	**67 (18.4%)**	
2.1	Overly directive therapist		46 (12.6%)
2.2	Therapist not affectively available		21 (5.8%)
3	**THERAPY MODELS**	**53 (14.6%)**	
3.1	Creative techniques		24 (6.6%)
3.2	Various techniques, models or tools		22 (6.1%)
3.3	Group therapy		7 (1.9%)
4	**THERAPY WORK**	**127 (34.9%)**	
4.1	Lack of effective therapy for CSA effects		55 (15.1%)
4.2	Poor techniques or interventions		42 (11.5%)
4.3	Harmful practice		30 (8.2%)
TOTAL		**364 (100%)**	**364 (100%)**

1 Accessing Therapy

When asked what was unhelpful in therapy, one hundred and seventeen (32.1%) responses related to issues about accessing therapy. Of these: twenty-eight (7.7%) reported that the amount of therapy the participant had was insufficient; twenty-seven (7.4%) reported that there were emotional costs to accessing therapy; twenty-five (6.9%) responses referred to difficulties with funding; twenty-five (6.9%) commented on difficulties with the type of therapist they had access to, and twelve (3.2%) referred to practical difficulties accessing therapy.

1.1 Insufficient therapy available

Of the 28 responses that referred to having insufficient access to therapy, 18 (7.7%) were complaints that therapy was too short. Complaints included:

- The numbers of therapy sessions were insufficient: *"Help finished too early, needs to be ongoing"; "Having therapy cut off before solving my problems"; "Being told to end sessions because funding ran out"; "Having a time limit put on the therapy 'for my own sake'"; "Being told I was "cured" and no longer qualify for assistance"; "Not enough time – very unhelpful to stop in the middle of things"*.
- The therapy 'hour' was insufficient: *"One hour sessions too short"; "The sessions only went for one hour"; "Sessions not long enough"; "The fact that I had to stop (ie) time factor (ie) one hour for session – (Sorry hour is up)"*.
- The frequency of therapy sessions were insufficient: *"It was only once a week, 2 times would have been better";* and *"Insufficient time per week, at times 3 hours a week was necessary"*.

Five of the 28 responses reported difficulties accessing therapy. Responses included complaints such as: *"The amount of time it took to find a good therapist"; "Long waiting list to get an appointment"; "Urgency – waiting on long waiting lists";* and *"Therapist who said I'd have to come for 2 years twice per week initially, and since I needed such intense therapy she couldn't see me cos (she was) too busy"*. A further five responses stated that therapeutic support was unavailable between sessions, for example: *"When I was in a bad way my therapist was overcommitted and couldn't see me immediately"; "(There was) no back-up or future consultations";* and there was a *"Lack of outside appointment time support"*.

1.2 Emotional costs of therapy

Twenty-seven (7.7%) responses reported a range of emotional difficulties surrounding therapy that made continuing to access therapy difficult. Participants reported that it was not just the therapy hour that caused them distress and made staying in therapy difficult, but that they also experienced distress before and after therapy. Examples of responses included: *"Driving to therapy and back on your own, even though I know you need the time on your own"; "I found it difficult to go home and carry on after counselling";* and *"(The) emotional upheaval, the stress that it caused";* and *"(Therapy) brought things that happened out, which I wish had not come out, going home in tears afterwards, it was making me think more of the rape, bringing it out made how I felt worse"*.

The time in therapy was also described as difficult for example reliving traumatic events: *"Picturing clearly and describing abusers";* and *"Going back to relive events, flashbacks, (and) explaining how I felt to complete strangers"*. Talking about past experiences was described as unhelpful. Responses described: *"Going over the past experiences by talking"; "Too much talking about past experiences was emotionally painful";* and *"Talking incessantly, having to go over the same ground again and again"*.

Of the 27 responses, three referred to a wide range of emotional costs outside the bounds of the therapy process: *"(There was a) lack of support from others in my life"; "Societal stigma's concerning seeing a 'therapist' and issues surrounding mental health";* and distress due to *"No justice as brother (offender) (was) underage"*. A further three responses stated that therapy sometimes impacted on or involved their relationships with partners or friends. For example, one response stated that having *"Joint therapy with partner at the time"* was unhelpful.

Two of the 27 responses referred to ambivalence about therapy. Therapy was difficult but ultimately necessary: *"I hated therapy but I knew it was necessary to get well";* and *"I found … therapy difficult but still an opportunity I would like available to others"*.

1.3 Funding issues

Of the twenty-five (6.9%) responses in this sub-category, problems with accessing therapy through the ACC scheme were reported thirteen times. The other twelve responses referred to the cost of therapy being unhelpful.

There were two major difficulties with accessing therapy through ACC, these were:

1) The limited number of sessions subsidised or allocated by ACC: *"ACC restricted the amount of sessions, (I) felt pressured (to finish therapy)"; "The time limit set by ACC"; "Only 5 sessions on ACC"; "Lack of understanding by ACC of how long healing takes"; "ACC do not fully subsidize (the cost)";* and:
2) The difficulties maintaining therapy through the ACC scheme: *"Having to go thu ACC and to one of their assessors"; "My therapist had to fill in forms every few months to assess where I was in my counselling"; "Having to reapply for funding on a number of occasions"; "Having to undergo interviews with an ACC assessor"*.

Cost of therapy – Twelve responses complained about the cost of therapy, including: *"The COST"; "(Therapy was) <u>financially</u> crippling"; "Worrying about having to pay for the therapy"; "The financial cost (of therapy) on top of emotional burdens"; "The cost- as, if I had little money, it meant I had to sacrifice other parts of my life to continue (therapy)";* and *"The cost (of therapy) although (the) sexual abuse centre kept it to a minimum"*.

1.4 Choice of therapist

Twenty-five responses (6.9%) complained about the type of therapist the participant saw – in terms of the: clinicians' gender; their lack of training; professional background; their attitude and/or behaviour; their lack of a survivor-status; their sexual orientation; or their ethnicity. The type of therapist referred to as unhelpful included comments about:

- Male therapists (5): *"Having to build rapport with a man!"* ;
- Therapists' lack of training (5): *"Therapists who weren't experienced enough";*

- Doctors (General Practioners) (3): *"When going to a GP about initially getting psychotherapy it was suggested by the GP that may be I encouraged it (the CSA) by wearing "skimpy nightwear";*
- Psychiatrists (2): *"Psychiatrists visits – only gave me more pills"*
- Mental Health workers (2): *"Seeing the counsellor attached to the Psych (Psychiatric) Unit";*
- The lack of survivor-therapists (2): *"I would have felt more comfortable if the therapist had experienced CSA themselves";*
- Other types of therapists reported as unhelpful or lacking included (one response each): a student counsellor; an Alcoholics Anonymous counsellor; a lesbian counsellor; *"An older woman"* who was referred to as *"too pure to comprehend nature of abuse"*; the lack of a Samoan counsellor and the lack of a Maori/lesbian counsellor.

1.5 Practical Issues

There were 12 responses (3.2%) about practical obstacles when participants were attempting to access therapy. Examples included:

- Having to find another therapist (4): *"Changing therapists - having to tell story over and over again";*
- Travel and babysitting difficulties (3): *"Having to travel out of town for counselling"; "Babysitter problems to do this (therapy)"*;
- An uncomfortable therapy environment (3): *"The physical environment was run down, (it) cheapened processes for me"* ;
- Other practical issues (2): *"The lack of privacy with counsellors in my home town."*

2 Therapy Relationship

Sixty-seven (18.4%) responses referred to difficulties when therapists were unsupportive by being either overly directive (12.6%) or not affectively available ((5.8%).

2.1 Overly-directive therapist

Of the 67 responses (12.6%), 46 (12.6%) referred to therapists being overly directive by being:

- Too fast: *"Sometimes I felt things were happening too fast and overwhelmed me"; "(Therapist) trying to make me do an exercise I didn't feel ready for";*
- Impatient or 'pushy': -*"I felt my counsellor could have been a bit more patient – I did understand that it was only an hour session and time was money but rushing someone who had grown up in a sick and sad life… it takes time to unlock all the sad stuff"; "Pressure to consider group therapy";*
- Unrealistic: *"Unrealistic expectations and demands";*
- Demanding: *"Being preached at about forgiveness of the abuser"; "Being told to stop obsessive behaviour"; "Being told to forgive!!!";*
- Being judgemental: *"Being told* (by the therapist that) *I needed psychiatric help because I smoked marijuana and I wasn't allowed to swear – which in turn reinforced what I believed of myself at that time – not good enough and crazy!";*
- Disrespectful, patronising or blaming: *"Therapists who treat you as unwell"; "Being told I was possibly being manipulative when I said I wanted my husband to notice how I was feeling";* and
- The expert: *"(Therapists) who think they know all the answers"; "psychoanalytical approach of one therapist – told me x=y when I knew otherwise"; "(therapists) who tell you what to do".*

2.2 Therapist Not Affectively Available

Twenty-one responses (5.8%) referred to their therapist being unavailable to them in different ways particularly emotionally but also sometimes mentally and physically. Participants described therapists as unavailable emotionally when they were:

- Lacking in empathy: *"Lack of empathy by counsellor"; "Therapist wasn't really able to go to the level of emotional support I needed"; "Not offered empathy/sympathy for the trauma – recognising there are difficulties was too matter of fact – no emotional quotient"; "Sitting week after week looking at me – a me no therapist knew";*
- Unresponsive: *"Therapist distant and unresponsive"; "She was completely unresponsive"; (Therapist) had no experience to be present with me";* and
- Clinical - *" Too clinical"; "Feeling like just another patient"; "Basically being a number!!"; "Being immersed in it whilst the therapist observed".*

Some described therapists as unavailable mentally: such as – *"Lack of concentration";* and the *"Therapist NOT even listening"*. A few reported their therapist being physically unavailable such as: *"Sometimes the therapist was tired and worn out";* and *"When therapy sessions were interrupted and the therapist got up and walked out"*.

3 Therapy Models

Fifty-three (14.6%) responses referred to a number of specific therapy techniques, models or tools as unhelpful. Of the 53 responses about unhelpful therapy: 24 (6.6%) referred to 'non-talk' therapies such as 'creative expressions'; 22 (6.1%) referred to a variety of types of therapies; and seven (1.9%) responses referred to group therapy.

3.1 Creative techniques

Twenty-four (6.6%) responses reported creative techniques as unhelpful. Twenty-three reported that action methods such as role-play, psychodrama, talking to chairs and hitting cushions were unhelpful. Responses included: *"Role-play- pretending to be people I wasn't"; "Play-acting, attacking a pillow (for goodness sake!!!)"; "Psychodrama – the residual effect was me feeling split apart and not put back together"; "Screaming and pillow bashing"; "hitting things to release anger"; "Talking to chairs"; and "Using psychodrama- I didn't understand it and it felt silly"*.

The one response that did not refer to action methods was a criticism of having to draw in therapy: *"Being forced to 'draw pictures' when I didn't want to"*.

3.1.2 Various techniques, models or tools

Twenty-two responses reported a variety of therapy techniques, models or tools as unhelpful. Examples included:

- Literature - the way it was used or not used (n=4): *"Not encouraged to read any literature on the subject"; "One therapist …suggested I read several books about other CSA survivors – this was too much for me at the time";* and *"Receiving countless photocopy pages of "The Courage to Heal" with no follow-up discussion what-so-ever"*.
- Psycho-pharmaceuticals – the use or lack of medication as an option (n=3): *"Anti-depressants, made me worse"; "Of the four or five therapists I saw not one suggested psycho-pharmaceutical approach"*.

- Religion or the use of prayer (n=3): *"Talk of God"; "The very first Christian counsellor I went to only the once said "lets pray about this and put it all behind* – (I was) *suffering depression"*.
- A variety of other tools or models referred to included: *"T.A"* (n=2); *"Psychoanalytical approach"* (n=1); *"Gestalt therapy"* (n=1); *"NLP"* (n=1); *"Talking to the child in me"* (n=1) ; *"Doing homework!"* (n=1); *"Going to self defence classes fuelled the anger"* (n=1); and *"Visualisation – burying it all in a sea-chest and throwing the key away"* (n=1).

3.3 Group therapy

Seven responses (1.9%) reported that group therapy was unhelpful when the group was badly facilitated or unavailable.

4 Therapy Work

One hundred and twenty-seven responses (34.9%) referred to aspects of therapy work as unhelpful. Participants described therapy work as unhelpful when: there was a lack of information; therapy techniques or interventions were poorly carried out; or when the therapy practice was harmful in some way.

4.1 Lack of effective therapy for CSA effects

The largest number of responses (15.1%) in any sub-category to the question what was unhelpful about therapy appeared in this subcategory. Participants reported therapy as unhelpful when there was a *lack* of:

- Help to talk about the effects of the CSA– *"The counsellor didn't want to talk about it"; "First counsellor dealt with problems I was having with an alcoholic partner but didn't deal with my CSA"; "Most therapists I worked with only dealt with current problems eg not sleeping";* and *"Not having CSA long-term effects explained clearly"*.
- Interaction or positive management of the therapy process –*"Passive involvement by therapist"; "Long silences – not asking enough questions"; "Slow to pick up cues that need elaborating"; "Sitting without speaking for long periods of time"; "Counsellor... just sat there and said "Uhuh", "Yes", "Mm", without giving me anything constructive"; "At first it was good having someone*

to listen to me but I felt it was too non-directive"; and *"Therapists who seemed sweet but ineffective"*.

- Structure or direction– *"Allowing me to avoid the issue"; "(I could) easily manipulate to avoid painful work"; "Sensing the therapist wasn't sure where to go";* and *"I was given perhaps a little too much freedom to go on"*.
- Encouragement or reassurance –*"Not being asked when I wanted to come again – maybe they thought I didn't have a real problem";* and *"Not being reassured I was okay, that my problems were real and bad"*
- Solutions or information – *"The counsellor didn't offer me any solutions to help me"; "Gave little practical advice"; "Lack of clear diagnosis"; "Lack of education on new behaviour";* and *"Lack of information on condition"*.
- Focus on current abusive situations: *"Lack of labelling people's behaviour as abusive";* and *"The abusive nature of sex with my husband not fully recognised"*.
- Direction and referrals – *"I felt didn't get any direction in terms of support group therapy – I had to search for it myself";* and*"Not being referred on to a GP (for my) major physical health problems"*.
- Following through – *"Therapist not following through on aspects of therapy";* and *"Left emotionally wound up and now what!!"*.
- Movement through therapy – *"Going over 'old ground'; "Didn't get to the heart of problem quickly enough"; "Repetitive questions in some sessions";* and *"Telling same stories and getting angrier"*.
- Progress- *"Frustration at the lack of progress in most cases"; "Lack of forward progress"; "Leaving and still feeling the same"*.
- Goals being achieved – *"Not being able to like myself much more than I did"; "No real lasting benefits- knowing why I do things doesn't mean I can stop doing it"*.

4.2 Poor techniques or interventions

Forty-two (11.5%) responses referred to practice issues by therapists that the participants were critical of. (Whereas 4.1. focused on gaps (or omissions) in therapy, this sub-category focuses on techniques the therapists carried out (commissions) that were deemed to be unhelpful.) Participants reported that sometimes therapists were:

- Inadequate in assessing participants' needs or inadequate in providing therapeutic support – *"Being told I was 'cured' and no longer qualify for assistance"; "Made to feel my case was trivial"; "Being told I was only depressed – see my doctor";* and *"I was asked to write a letter, next session we burnt it and I was told I did not need any more sessions"*.
- Too interventionist – *"Too eager to rescue"; "Therapist who talked too much";* and *"Constantly questioning my feelings"*.
- Poorly attuned to the participant needs– *"Sometimes the focus shifted to my siblings' abuse – I needed the therapist to be mine"; "Therapist discussing issues not relating to me"; "When I was told that my parent must have had a bad life as well"; "When I was told (to) – think of how it feels being an abuser"; "Brushing off effects of CSA"*.
- Poor at providing or conveying information: *"Advice that could not be put into practice"; "Simplistic explanations of relationship dynamics – eg parent, adult, child";* and *"Parrot fashion responses – quotes from the manual"*.
- Poor at implementing some techniques or interventions - *"Opening the issue then not dealing with it";* and *"My husband was brought into two sessions and I was a child again when the therapist and husband spoke about me as though I wasn't in the room"*.
- Poor at time keeping or session management – *"Having to wait for long periods when the therapist was running late"; "Being interrupted by phone calls to the therapist, when I was seeing her"; "The session being interrupted by phone or other people";* and *"Clock watching by the therapist"*.

4.3 Harmful practice

Thirty responses (8.3%) reported different aspects of the therapy practice that were classified by the researcher as potentially harmful rather than merely unhelpful. Responses about harmful therapy practice included difficulties with:

- Being blamed for being abused: *"Told I chose to be abused, violence, rape by partners with alcohol/drug problems";* and *"Therapist blaming me"*.
- Boundary issues*: "Counsellors who then became my friends – not understanding power imbalance between us or my needs to have boundaries modelled"*.

- Sexual boundaries: *"Counsellor with obvious sexuality/sex problems who imposed them on the therapeutic setting*". Touch boundaries: *"A male counsellor who touched me without consent";* and *"Hugs when not wanting to be touched"*.
- Unresolved therapists: *"Therapist doing her work through me"; "Therapist who "shared" their own issues";* and *"The therapist …constantly talked about her own experiences and I could still feel her anger"*.
- Confidentiality or ethical considerations: *"My confidentiality was not maintained"; "Knowing what I was going to say would go back to my GP (who had already told me how pleased he was that (the offenders were not) my father or brothers)";* and *"One therapist destroyed the trust I had built up by doing something I found ethically unacceptable"*.
- Labelling: *"Being labelled damaged";* and *"Being labelled, and told I have this/that mental problem, DSMIV"*.
- Angry therapists: *"More than once (the therapist) shouted at me (and, I) was told I was difficult"; "Telling me that I am being irrational"; "My therapist responding angrily when I expressed suicidal feelings"; "A therapist getting angry with me";* and *"Bullying"*.
- Insulting comments: *"One psychologist said "don't lie down and die about it";* and *"When I told a therapist that I wished I was dead, he replied, 'too late for me to help you now, but if I had met your mother I could have aborted you";*
- Racism: *"Racist therapist"*.
- Irresponsible practice: *"The therapist not taking seriously vague thoughts of suicide";* and *"One therapist thought it would be a good idea to confront my abuser – I found that hugely daunting and very detrimental";*
- Being forced out of therapy: *"Being dumped by my…therapist when I expressed interest in doing a group psychotherapy programme elsewhere";* and *"Constant requests for more money, less interest in me when I couldn't produce more funds, I felt forced to leave over money issues"*.

Summary of what was unhelpful in therapy

Access

Almost a third of responses reported that therapy was unhelpful when access was difficult such as: when therapists were unavailable or when participants received insufficient time in therapy; the emotional costs of attending therapy were too high; when participants were unable to pay for therapy; when ACC limited their number of their sessions; when participants did not feel compatible with the therapist or the professional lacked training or understanding of the effects of CSA; and when there were practical obstacles to attending therapy.

Therapy relationship

An unhelpful therapy relationship was described as when the therapist was either overly directive (pushing the therapy too fast, being demanding, impatient, judgemental, unrealistic, or acting as the expert) or not affectively available (being emotionally unavailable including lacking empathy, being unresponsive and clinical, or being mentally or physically unavailable.

Therapy Models

Certain uses of creative expression, particularly action methods such as role-play and psychodrama, were mentioned as unhelpful. A variety of therapy models were also referred to as unhelpful, for example: the way literature was introduced or not introduced; the use of or lack of options regarding the introduction of psycho-pharmaceuticals; when religion was used in therapy; and the way a variety of other therapy models, tools or techniques were used. Group therapy was also reported as unhelpful when badly facilitated or not available.

Therapy Work

Participants found therapy sessions unhelpful when:

1. There was a lack of effective therapy for CSA effects such as a lack of (omissions): help to talk about the effects of the CSA; interaction or positive management of the therapy process; structure in the therapy; encouragement or reassurance; information; focus on current abusive situations; direction and

referrals; sufficient movement or progress through the therapy process; or goals achieved.

2. Techniques or interventions were poorly carried out (commissions), including when therapists were: inadequate at assessing the needs of the participants and in providing sufficient therapeutic support; too interventionist; poorly attuned to the participant's needs; poor at providing information; poor at implementing techniques or interventions; or poor at time keeping or session management.
3. Therapy practice was harmful when there were problems with: blaming; boundary issues; confidentiality; labelling; or with therapists who brought their issues into therapy, were abandoning, angry, irresponsible, racist, or insulting.

Missing From Therapy

In the postal questionnaire, after being asked what participants found helpful and unhelpful in therapy, participants were then asked if there was anything missing from therapy that they would have wanted included. Many of the participants' responses to this question echoed the previous question about what was unhelpful in therapy.

When asked what was missing from therapy, participants were asked to give up to three responses. They gave a total of 241 responses (Table 22) (see Methodology Chapter for discussion of category development). The response data formed four major categories: 1) access issues; 2) therapy relationship; 3) therapy models; and 4) therapy work.

Table 22. What Was Missing From Therapy

	Title of Sections, Major Categories and Sub-categories	Major category (n) (%)	Sub-category (n) (%)
1	**ACCESSING THERAPY**	**59 (24.5%)**	
1.1	Sufficient therapy		24 (9.9%)
1.2	Trained, aware, compatable therapists		18 (7.5%)
1.3	Funding		12 (5.0%)
1.4	Pleasant Environment		5 (2.1%)
2	**THERAPY RELATIONSHIP**	**35 (14.5%)**	
2.1	Listening, supportive interactions		35 (14.5%)
3	**THERAPY MODELS**	**46 (19.1%)**	
3.1	Various therapies and techniques		25 (10.4%)
3.2	Group therapy		13 (5.4%)
3.3	Therapy for family members		8 (3.3%)
4	**THERAPY WORK**	**101 (41.9%)**	
4.1	Therapy focus and processes		66 (27.4%)
4.2	Attention to therapy framework		15 (6.2%)
4.3	Inter-session support		13 (5.4%)
4.4	Other issues		7 (2.9%)
	TOTAL	**241 (100%)**	**241 (100%)**

1. Accessing Therapy

Participants reported a number of difficulties accessing therapy including: obstacles to gaining sufficient therapy; and accessing well-trained, knowledgeable and aware therapists to work with the effects of CSA.

1.1 Sufficient therapy

Twenty-four responses (9.9%) stated that what was missing in therapy was sufficient therapy time. Responses stated a need for therapists to be more available, longer therapy sessions, and a longer duration of the course of therapy, as well as more support between and after therapy sessions. Apart from responses complaining that therapy ended too soon, some responses indicated a wide range of obstacles to gaining access to therapy including: time, distance, and other practical obstacles. Participants who worked full time could only manage weekend or evening appointments - when few therapists were available. Some participants reported having to travel as far as 45 kilometres to see a therapist. In terms of practical obstacles, what was missing for some participants were: *"Petrol vouchers"* to get to therapy; *"Home visits"* for those who were unable to leave

their homes; *"Child care";* less time delays waiting to see a therapist; and help and support when having to change therapists.

1.2 Trained, aware, and compatible therapists

Eighteen responses (7.5%) referred to not having access to trained, knowledgeable and compatible therapists. Participants wanted therapists to be more aware of a range of social and cultural issues such as the impact of: colonisation; poverty; and being gay. More Maori therapists and survivor-therapists were called for.

1.3 Funding

Twelve responses (5.0%) reported that they experienced gaps in funding and information of how to access ACC funding.

1.4 A pleasant environment

Five responses (2.1%) referred to a lack of a pleasant therapy environment. Criticisms of therapy rooms included that they were: *"Uncomfortable", "Small", "Shabby",* lacking in *"Sound proofing*", and lacked *"Bright walls", "Positive posters",* and *"Comfortable chairs".*

2 Therapy Relationship

For some participants, missing from therapy were therapists who listened, were warm, interactive and those with whom they felt safe.

2.1 Listening, supportive, interactive therapists

Thirty-five responses (14.5%) reported that missing aspects of therapy were interactive, caring therapists who listened and provided support. Complaints in this sub-category ranged from therapists who were under-involved to those who were intrusive.

Several participants complained that their therapists lacked: *"Empathy"; "Warmth"; "Connection"; "Personal interest";* and *"Commitment"* to them. A few reported that the therapy felt *"Cold"* and *"Clinical"* and that they would have preferred an individualised approach - rather than a *"Text-book approach".*

Some respondents complained that their therapists were too *"Passive",* or that they lacked *"Active involvement"* or *"Participation"* in the therapy. One participant would have liked an acknowledgment of her as *"A person not just a victim or a case".* Several participants wanted the therapist to focus on their *"Feelings"* rather than giving them

"Diagnostic labels". Some wanted reassurances of their normality, others wanted the therapists to acknowledge and validate their abuse experiences.

A few participants commented that what was missing was the therapists *"Listening"* to them. Some complained that their therapist should not *"Assume they know the meaning"* of their client's trauma. A number criticised therapists who chose the focus of therapy. A few complained that their therapists over-disclosed about their own issues. For other participants what was missing included: therapists' with non-judgemental attitudes; feeling *"Safe"* with the therapist; and some self-disclosure from the therapist to lessen the power imbalance.

Some participants complained that what was missing from therapy was their therapists providing them with: reassurances about the effectiveness of the therapy process; belief in the participants' ability to recovery; positiveness; and/or hope. One participant commented that her therapist lacked energy and seemed *"Too tired"*. Another missed some form of touch within therapy.

3 Therapy models

A number of participants complained that missing from therapy were various therapies and techniques as well as group therapy and therapy for family members.

3.1 Various therapies and techniques

Twenty-five responses (10.4%) reported wanting additional therapy techniques or adjunct therapies. Some responses reported that what was missing was different types of therapies beyond *"Just talk"* therapies such as: *"Journaling and writing exercises"; "Art therapy"; "Action methods"* (including two chair work); *"Assertiveness training"; "Self-defence lessons"; "Sex therapy";* and *"Drug therapy"*. Several participants said they wanted more therapy techniques to help them: *"To remember"; "To forgive"; "To understand the nature of addictions";* to learn *"Time-management skills"* and *"To deal with men"*.

Some wanted more therapy techniques to help them regulate the effects on their bodies (not just their minds and behaviour) including: help or information about the physical effects of PTSD; *"Nutrition and exercise programmes";* and *"Massage"*. Others wanted: more appropriate literature especially *"Case studies about other NZ*

participants"; more secular therapy – reporting that there was *"Too much religion in therapy sessions";* and re-parenting techniques.

3.2 Group therapy

Thirteen responses (5.4%) reported the lack of availability of group therapy, especially in rural areas, and of the lack of availability of on-going support groups after one-on-one CSA therapy was complete.

3.3 Therapy for family members

Eight responses (3.3%) reported that therapy for family members was missing from therapy. Several participants reported wanting support and education for their partners, children and other family members either through their inclusion within the participants' therapy sessions or through family members having their own therapy sessions.

4 Therapy Work

Some participants found aspects of therapy processes, the therapy framework, and inter-session supports missing.

4.1 Therapy focus and processes

Sixty-six responses (27.4%) reported that aspects of therapy work missing were related to the focus and process of therapy.

Missing therapy focuses included: a general *"Lack of focus on CSA"* issues, and a lack of focus on some of the broader effects of CSA such as *"Day-to-day life-skills"*, *"Coping skills"* and *"Self-esteem"*. Missing information about the dynamics and effects of CSA as well as a lack of 'you were not to blame' messages. Several participants wanted the focus of therapy to be: on *"Forgiveness"* rather than focus on: *"Heaps of anger";* to *"Let go of the past and move on"*, or; on the *"Self as an adult, not as a child"*. Missing therapy focuses also included work on: relationships; parenting; sexual difficulties; shame and guilt issues; help with symptoms of PTSD such as *"Nightmares";* and help to deal with the *"Avoidance of physical touch"*. Other respondents complained of insufficient therapy focus on: *"Multiple personalities";* a current *"Abusive professional relationship";* acknowledging *"Injustice";* acknowledgment of the strengths and skills to have survived the CSA; the development of *"Coping skills"* to deal with disclosures of CSA; a therapist accompanying them to

the site of the CSA; and help to confront the offender in writing or in person. Some respondents complained that missing from therapy was: *"Progress in healing"*; *"Realism"*; *"A wider perspective"* (of life outside the therapy room); and strategies to help deal with life after therapy had ended.

Missing therapy process included: sufficient *"Time"* in therapy before feeling pressure to talk about the CSA; help to work through issues *"…rather than just lifting the lid on issues"*; help to understand the link between depression and a history of CSA; "*Encouragement*" to help direct the focus or pace of therapy; therapists who were comfortable with strong emotions; work on *"Deeper issues"* such as support to *"Work through grief"*; questions to help the therapy session *"To get started, rather than (have) just silence"*; and more *"Challenges"* in therapy but not those that were *"Carried out too harshly"*.

4.2 Attention to therapy framework

Fifteen responses (6.2%) reported that what was missing from therapy was attention to the therapy framework such as introductory information about the process of therapy (how therapy worked) and better structures (time-keeping; note-taking) within therapy. For example, participants wanted clear messages from the beginning of therapy about: their *"Rights"* in therapy, the *"Ethics"* of the therapy process; and discussion about the course of therapy including how *"Hard"* and *"Scary"* the process of therapy could be and; better structures within the therapy such as: the therapist being punctual; more progress assessments; notes being kept; time-out options (especially when little progress was occurring); tape-recordings of session; and appropriate finishing-up of therapy sessions (so they did not leave feeling overly distressed).

4.3 Inter-session support

Thirteen responses (5.4%) were about the lack of inter-session supports from their one-to-one therapist (such as phone calls or follow-up), as well as *"Extra-therapy support"* from mental health staff (such as crisis teams and help lines) that were knowledgeable and understanding about CSA. After therapy had been terminated some participants reported that they would have liked help from follow-up courses such as ways to maintain *"Positive thinking"* and *"Self-help strategies"* to consolidate their therapy work. Some would have liked occasional check-ups from their last therapist - especially after long-term work.

4.4 Other issues

When asked what was missing from therapy, seven responses (2.9%) commented on other issues largely outside the bounds of therapy. Participants: 1) lamented the current lack of understanding of CSA in the community; 2) wished that the pre-1970s era had acknowledged and acted to deal with CSA; 3) (an older participant) regretted the lack of abuse-focused therapy available when she was younger; 4) would have liked to have the therapist some how make the offender acknowledge and apologise for the CSA; 5) wished they had been able to confront the offender; wanted their family's support in their healing and; 6) would have liked to have been able to talk to their parents about the CSA before their parents had died.

Summary of What Was Missing From Therapy

Access

The most frequent aspect missing from therapy was the participants' ability to gain sufficient therapy for their needs. Other obstacles included: gaining access to trained and aware therapists who were also compatable with the participants. Funding was a problem for some. Finding therapy in a pleasant environment was a problem for a few.

Therapy Relationship

Participants reported that several aspects of the therapy relationship were missing including therapists: who: listened; provided empathy; warmth; reassurance; responsiveness; were supportive of them choosing the focus of therapy and; therapists who were positive, hopeful and not tired.

Therapy Models

A number of therapy techniques, and adjunct therapies were reported as missing such as: journaling; art therapy; action methods; group therapy; and therapy for family members.

Therapy Work

The most frequently reported aspects missing from therapy work were sufficient focus on a variety of effects of CSA and therapy processes including: sufficient time in therapy before feeling pressured to talk about the CSA; and help to work through effects of CSA. Other aspects missing from therapy included attention to the therapy framework such as: explanations about participants' rights, therapy processes and ethics, and inter-session supports such as follow-up contact outside of sessions.

Main Reasons Therapy Relationship Ended

Participants were asked to give up to three main reasons that their therapy relationships ended. They gave a total of 329 responses that were divided into two major categories: access to therapy and therapy practice issues (Table 23).

1. Accessing Therapy

Access to therapy ended for four main reasons: the cost or the termination of ACC funding; the participant moved location; the therapist became unavailable; or practical barriers to continuing therapy.

Table 23. Main Reason Therapy Ended – Type And Frequency Of Participant Responses.

	Titles of major categories and subcategories	**Major category n %**	**Sub-category n %**
1	**Accessing therapy**	**105 (31.9%)**	
1.1	Costs or ACC funding ended		49 (14.9%)
1.2	Participant moved location		24 (7.3%)
1.3	Therapist became unavailable		20 (6.1%)
1.4	Practical barriers		12 (3.6%)
	Therapy practice issues	**224 (68.1%)**	
2.1	Positive outcomes		114 (34.8%)
2.2	Lack of progress or poor abuse-focused therapy practice		45 (13.6%)
2.3	Angry with therapist practice		29 (8.8%)
2.4	Therapist decided therapy should end		13 (4.0%)
2.5	Emotional barriers to staying in therapy		12 (3.6%)
2.6	Moved on to other therapies or support		11 (3.3%)
	Total	**329 (100%)**	**329 (100.00%)**

1.1 Cost or ACC funding ended

Forty-nine (14.9%) of responses related to the: prohibitive costs of therapy; ACC funded therapy ending; and pressures on therapy agencies. Of these, 33 responses reported that the therapy ended when: the participant could no longer afford therapy; the funding for the therapy was *"Taken away";* or the therapist put up the fees. Of the 49 responses, 16 responses reported that therapy ended because their ACC funding ended or there was *"Pressure from ACC to end therapy"* because the number of therapy hours had "*Built up*".

1.2 Participant moved location

Twenty-four responses (7.3%) reported that therapy ended because the participant had moved away from the therapist.

1.3 Therapist became unavailable

Twenty responses (6.1%) reported that therapy ended because the therapist moved locations, left the agency, became ill or died.

1.4 Practical barriers

Twelve responses (3.6%) commented that they ended therapy due to: travel difficulties; child-care problems; a mental or physical illness; the birth of a child; or because of time factors such as: the amount of time therapy takes; beginning a full-time job and the therapist's hours were not flexible enough to accommodate this change.

2. Therapy Practice Issues

Participants reported six different themes regarding therapy practice that caused their therapy to end: positive outcomes; lack of progress or poor abuse-focused therapy practice; anger towards their therapists; therapists deciding the therapy should end; emotional barriers to staying in therapy; or moving on to other therapies or other supports.

2.1 Positive outcomes

One hundred and fourteen responses (34.8%) stated that therapy ended because of positive outcomes. Participants reported positive outcomes including: they had achieved sufficient progress; they had achieved their goals; their 'symptoms' had reduced; and/or they felt emotionally strengthened and ready to move on. Some decided they were able to cope without therapy. Several were ready to move on to other priorities such as new careers, educational opportunities or relationships. Some participants wanted time out of therapy to consolidate the therapy work they had done. For many participants there was a *"Natural wind-up"*, a feeling that the therapy had *"Run it's course"*, or the therapist and participant agreed that sufficient progress had been achieved. Many in this category seemed to have 'left the door open' to therapy should they require it in the future.

2.2 Lack of progress or poor abuse-focused therapy practice

Forty-five reasons (13.6%) for therapy ending was the opposite of the first: lack of progress in therapy or the therapy practice was poor. Some participants felt that the therapist did not fully grasp the effects of the CSA or did not follow-up on the disclosure of CSA - so they left the therapy relationship. Some participants felt they were in the *"Too hard"* category for therapists to cope with, so the therapy ended. A few participants complained about therapists' skills reporting that the therapists were *"Not experienced enough"* or *"The counsellors' skills and qualifications were at a minimum"*. For others there were boundary issues: *"The therapist grew to be friends"* or therapist's poor time keeping issues: *"I waited over an hour"*. Other participants said the therapy became *"Stale"*. Some participants reported that their own motivation to attend therapy dwindled, and others said they wanted a new challenge so went on to try another therapist. A few participants said the therapy was not helpful enough to continue. A few participants reported that some therapists were involved in "spiritual healing" and they moved on to find more secular therapists.

2.3 Angry with therapists' practices

The issues described within this category overlap slightly with the previous category that related to poor practice, however the tone of the responses in this category seemed to be angrier with the therapist than the earlier category. Twenty-nine responses (8.8%) reported a variety of reasons for being angry with therapists including: participants feeling that the therapist was disinterested in them; the therapist was a *"Self-talker";* the therapist was unprofessional because she/he were late or took phone calls in the session; the therapist was sexually inappropriate and *"Hit on"* the participant; the therapist used *"Dubious methods";* the therapist *"Made my situation worse";* or *"The counsellor said things which really upset me and undermined my confidence"*.

2.4 Therapist decided therapy should end

Thirteen responses (4.0%) suggested that the therapy ended, mostly against the participant's preference. Examples included: the therapist *"Couldn't help me any more";* or *"There was nothing more they (therapist) could do for me"*.

2.5 Emotional barriers to staying in therapy

Twelve responses (3.6%) reported emotional barriers that led to them ending therapy such as: feeling too depressed to attend therapy; another stressor was overwhelming; fear of becoming dependent on the therapist; being tired of the therapy; *"Felt worse"* after therapy*;* it was *"Disturbing talking about the past";* it was *"Too painful to go over the abuse"; "It became the only focus of my life";* and *"I didn't want to feel like a 'victim'"*.

2.6 Moved on to other therapies or support

Eleven responses (3.3%) reported that the participant moved on to other therapies or supports including: drug therapy; group therapy; an inpatient facility; Bible healing; a male therapist; and a therapist seen previously.

Summary of why therapy relationships ended

Only one third (34.8%) of responses referred to therapy ending for positive reasons. A further third (31.9%) of responses referred to therapy ending because access became problematic. Of these, half (14.9%) of the reasons were due to the cost of therapy or ACC funding ending. Just over a quarter (26.4%) of reasons for why therapy ended were related to less than satisfactory therapy experiences and 6.9% included emotional barriers or participants moving on to other therapies.

CHAPTER EIGHT – THE INTERVIEWS

Following the postal questionnaire, a sub-sample of 20 participants took part in face-to-face interviews that specifically focused on their helpful and unhelpful therapy experiences. This chapter presents some of the key themes of this sub-sample. Relevant themes are compared with the synopsis of recommended 'best-practice' abuse-focused therapy guidelines outlined in Chapter Two. (For ease of reference this synopsis will be referred to as a whole such as 'abuse-focused therapy guidelines' or guidelines in 'Chapter Two').

Key themes that emerged from the 20 interviews included: the process of accessing therapy and finding a therapist to work with; and interactions that could be helpful and unhelpful in therapy. Interviewee participants were not asked what pseudonyms they preferred therefore, the letter "P" has been used to signify 'participant' and the number assigned represents their interview number. (The sub-sample numbers began at six because they followed on from the five Pilot interviews – hence the sub-sample ranges from P6-P25).

Similar to Dale (1999) this chapter gives more space to aspects of therapy that participants found unhelpful because this feedback is scarce in the literature and survivors of CSA seem to have difficulties giving criticism directly to their therapists. The aim of this study is not to undermine the value of therapy for survivors of CSA but to illustrate some of the therapeutic errors and miscommunications that can occur in the hope that future clinicians will be able to learn from this material.

Most interviewees in this sub-sample had a range of helpful and unhelpful therapy experiences. It seems that the therapists they encountered ranged from superbly knowledgeable, skilled, warm, attentive, generous, caring, and life-saving therapists to those who were poorly skilled, disrespectful, abusive, and harmful. In their postal questionnaires: eight of the twenty participants (40%) had rated therapy as 'Very helpful'; six (30%) as 'Somewhat helpful'; three (15%) as 'Made no difference'; two (10%) as 'Somewhat unhelpful' and one (5%) as 'Very unhelpful'.

Process Of Accessing Therapy

At the beginning of each interview interviewees were asked about the circumstances that led them to therapy and the process they went through finding a therapist.

The effects of CSA that led the women to seek help

Most of the 20 said that they had always been aware of their CSA experiences although many had "*tried desperately*" to put these experiences out of their minds. As well as attempting to suppress or avoid their memories of their CSA experiences, each person in the sub-sample reported a number of difficulties in their adult lives all of which are well-documented effects of CSA (Chapter Two). For example, almost half spontaneously reported that they had felt suicidal at some point in their lives. As P8 reported: *"I felt suicidal from about the age of five to be honest"*…and P23 stated: *"I'd been…thinking about suicide on and off to various degrees for many, many years"*.

In addition, interviewees reported: *"feeling depressed for years"*; nightmares and sleep disturbances; feelings of "*absolute terror every single day";* hating themselves so much they *"just wanted to die"*; exhausting bouts of intense (seemingly irrational) panic attacks; feelings of being "*different*" from others and *"a freak"*; feelings of isolation and loneliness because they could not cope with relationships; only being able to have casual sex and having to be drunk to do so; feeling unable to have a relationship without it being sexual and referring to themselves as promiscuous; experiencing "*over the top anger*" and *"almost foaming at the mouth"*; becoming violent and using weapons; having fears of harming or killing their children; avoiding having children to ensure that any child they had would not be harmed; feeling terrified of and/or loathing for men; being involved in a series of failed relationships and marriages; experiencing revictimization in the form of domestic violence, rapes and/or sexual harassment; having previous histories of chronic self-harming and/or of being drug and alcohol dependent.

Many of these difficulties left interviewees feeling that they were *"mad"* or *"crazy"*. Living every day with feelings of terror, self-loathing and being unable to get close to other people meant that for many staying alive was a daily struggle. For example, P23 reported that she entered therapy after years of battling suicidality, attempts at

suppressing thoughts of the CSA, and a destructive level of self-hatred following CSA by her father from age three to twelve. P23 stated that before entering therapy:

> *I'd just been running away trying desperately to forget, feeling filthy, dirty and self disgust…all these feelings of self-revulsion and I had quite a fixation about the fact that my father's blood was running around my body…I'd want to strip that blood out of my body…I mean I hated myself so much because of what happened to me …that was the legacy (of CSA). P23*

P22 had experienced CSA from age two and a half to age 15 by her father, a boarder, an uncle, two neighbours, a stepfather, a cousin, a family friend, an acquaintance and a stranger. She described some of the wide-ranging consequences to her life that she attributed to CSA and that eventually led her into therapy:

> *…It (the CSA) impacted on the people I chose to relate with, it impacted on my access to education; thinking that I was nothing and deserved nothing; to choosing relationships with people that treated me like I was nothing. So now I have three children, who I love very much, but my children have different fathers…(and) I don't think I would be on a Benefit if I wasn't (abused)…It's just…all these consequences… (P22)*

Understanding the long-term effects of CSA

Despite most interviewees being aware of their histories of CSA and experiencing significant effects from this childhood abuse, few had made the connection between their past experiences, and present adult difficulties, and deliberately sought therapy to discuss their CSA experiences. For example, although P19 had never forgotten the CSA (to the level of penetration) by her step-father from when she was nine to fourteen years old, she went to her doctor with a list of difficulties, but did not mention the CSA. She had little understanding of the possible link between her CSA experiences and her current difficulties:

> *I was suffering depression, confusion, no self-esteem…want(ed) to kill myself… so I went to my doctor and basically told her I felt like I was going mad. (P19)*

This finding is similar to other studies (Mullen et al., 1996; Wurr & Partridge, 1996) that have found that some survivors of CSA seek therapy for the difficulties in their lives (such as depression, fears, suicidality, relationship difficulties, and/or alcohol and drug dependence) often from generic therapists (such as relationship counsellors, mental health workers, student health counsellors, church counsellors, eating disorder services, drug and alcohol services, crisis teams, and psychiatrists) without necessarily

immediately disclosing their histories of CSA or making the connection between their abuse histories and their current difficulties.

Many of the 20 sought therapy from generic therapists and it seems that very few were given assessments that included questions about past or present experiences of violence. The lack of a complete assessment that included questions about child and adult experiences of violence and abuse (as recommended in Chapter Two) precluded any discussion of CSA experiences and the acknowledgement that violence can have an impact on adult mental health. Therefore, although most participants sought therapy for the effects of CSA, their histories of CSA were not always identified and they were not given the opportunity to consider for themselves if there was a connection between their past experiences and their present difficulties. One of the most extreme examples came from P18. P18, a 56-year-old woman, was desperate to get well and be rid of the "*terrors"* she lived with after being sexually abused from age six to age 17 by her brother-in-law. She was willing to try any therapy and she saw over 20 male therapists from 1963 until 1997 including psychiatrists, doctors, church counsellors, and a psychodramatist. She was angry that not one of them asked her if she had experienced child sexual abuse. She stated:

> *Good topic for a book isn't it – "No one ever asked me"…you really need someone to ask you (about the CSA)…Now…I've wasted all these years just for the sake of someone asking me. But maybe they didn't know either then…(but) they should of from the seventies on surely, shouldn't they? (P18)*

Some interviewees commented that even if they were asked about an abuse history in therapy they were not sure if what they experienced constituted CSA. Some said it was difficult to talk about the CSA because they had minimized the experience to themselves – especially if the CSA did not include penetration. A few of these participants used their therapists' reactions as reality checks. For example P15 was not sure if two years of genital fondling from age six to eight years by a male friend of her parents was regarded as CSA:

> *My sexual abuse wasn't rape, there was no intercourse as such and so I very much belittled it as not being bad enough to be abuse…and (for the therapist) to say that what happened to you was bad enough to be sexual abuse …was really important. (P15)*

Some interviewees however had begun to make the connection between their CSA histories and their current difficulties for themselves prior to therapy. An example of a tentative connection being made was reported by P17. She had experienced CSA by her grandfather and a male family friend to the level of penetration from age eight to eleven. When she phoned a therapist for the first time she reported her difficulties to the therapist and then said:

> *Up until now I've always blamed myself but I'm wondering, would the fact that I have been sexually abused have anything to do with that or play any part in my functioning?*

Others entered therapy feeling that they needed help from professionals to talk about the CSA because they had not talked about it before. For example P15 had not disclosed the CSA for 22 years:

> *I'd never talked to anyone about what this man had done to me. I hadn't spoken about it to anyone (P15)*

Some needed to know that their therapists would not *"be grossed out"* by their disclosures of CSA and that they would be strong enough and *"together enough"* to cope. They also needed to know that their therapists understood their fears of their own reactions to telling about the abuse for the first time.

Some abuse-focused therapists did ask about CSA but did so in such a cold and clinical way that the interviewees reported they did not want to answer them. Some interviewees said they denied their CSA experiences rather than disclose such a sensitive topic to a therapist that they could not trust. For example one interviewee reported that she had gone to see an ACC registered therapist to lodge a claim for subsidized therapy. While taking down the details in the first session, the therapist was looking at the form, ticking appropriate boxes and she casually asked "*Did penetration take place?"*. The participant reported feeling huge anger at the therapist for asking her such a painful question in such a matter of fact way. She left the session feeling suicidal and not wanting to proceed with the claim to ACC.

The abuse-focused therapy guidelines (in Chapter Two) recommend that therapists be prepared that some survivors of CSA can enter therapy still feeling huge amounts of

shame about their CSA experiences and they are likely to have difficulties talking about them. As one interviewee (P16) commented going to therapy was as inviting as *"having to clean the toilet for an hour"*. P23 reported that she had stayed away from therapy for as long as she could, to avoid facing up to actually having to discuss her CSA experiences. When she finally entered therapy, as she had feared, talking about the CSA caused her to feel a great deal of distress:

> *I had spent many years running away from the issues…I reached crisis point …the first time I'd made a disclosure…I was ashamed and felt guilty and dirty and filthy and all those things that you feel (when you talk about CSA)…*

Difficulties asking for help

Several interviewees described the courage they needed to ask for help. Their difficulties were compounded when they had to apply to ACC to have their therapy subsidized. P11 had experienced CSA to the level of penetration until the age of 18 years by her father, a brother-in-law, and a family friend. She did not disclose the CSA for 31 years. P11 commented that:

> *…It's damn hard to ask for it (ACC funding) and the courage that it took me to go to my doctor and say… this happened to me… I mean that was a really, really hard thing to do. I still had the message…that I 'was' my abuse…that I was a bad person (and)…by admitting it (the CSA) to people they would know that I was a bad person and I would be judged… I felt dirty… (P11)*

Threats or silencing associated with CSA made it difficult for some participants to disclose enough about their CSA experiences to gain funding for therapy. P11 continued:

> *The message that you're given from the very first incident from abuse is you don't talk about it and the first thing you have to do, in order to get help (ACC funding) to talk about it (the CSA), is to talk about it and you haven't got the skills to do that yet…it just doesn't feel safe.*

Pressures on therapy

Several interviewees seemed to enter therapy feeling internal and external pressures to quickly work through the effects of CSA. Although the therapy guidelines (Chapter Two) mention pressures on therapy, there does not seem to be sufficient advice to therapists about how to help their clients to work with these pressures. The following quote echoed a number of participants' responses:

> *I was 45…when I started going (to therapy)…(and I thought) I haven't got time to muck around… I was in a personal hurry… I wanted to know everything at once and I do realize it now that you can't do it all at once, it takes time to assimilate and think things through…but I was in a hurry. (P24)*

A number of participants also reported that they felt pressure to "heal" quickly due to their own limited ability to pay for therapy or from those who were funding their therapy. P24 was allowed ten hours of therapy before reapplying for more:

> *The moment that it was ACC funded, I personally felt pressured to get through my need for counselling in the time-frame that they (ACC) allowed which just wasn't possible…I can understand that they haven't got an unlimited budget but it was quite off-putting…it made me feel…gosh I better hurry up and get through this.*

Another example of pressure to move through therapy quickly came from P6. She had experienced CSA to the level of penetration by her father from pre-school to pre-puberty. She had struggled with self-hatred, alcohol abuse, and had also experienced sexual abuse by a professional when she was a young adult. She took more than 30 years to disclose the CSA. After one year of weekly therapy sessions the religious order she belonged to was no longer willing to fund her therapy:

> *They weren't willing to (fund therapy), they…told me that this (therapist) had a tendency to get people dependant on her and this was what was happening to me and I needed to be responsible for myself and (they said) I was becoming…just a person who liked therapy. I didn't agree but I still had no confidence at that point…I wouldn't have been able to be assertive about continuing (therapy).*

Finding a therapist

The review of abuse-focused therapy guidelines (Chapter Two) highlighted the need for a safe and trusting therapeutic relationship so that the work of therapy could take place. A number of interview participants confirmed that, from the beginning of therapy, they were assessing how comfortable they were to work with their therapists. A large part of feeling comfortable and safe seemed to depend on whether they felt understood. Examples of needs involved in selecting a therapist included:

> *I just needed someone to really understand me.* (P19)

> *(Choosing a therapist was) a bit like if I was choosing a midwife…it has to be somebody that I feel comfortable, safe and that I can trust (P11)*

> *(It was) almost like the constant search for re-parenting…or trying to find the mother you never had (P21).*

Interviewees' feelings of being understood and compatible with their therapists were sometimes attributed to factors over which therapists had little control, such as the therapists' gender, sexual orientation, personality, ethnic background, age, world view, or their body shape and size. Several of these factors were only discussed lightly in the therapy guidelines reviewed in Chapter Two.

Gender

Findings from the sub-sample would support Briere's (1996b) comments regarding most women's preferences to work with women therapists, at least at the beginning of therapy. Five interviewees who were given referrals to male therapists spontaneously reported that they did not follow-up these referrals because they did not want to with a male therapist. On the other hand, two of five interviewees in the sub-sample who had worked with male therapists reported that their therapists were nurturing and sensitive.

One of the added risks when seeing a male therapist is the potential for further exploitation (Chapter Two). One of the five interviewees who had seen male therapists (P18) spontaneously talked about an episode of gross sexual exploitation by one of the 20 male professionals she had seen. She described being tied-up and raped over a number of days by a male church-counsellor from whom she had sought counselling for incestuous abuse. Prior to this she had experienced a different form of abusive and unethical treatment by a male psychiatrist in the 1970s. She contacted him from looking through the phone book because: *"I was very thin and I couldn't sleep"*. She went to him for therapy and said that she paid a lot of money to sit in silence with *"him behind a desk with a clock ticking"*…. P18 said *"he didn't help"* her with talk therapy and instead gave her medication.

> *He put me on all these heavy…barbiturates and I lost more weight… I was drugged out of my brain really…All my pay went on trying to get myself well and I ended up on the sickness benefit because of the drugs …I couldn't function as a (professional) and I remember going on the bus …I was swirling round …it was the effect of the drugs…so he put me into a private hospital which cost more…*

She was unable to tell him about the CSA and he suggested she was resistant:

> *He kept saying I wouldn't talk to him …then he came in one day …he said "I want to take your blood pressure". So trustingly … I held my arm out and then he jabbed me …I really fought it and he was angry…and he put me to sleep for a week…they wouldn't let my mother in to see me… my sister came in… and said "if you don't stop whatever you're doing to my sister, we're getting the Police"…*

P18 was upset that because of the *"deep sleep therapy"* she not only lost a week of her life but also her ability to continue in her professional work was destroyed. Due to the treatment she had lost large parts of her memory.

Despite being heavily medicated without her consent, raped, infantilized (one male therapist fed her with a baby's bottle) and treated badly by several others male therapists (including one left her waiting outside his office for four hours), P18 found some healing from two male professionals. One was her doctor whom she saw for therapy once a week for over five years until he died. She attributed her ability to marry from working with this safe male:

> *I've always hated sex and I never wanted to get married because men to me mean to be raped … I didn't think they (men) had any feelings and they were just this…figure of fear and he (doctor) helped me with that (by) just talking about it*

She saw a second helpful and safe male therapist for several months through a residential treatment programme. He came to say good-bye to her the day she was leaving:

> *He came over and put his arm around me and he said, "I'll miss you" and he started to cry. I can remember touching his tears. I had never seen a man cry. I didn't know if they were real. I was touching these tears and thinking: There are kind men…and that was a really healing experience for me knowing that not all men are bastards and rapists and abusers.*

Another interviewee, P15, reported at first she would not have wanted to work with a male therapist but later in her process she did. One part of the therapy that she found particularly helpful was when he:

> *Talked about his wife who had been sexually abused … it was great…it told me that men could understand and that men did have the ability to be able to be in a relationship with someone (who had experienced CSA) and make it work.*

Sexual orientation

Two interviewees who identified themselves as lesbian valued working with lesbian therapists. A number of heterosexual women also reported valuing working with lesbian therapists. However, one participant (P11) reported feeling uncomfortable with lesbian therapists. The participant wanted to work on her relationships with males and did not believe that lesbian therapists would be sufficiently non-biased towards males to help her with this issue. In reference to one lesbian therapist P11 stated:

> *I just sensed her distrust of men…I didn't feel that that was going to help me get on with my life and…having successful relationships*

Personality

Some participants preferred therapists who were calm, peaceful and quiet. Others preferred the opposite and felt comfortable with therapists who were outgoing, bright and *"bubbly."*

Ethnic background

Differences in ethnic backgrounds seemed to become an issue when participants felt that their therapist did not understand them. For example: all six Maori interviewees and the one Pacific interviewee were asked if they would have preferred to have worked with therapists from their own ethnic background. All stated that they felt comfortable working with Pakeha therapists as long as those therapists had an understanding of their cultural backgrounds. (Annie's story in Chapter Nine provides a good example of this point). When therapists lacked cultural understanding there was the potential for harm. For example, P7 complained that many of her Pakeha therapists did not understand her Pacific culture or her home environment. The participant was living in a crowded house with a large extended family and was obliged to do the bulk of the domestic work. Her Pakeha therapist's attempts to encourage her to be assertive and stand up for her rights (not to have to do so much domestic work) resulted in her being abused by her family.

> *What I was being taught in the counselling room was that I didn't have to put up with this…according to Pakeha law, which didn't fit into my home environment so that was a big conflict…I couldn't practice what I was being taught in the counselling session back in the real world…When I did try to practice it I got knocked down real fast: physically; mentally; sexually…I think awareness of other people's culture is fundamental.*

Age

A few participants described preferring a therapist close to their own age or older. The desire for a close matching of age seemed to relate to the ability of the therapist to understand participants' world-views.

Views and experiences

Some participants described feeling "safer" with therapists who had similar views or experiences as them:

> *Two (therapists) were both feminists and so that was instantly…something I was more comfortable with. (P21)*

> *…The woman I got was a feminist and an advocate so she was used to advocating for battered woman and she was brilliant (P9)*

Having a therapist with a different world-view (especially if the therapist shared their views in therapy) could be problematic however:

> *A lot of them were ardent feminists…they were anti-men…if they do have particularly strong views on half the population then it's not necessarily safe (or) impartial counselling (P23)*

> *Her (therapist's) belief was that we are a karmic being and that we choose our lessons in life…and I thought "Well great, next time I'll learn how to be stabbed, I might at least die quicker". (P25)*

Sometimes interviewees deliberately sought therapists with similar experiences to them. For example, some who were parents preferred their therapist to be a parent too to ensure that the therapist would understand the stresses involved. Some preferred therapists who were also survivors of CSA. For example, when P19 was in search of a deep understanding of her CSA experiences (that she had not found in the therapists she had previously seen), she decided that she would have liked to see a survivor-therapist:

> *I needed somebody to say that they understood what I was going through…somebody who'd been through something similar…*

Some interviewees who had had unsuccessful early therapy experiences based their selection of later therapists on those experiences. For example P17 stayed with a second therapist that was satisfactory but not particularly helpful because: *"the previous counselling that I'd had was really so hideous in terms of professionalism"*.

Body shape

Some interviewees commented that their therapists' body sizes affected how comfortable they felt with them. For example, P16 met a physically "large" woman therapist whose size influenced her decision not to work with her. Later she realized that what stopped her from working with this particular therapist was that the therapist's size had reminded her of her mother and brought back the pain of having lost her mother's support early in life. On the other hand some participants reported that they felt secure working with a therapist who was bigger than them. The therapists' larger size seemed reassuring:

> *She was a lot bigger than me…so I think she conveyed kind of a comforting presence…she was quite tall and solid frame…there's something reassuring about big people. (P12)*

Multiple factors

In many cases the interaction of a number of factors caused interviewees to select or reject therapists.

> *I didn't find her very warm, I found her…quite a cold person… I found her quite old and uptight and grey…her house smelt funny, musty…I didn't like the environment…it was horrible, so I didn't enjoy that and I didn't like her. I didn't feel like I could engage with her …I felt like she looked down her nose at me. I didn't feel very valued by her. It was just her whole attitude…towards me…we just didn't connect. (P22)*

The same interviewee later found a therapist that she did feel comfortable with:

> *Well, I don't know how this will sound, but this woman also shared with me the background that she came from. She came from a very abusive background too so we kind of had a rapport …she was a very spiritual woman and I am too so we had some…commonalities there, so it was very easy to have a close relationship with her. It was still a professional relationship but it was close in terms that we were both Maori, we were both very spiritual and the negative side of things (CSA).*

Several participants said that they had a "gut feeling" about whom they felt comfortable working with. P11 reported that she knew she felt comfortable with her therapist by *"instinct"* and because there was:

> *An instant click…when you meet somebody and you take a liking to them…in other circumstances I could have had a friendship with her which was how I felt about (her)…she seemed a very secure, confident, and together in her own*

personal life…I felt safe and…I had a personal rapport to identify with her and I felt … that she understood me.

Despite the interviewees' conscious and intuitive selection processes that therapists often had little power to change, sometimes a proactive therapist could help overcome some of the emotional, practical and financial obstacles that could cause an interviewee to drop out of therapy early. (See Bella's story in Chapter Nine).

Given the amount of courage a number of interviewees needed to attend therapy, it was not surprising that many participants talked about the need to feel "safe" with their therapists before they could work comfortably with them. Dale's (1999) recommendation that therapists need to work hard to build rapport and safety for their clients early in therapy due to the fears clients need to overcome at the beginning of therapy was supported by this study.

Helpful And Unhelpful Therapy

The interviewees were asked about aspects of therapy that helped and did not help them work on the effects of CSA.

Clients' rights

The review of therapy guidelines (Chapter Two) recommends that therapists outline the therapy process (including clients' rights and therapists' limitations) at the beginning of therapy. Several interviewees reported that it would have been helpful if their therapists had carried out this practice so that they would have known their rights and responsibilities as therapy clients from the outset.

> *I had no idea what it involved and I kind of felt I was lost…I would have loved for her (the first therapist) to have sat down and explained the process of counselling, what was expected of me, the fact that I was expected to do some work…and it would be painful at times…what she could do and couldn't do…(and) that it (therapy) can be a really lengthy process…(P17)*

Similarly, P25 reported that after rejecting some therapists because she felt "scared" of them and after having a great deal of difficulty escaping other therapists with whom she did not feel comfortable, what was most helpful to her was when in the initial session:

> *My last counsellor… said…"We've got a contract. If there's anything that you're uncomfortable with or you don't understand that I say…I'll…ask you*

what you feel about it or you can interrupt me and tell me how you feel about it. If you don't like it (the therapy exercise), we're not going to do (it)"

P25 reported that the contract was empowering and that encouragement to be assertive was important for people who had been disempowered earlier in their lives.

…(The contract was) very clear, and I think that gives people a lot of power … because a lot of people who suffer from any sort of abuse, they need to be told that they have the permission, to…interrupt, the permission to speak out, the permission to say "No" and permission to do what they think is right…(clients) need that…especially…(those who survived) child trauma.

Furthermore, she believed that had her earlier therapists given her a similar contract, she would have been able to be more assertive with them and may not have stayed with some therapists so long.

Clients as Equals

Abuse-focused therapy is based on the premise that the therapy relationship is an equal one (Briere, 1992a; Dalenberg, 2003). It is the therapist's job to remind their clients that they (the clients) are the expert on their experiences and ways of healing and the therapist's role is to consult them and to work in partnership with them. An example of an equal therapy relationship came from P10:

(The therapist treated) me…like I'm an adult who wants help and I've asked. I've contracted with her for her to help me and that it's just that – I'm buying her professional help…she communicated that we were in a contract together and that it was equal…(that) empowers me

Unfortunately some therapists had not encouraged interviewees to be equal (as will be expanded later), and some interviewees stayed with therapists who were not of particular benefit to them because they believed that the therapist was the expert and knew what was best for them. This situation can leave the client in a passive role waiting for the therapist to heal them:

I saw her as the professional; the one who knew everything; the one who had the answers; the one who's going to heal me (P7)

Therapists' knowledge of abuse-focused therapy

As outlined in Chapter Two, to work with survivors of CSA a therapist's knowledge of the dynamics and effects of CSA is regarded as vital. Several interviewees' accounts

supported this view and further reported that, although rapport and compatability with a therapist was important, an effective therapist also had to have a good knowledge of the dynamics and effects of CSA and of abuse-focused therapy. One interviewee described a helpful therapist as including:

> *Someone who has (a) professional knowledge base, someone who really knows …as much as possible about the effects of CSA, the consequences of it, (and) how it can impact on our lives (survivors of CSA) as…teenagers, middle age…different stages… (P22)*

Another interviewee commented that it was *"essential"* for a therapist to have a good understanding of the effects of CSA because if they did not know about the effects then:

> *They won't know what can be hidden and how to help a person assess (the effects) and confront (their issues)…(P11)*

Furthermore, a knowledgeable therapist was described as one who was able to anticipate their client's needs. P10 found such anticipation by a therapist as particularly valuable:

> *The great thing about her is that she anticipated how I might feel and so she might say, "I'm going to make an appointment for you in three days" and I would just feel like I just wanted to cry and because she knew…she obviously looked at me and seeing how the session had gone,…knew that I couldn't last a week…so it's like…her knowing and understanding what might happen, (because it's a very horrible thing to be desperate)…she catered for (my needs).*

Several interviewees described therapy experiences that suggested that unfortunately some of their therapists did not have sufficient specialized knowledge. A number of participants reported that unless they found therapists who were aware of the wide ranging effects of CSA and how to help participants work through these effects, then they were left feeling *"frustrated"* and *"as though there was something missing"* (P19). For example, P15 complained that although the therapist she worked with was well qualified in other areas, she was not specifically knowledgeable about abuse-focused therapy. Consequently:

> *I spent several months with a therapist and actually got nowhere and then realized that it's probably because she actually wasn't able to work through it (the CSA) with me and she was kind of stumbling in the dark…That's no disrespect to her qualifications in other areas but she didn't really know what to do with me.*

Assessment as a process

Abuse-focused therapists know that a full assessment of the effects of CSA takes time and rapport building (Chapter Two). Yet, a number of interviewees complained of a pattern of going to therapists, disclosing their CSA experiences, going over some of the details and then the therapists saying there was nothing more they could do for them. P19 found herself in this situation with three different therapists. Although P19 was an articulate, professional woman, outside of the therapy sessions she was struggling with: suicidality; a huge amount of anger that occasionally became potentially lethal (she described herself as an *"axe-murderer"* when she became angry and reported that sometimes *"knives were involved*"); drinking excessive amounts of alcohol; the inability to have sex in a committed intimate relationship (she could only have casual sex and needed to be drunk); enormous amounts of anxiety in social situations; and debilitating amounts of low self-esteem regarding her work (that her colleagues considered outstanding). All three therapists that P19 saw gave her between three and five sessions and then said either she *"was fine"* or there was *"nothing more"* they *"could do"* for her. None of the therapists helped her to understand or deal with the CSA effects in her life, treated her depression or suggested other treatments.

The description from P19 of lack of therapeutic help to deal with these issues suggest that her therapists did not conduct a full assessment, were unaware that the difficulties she faced were potentially effects of CSA, and/or they did not know how to help her work through these difficulties. Not surprisingly P19's strong message to therapists was to "*look deeper*". Similarly, Briere (1996b) suggested that therapists look below their client's 'cover story' (the clients' initial self-assessments). He also emphasized that with abuse-focused therapy the assessment process should be an on-going one because new issues could surface throughout therapy.

The review of abuse-focused therapy guidelines (Chapter Two) recommended that assessments were 'a process' and stated that the disclosure of an abuse-focused history can require time and trust building with a therapist. In contrast, P8, who had experienced severe physical, emotional and sexual abuse from a very early age, reported that she saw a psychiatrist (after being admitted to hospital following a suicide attempt) and after half an hour the psychiatrist gave his diagnosis. He said:

> *I had a personality disorder with schizoid overtones…I was really upset because…that was always a big fear of mine as an adolescent that I was going to be a nutter… (P8).*

In contrast rather than giving them psychiatric labels, most interviewees wanted their therapists to help them to understand how CSA had effected their lives, from a holistic perspective. They did not want to be treated as a 'case' or as a collection of 'symptoms'. For example, P22 found it helpful that over the course of therapy her therapist helped her make sense of the whole of her life, not just the abusive parts:

> *She (therapist) was really good because we just started right at the beginning of my first abusive experience…and we went right through everything and every negative and positive significant event in my life – we worked through the whole lot…she had a wonderful holistic approach and we…integrated all of that stuff.*

Testing the waters

Chapter Two describes the 'testing the waters' approach with which some clients begin therapy (Courtois, 1988). This refers to clients giving their therapists a small piece of traumatic material to see how the therapist handles it. If the therapist does not handle the information in an appropriate and sensitive manner then the client can move on to try another therapist without having experienced too much distress. An example of this approach was described by P11 when she told her new therapist that a member of their family had sexually abused her sister as a child. If the therapist handled that piece of information then she would feel more trusting to tell her about the CSA she experienced. However:

> *I realized she (therapist) wasn't an appropriate person for me to talk about the (CSA) with because she just didn't want to talk about it. She changed the subject, as soon as I mentioned abuse she changed the subject. So, (I thought) OK, this lady's got her own agenda and I left (the therapist).*

P11 described how the therapist's reactions affected her:

> *There were two levels: one thing was immediately realizing that there was something not OK about her; but on the other level it was like…it's still not OK to talk about it…It's been thirty years and I still can't talk about it!*

Abuse-focused therapy guidelines (Chapter Two) are clear that some therapists will not be able to cope with the topic of CSA and that these therapists have a duty to refer on when necessary (Courtois, 1997). P17 highlighted the harm that could be done to a

client when it is discovered too late that the therapist could not cope with some aspects of CSA:

> *I can remember starting to tell her about the pain when my grandfather was abusing me and how much he hurt me…There is physical pain for a little seven or eight year old girl – huge physical pain when she's sexually abused and that needed to be talked about and…addressed in the nice confidential surroundings…I said to her "It really, really hurt me" and she just shut off, she just shut off. I remember going home feeling quite distraught…weepy and feeling pretty disgusting because it hadn't been followed through and it's not something that's going to be picked up next week…I never brought it up again.*

Listening and understanding

The therapy guidelines (Chapter Two) make the rather obvious point that therapists need to listen closely to their clients. Several interviewees commented that they valued therapists who listened and tried to understand them. Some examples included:

> *(A good therapist is) someone who's easy to build a rapport with and just all the other…basics like non-judgementalness…someone who's a really good listener who makes eye contact with you, who validates what you're saying, (so the client) feels good in terms of feeling …validated, respected, listened to. (P22)*

> *(The therapist) proved that she was listening by: mirroring what I'd said; rephrasing what I'd said; checked back what I'd meant; and that she'd understood it. So there was always this clarifying going on… if it was wrong well then (I) could correct it…it confirmed…that she was listening and knew what I was saying…" (P9)*

Often being listened to merged with feelings of warmth and empathy:

> *She had an enormous capacity to listen…she also had the capacity to convey that she understood where I was at…she conveyed extraordinary warmth and empathy…she was warm throughout (the therapy) even when I was dealing with incredible rage… (P6)*

A therapist's listening skills also extended to listening and responding to what the participant wanted to achieve in therapy:

> *One of the things I really valued about (the therapist) was she respected my right to call the shots and say, "No, that's an area I'm just not interested in dealing with" …and she didn't push…she allowed me to set my own boundaries…(P23)*

Several participants reported that unfortunately some therapists did not listen:

> *The drawing really got up my nose and it happened every week. She had a huge roll of newsprint and I did say to her…that I "felt uncomfortable" and I "felt stupid" and "it wasn't me" but she'd still be ripping off the paper and putting it on the floor (saying) "Well you put how you feel on there. You've told me you feel stupid. You draw how you feel stupid" I didn't like her methods and it didn't actually do anything for me…so I finished therapy with her. (P17)*

> *I brought up my eating issue and she said: "We won't discuss that now, we'll talk about the sexual abuse", but the big issue for me at the time was my weight thing. (P7)*

A therapist's listening and understanding needed to be on several levels. For example, P15 had told her therapist that her husband *"pushed me about a bit"*, had *"forced me to have sex against my will"*, and *"blamed my abuse for me being totally abnormal"*. Yet the therapist recommended to P15, when she was experiencing a lot of flashbacks of the CSA. that:

> *Sex needed to stop for awhile…it was up to me to make that decision… and stick to it and it should be heard…But the reality of going back into a marriage where you have a husband who sees your refusal to have sex as being out and out rejection…- it wasn't actually safe for me to be able to do that…not practical (or) realistic…*

When P15 told the therapist that what she was saying was good in theory but she could not put it into practice, the therapist made it worse by saying:

> *"Tell him to have a wank"…After that session I never went back to see her again because one of the things that had happened during (the CSA) was that (the abuser) had masturbated over me and even the thought of having to go and say that to (my husband) was incomprehensible. What she was saying was theoretical… it was text book stuff…(but) not safe (and) not practical…she should have heard me…*

Normalization

Much of the abuse-focused therapy guidelines (Chapter Two) seems to be premised on the theory that survivors of CSA had been left alone for years to cope with their experiences of CSA and that this had left them believing they were 'crazy'. Many interviewees' accounts would support this theory. Just helping a participant make the

connection between the CSA and the effects on her life appeared to have a liberating effect on P22:

> *Before therapy (I had) all of these bad beliefs…about myself (and) I never ever made any connection that the horrific abuse that I'd lived through could have attributed to my drug abuse; my alcohol abuse; my promiscuity; my inability to have non abusive relationships with people…I never made any connection that (the effects were) connected (to the CSA) – therapy set me free from that…therapy has saved my life.*

Some interviewees reported that their therapists helped them decide which effects were likely to be as a result of the CSA and which were common to those who had *not* experienced CSA. For example P15 reported:

> *A lot of the (CSA) was…oral sex…so that…was a big issue (in my marriage)…and one of the things she (therapist) said was that "A lot of women don't like oral sex,…because you've been abused, it doesn't necessarily mean that's why you have issues with oral sex"…so there was…a lot of…normalization and that was really important…(P15)*

Interviewees welcomed therapists who reassured them that they were not "crazy" but were experiencing effects of CSA.

> *She was extraordinarily calm with me and no matter what happened she…didn't say it (the CSA) was terrible or anything. And reasonably early on, she said to me, I want to tell you that you're not crazy and it was absolutely incredible because I had thought, since I was nine, that I was crazy (P6)*

Another reflected back over the five therapists she had seen and decided that the most helpful therapy came from the only mental health professional who normalized the effects of CSA that she was experiencing. The professional was a psychiatric nurse when she was in an in-patient unit after attempting suicide. The nurse reassured her that it was understandable that she would feel suicidal given the extensive CSA and neglect she had experienced as a child:

> *She gave me understanding…she said…...you've been through this and it's fair enough that you feel like that (suicidal)…She was the only (mental health professional) that said…"It's OK that you feel…that way because of the things that have happened to you"…that's why I related to her…because she had that reaction (P8)*

Other interviewees reported relief when therapists normalized their feelings:

> *(The therapist said) "It's pretty normal that you're feeling these things considering what's happened"…that was just a relief for me… (P13)*

> *I remember her (the therapist) saying "Well, that's what normally happens"…so that was good for me …I realized then that I wasn't actually such a freak at …school…I had a reason to be that way. (P17)*

Responses to disclosures of CSA.

Therapy guidelines in Chapter Two recommend that therapists neither over-react nor under-react to disclosures of CSA. This recommendation seemed to be true for Bella's story (Chapter Nine) because she did not return to her first therapist whose response to her disclosure of CSA was *"that's the most horrible thing I've ever heard"*. In contrast, P15 appreciated her therapist having a strong response to her disclosure of neglect and CSA. When P15 told her therapist that, in addition to the CSA, she could never remember her parents telling her that they loved her the therapist said: *"God that's awful. You can't remember your parents telling you that they loved you. That's horrendous. That must feel awful"*. P15 had minimized to herself her parents' lack of demonstrable love and had thought that her family interactions were *"normal"*. She acknowledged that, because of her own views, her therapist's response was *"a bit risky in some ways"* because the therapist's response could have *"elicited a number of different reactions"* from her. However, she *"admired"* her therapist for *"being honest"* and taking such a risk on an issue *"that some therapists have skated around"*. Furthermore, P15 found, that her therapist's strong response (in the face of her own minimisation) triggered:

> *A huge turning point in my life (because)…it led me to …really look at my whole childhood and make real conscious decisions about how I was going to be with my children.*

P15 attempted to clarify the different responses between Bella's response (Chapter 9) and her own response (above). P15 believed that there was a *"right"* type of shock that a therapist should show when hearing about abuse. In her view, therapists expressing shock should not be focused on the 'content' of the disclosure but should be focused on the therapist feeling *"sorry that such an awful thing happened"* to their client.

> *It's not shock as in "oh my god what you've said is awful", it's more shock in what you've said is an awful thing for a child to have been through… You don't*

want them (therapists) to…look as if it's an every day occurrence, because that doesn't validate how awful that experience was…you want some response …that (shows) someone responds to you (and) encourages you to actually say more…(P15)

Focus on strengths

The therapy guidelines (Chapter Two) and Briere (1992a) in particular recommend that therapists focus on the survivor's strengths. Several interviewees reported that finding a therapist who focused on their strengths was important. For example:

…There's something in her attitude of…one adult to another and (she understood) the suffering, but at the same time…she kept me (as) a mature adult who's managed…to get myself through life…and had done lots of things (P10)

Focus on being a survivor rather than a victim was also preferred.

I felt awful things had been done, but I didn't want to go round feeling like the victim. I just wanted her to help me…so that I could get on (with my life). (P10)

Assumptions about meaning

The therapy guidelines (Chapter Two) recommend that a therapist should not interpret meaning from a client's experience but should allow the client to find their own meaning. The following example supports the therapy guidelines:

(In the first session) I gave her a brief history of myself…and then I said "But what is bothering me at the moment is my job and …I get really hot in my job and…feel dirty"… the job was…like working in a fast food bar…and she (therapist) said, "Well the reason, you're not enjoying (your job)…is because when you get hot it reminds you of when you were sexually abused and you used to get hot then and that's what's throwing you into all this anxiety about it". And I said to her, "No I didn't used to get hot when I was sexually abused" because…I was often sexually abused at night and it wasn't particularly hot, it had nothing to do with it.

P12 felt angry with the therapist:

I was really annoyed with her interpretation …I… didn't go back to her because I didn't like her… it was very controlling telling me what my experience meant without me having any input into it. I thought she was arrogant…condescending…misguided and she wasn't listening to me at all really, because people cannot like their jobs for valid reasons in the present – not because of some childhood trauma!

Action and structure

Although therapy guidelines (Chapter Two) suggest therapists need to be flexible in their therapeutic approaches and pace, and that clients' needs in therapy may vary, the descriptions of the stages of therapy do not seem to provide specific details of how a therapist should deal with clients who want therapists to start at a place other than Stage One. However, P10 went to a therapist to deal with her history of CSA and she wanted to talk about the CSA in depth and immediately. In this case, P10 was grateful that the therapist did not refuse her (and say that her request was Stage Two work). The therapist heard what she wanted and provided it for her:

> *I went in, I told her what had happened (the CSA). I said, I want to do something about it… I don't (want to) just sit there…crying…so she said she wanted to do an intensive with me…it was action in capital letters which is exactly what I wanted. I didn't want any pussy-footing around. I really wanted to get stuck in. (P10)*

P10 was very happy with the intensive therapy she received and felt that although the pace was "intense" she felt "intense" and so the pace was just right for her.

The review of abuse-focused therapy guidelines in Chapter Two state clearly that although therapists should consult their clients and treat them as equals, the therapist is ultimately responsible for managing the structure and process of each session (Briere, 1996b; Meiselman, 1994). Some participants valued a more obviously structured approach to therapy than other participants. For example, P13 valued feeling that her "case" was being "managed". She described what she liked about the best therapist she worked with:

> *First of all she made notes and she'd refer back to them… and…I felt like my case was being managed…we'd discuss where I was at and what it was I was going to work on and we'd create a strategy… she'd say, "Well I think to deal with panic attacks…(as) a priority at the moment"…It was really simple. (P13)*

Some interviewees stated that they disliked a lot of structure, however, because too much structure felt *"clinical"*. Yet others complained that without such structure they felt they were left to *"wallow"* and would have valued a more structured approach. This point highlights that therapy is not a one-size fits all endeavour. It also highlights the

need to ask what works best for each client and to negotiate around focus, pace, structure and techniques.

Self-managing skills

Therapy guidelines (Chapter Two) clearly state that an overall goal of abuse-focused therapy is to teach the client skills so that they can self-manage their CSA effects. Several participants reported that they appreciated therapists who taught them skills to self-manage their CSA effects. For example:

> *I had them (panic attacks) in the middle of the night and so she'd say, "Well what we're going to do is…"…So I was in charge…of planning and preparing for…the panic attacks…and over a period of time they actually disappeared and I stopped being frightened (of them). That was very, very, very, powerful. (P13)*

> *I can have some pretty horrible flashbacks, and what she said was…where ever I was in having one, well especially…if I'm in bed, "Get out of the bedroom and go into another room and say, who am I…what's my name, how old am I, where am I, what am I wearing" so that I know that I'm not a little girl again. And it's just been absolutely wonderful…she just gave me those tools which were really helpful…(P10)*

> *…She always gave me homework, things that I had to practice…things to write down, things to watch out for and…she's helping me to…notice what's happening,…observe it…but…not be overwhelmed by it. Just really practical, wonderful things. (P10)*

'Passive' therapists

Some abuse-focused therapy texts (Briere, 1992a; Dalenberg, 2000; Herman, 1992b) are particularly clear that survivors of childhood abuse and neglect can feel abandoned when therapists are distant or non-involved. Many interviewees supported this theory. In fact, the term 'passive therapist' was developed from several participants' describing therapists who did not seem to get involved in the therapy. (The term 'interactive therapist' was developed from participants' comments and is the opposite of a 'passive therapist'. 'Interactive therapists' described therapists who anticipated their clients' needs, and who actively listened, taught, and guided their clients through therapy). A passive therapist was described by P8:

> *She was passive, very, very passive…there was no involvement as such,…as the client you are supposed to find your own solutions and sort your own crap out…they're just there to listen and facilitate rather than being actively involved*

in anything. I think sometimes people need ideas and suggestions…because…if they knew the solutions they might have found them already.

P6 was also frustrated with a 'passive' non-involved therapist:

(She was) totally passive …and every now and then I'd say to her "I'm finding this really difficult"…she'd sit there and no response…(P6)

Another complained:

I know therapists don't really like to influence the way you're going, they have this theory that… you will find your own answers, but if you're in severe crisis like I was, some pragmatic help would have been…helpful…(P12)

…Who said that people will find the answers themselves?…Where does that come from? Really, I think (what) that is saying is that you will make your decisions and have to live with them (P12)

Dalenberg (1998a) warns that therapists who failed to honour everyday interactions with their clients (such as shaking hands) risked offending them (Chapter Two). Dalenberg (2000) also warned therapists that survivors of CSA are not well served by therapists adopting a 'blank screen' approach. The following scenario supported this theory.

I came into (my therapist's) office and there was a man there and he was just saying "Bye"…and he went…and I came and I said (to her), "Was that your husband?" and she went very quiet and sober and wouldn't answer me…and then I realized, of course I'm not meant to know anything about her private life. (P12)

P12 went on to describe the impact of the therapist's response:

She wouldn't answer me (if the man was her husband or not)… it's as if I've crossed someone's boundaries. But I just thought she'd known me for…three years and I'd never rung her… I'd never…called on her house or… broken… appointments…I just felt like (her reaction) was…not called for, but I knew that that came from that particular (therapy) stance that you are like a…blank screen…and it's not correct to let the client into your life because that's not helpful for the client...but I felt offended…I wasn't going to stalk her husband or her or anything…It could have been an experience where the trust could have deepened, it didn't, it went backward…and…I was beginning to question the…whole…therapy ethos

Angry and abusive therapists

Dalenberg (2000) and other therapists (Briere, 2002; Courtois, 1999; Herman, 1992b; Meiselman, 1994; Salter, 1995) discuss a basic premise that therapy should be a safe place for survivors of abuse – a place where they could be safe from boundary violations as well as harsh criticisms (Chapter Two). It is therefore vital that therapists understand that they are likely to experience anger and other strong countertransferential feelings in this work and have training and supervision in dealing with their responses. A few participants in this sub-sample however, reported that some of the therapists were angry and unable to contain their feelings and personal issues. For example:

> *I went to see this guy (therapist)…he found me challenging…we used to have these long god damn convoluted discussions about semantics, about words that I used…and he told me that I was a bully…and he even shouted at me one day. (P8)*

Later P8 went to see a female therapist who she did not like very much and so, she asked to be referred on, but her request was turned into a therapy issue. Over time, the therapy relationship deteriorated from bad to worse:

> *I didn't want her (the therapist) near me…that sounds terrible…(but) I found a chair and put it the furtherest point away from her…I just did not like the woman and I don't think she liked me much either really…I kept saying to her, "I think that I need to go and see somebody else" and she kept saying "No, No, No…"…(later) things…deteriorated…and she actually shouted at me…(and said) I was difficult and I wasn't co-operating…I think she had a lot of personal issues.*

Benefits of therapy

This chapter has intentionally highlighted comments that might help therapists avoid mistakes. It is important therefore to state that the majority of therapy experiences were helpful in some way and for some (replicating Dale's (1999) study) therapy was life-saving.

> *Despite all the criticisms and so on… I cannot see any substitute to therapy…I cannot believe anyone could move through some of those issues without having skilled professionals… I believed myself to be utterly, utterly evil and I believed that any time I made a sound, (or)… did anything at all, I was thrusting this evil upon the world…if I had had a child, I would have seen that child as utterly evil. I'm convinced that I probably would have killed it…I wasn't even in my own skin, I lived in a world of utter terror…(Now through therapy) I've got a life of*

my own and that's absolutely wonderful. I guess virtually every day I remember her (therapist) and I thank her (P6)

Even the less than optimal therapists were frequently reported as helpful:

…Even the not so good ones (therapists)…were still helpful in terms of (helping me) understand my behaviour or my attitudes towards some people and assisting me in learning to trust my own intuition again and …putting me on to resources like books. (P22)

(At least I had) somewhere to go and express how I was feeling (P7).

P22 expanded on the theme of her mixed experiences of therapists and how encountering a mixture of therapists should be expected:

…It's also remembering that they're people too and I think it's unrealistic to expect that they're absolutely perfect because they're human as well.

Other participants reported the overall benefits from therapy:

…Feeling a lot happier in myself, able to look after myself a lot better in terms of what's going on in my head… (here is a) simple example -…at home (I was) walking around feeling absolutely miserable and crying with the cold and thinking, oh god I'm so miserable, I'm so cold what am I going to do. Normally I would have walked around all day like that and…then suddenly (I thought) I don't have to be cold and miserable, I've got firewood and (I lit a fire)…just that ability (to be self-caring)…I really didn't have before. (P24)

She (the therapist) was able to lead me out of the muddle…I (had been) surrounded in …a lot of …different feelings, different memories…and things that you could never ever forget…you just always try to damp it down…but everything was crowding in…what therapy did for me was to get me out of that god awful muddled state that I'd been in for such a long time (P23).

Like many of the other interviewees P22 had mixed therapy experiences. Nevertheless she said:

…Had I have not gone through therapy…I might not even be here…I've tried to kill myself a few times before (having) children and once after (having) children…Therapy…has saved my life…(it) set me free from (the effects of blaming herself for the CSA)…so therapy did save my life… if I hadn't had it …I'd probably would be an alcoholic or a drug abuser, I might not have my children. It would be terrible.

Summary Of Interview Themes

Almost without exception interviews with this sub-sample highlighted the strengths and completeness of the therapy guidelines when fully implemented. The interviews confirm key issues highlighted in the therapy guidelines especially: 1) the need for accessibility to therapists who were: affordable; warm; affectively available; interactive and safe (from sexual, physical, verbal and emotional abuse); 2) the need for therapists with specialized knowledge of abuse-focused therapy who were aware of the needs of survivors of CSA and who could conduct an holistic assessment of the wide ranging effects of CSA; and 3) the need for clients' rights and education about the therapy process to be outlined to survivors of CSA from the beginning of therapy.

Many of the interviewees entered therapy with a lot of fear of the therapy process and needed sensitive, knowledgeable help to learn about the therapy process, talk about the CSA and consider connections to their current difficulties. They particularly wanted to find therapists who were able to listen to details of their CSA experiences. In addition, they wanted to find therapists who were capable of being actively involved in all aspects of their therapy. They appreciated therapists who: listened and understood them; treated them as equals and with respect; anticipated their needs; helped them to stop blaming themselves for the CSA; helped them to normalize and make sense of their lives; and provided them with sufficient movement and progress through the therapy process, as well as those who taught them skills and helped them to self-manage the effects of CSA in their lives.

Interviewees frequently left therapists who were not open to hearing about their CSA experiences and those who did not have specialized knowledge to work with survivors of CSA. Furthermore, interviewees disliked therapists who were cold, clinical, overly structured, aloof, passive, non-communicative, non-involved, judgemental, arrogant, and/or abusive.

Perhaps the only issues not addressed in the therapy guidelines at great depth related to: 1) some of the processes that interviewees went through when selecting a therapist to work with including the therapists: gender; sexual orientation; ethnic background; and/or their world views and experiences) and;

2) how therapists could deal with clients who felt pressured to move through the therapy process quickly (for various reasons including time and financial pressures as well as their own needs for immediate progress).

It is understandable that the therapy guidelines did not focus on the first point (listed above) as their primary focus is on the delivery of therapy practices, however, further exploration of both points (listed above) could be of value to therapists and clients.

To remind us that therapy for women survivors of CSA can affect not only their own lives but also the following generation, the last words in this Chapter go to a participant who was quoted at the beginning. P23 survived incestuous abuse from her father, reported that she had felt suicidal from the age of five years old and was fixated on her father's blood running through her veins. After completing therapy she reported:

> *(Through therapy) my life totally changed…I stopped running away and (I have) plotted a course for the first time…moving in a positive direction and things that I never dreamt would happen happened…like for example…I never wanted to bring children into this world…I always believed I'd be a terrible mother…probably…terribly abusive…and I think I'm actually doing alright as a mother…all my children's pictures have got big smiley faces on them…P23*

CHAPTER NINE – THREE WOMEN

The themes identified from analysis of 191 postal questionnaires and the 20 interviewees will now be are explored by examining the differing therapy experiences of three of the interviewees. Pseudonyms have been used. The stories of the three women: Annie ("Feeling Comfortable With The Therapist"); Bella ("Mixed Therapy Experiences"); and Cathy ("The Textbook Therapist"); were selected to explore a range of therapy experiences. Annie had rated her overall therapy experiences as 'Very helpful'; Bella rated her overall therapy experiences as 'Somewhat helpful' and Cathy rated her overall therapy experiences as 'Very unhelpful'.

Annie: Feeling Comfortable With The Therapist (P20)

Annie has been selected primarily to emphasis the importance of the therapy relationship. The majority of Annie's therapy experiences (she worked long-term with two therapists) demonstrated what she described as 'very helpful' therapy although her story begins with a brief less than helpful experience.

Thirty-six year old Annie, a Maori woman, experienced severe sexual abuse from age four to age ten by her grandfather, a male neighbour and a number of neighbourhood boys. As a child Annie had been admitted to hospital with a genital infection. She reported that she had also experienced physical and emotional abuse from her extended family.

In the late 1990s when Annie was pregnant and was having flashbacks of CSA she described herself as a "*complete mess*". She got a list of ACC approved therapists and went to see the one closest to her. In the first session Annie said she *"swore a couple of times"* and the therapist told her not to swear. In the second session Annie mentioned that she smoked *"dope"* and the therapist suggested she should *"see a psychiatrist"*. Annie reported that she *"lied"* to the therapist and promised that she would not smoke dope again. Looking back Annie said she knew in the first session that she would not be able to work with this therapist but, because she had *"no experience"* of therapy, she thought *"maybe (all therapists are) like this"*. When Annie went back the second time she did not like the feeling she had that the therapist was *"not okay with who I am"*. She did not return.

A few months later Annie was having strong flashbacks of her grandfather abusing her and was crying every day. She felt *"on the point of…completely losing it"*. She went to see a therapist from a feminist organization. Annie described this second therapist as: *"awesome"; "just so non-threatening"; "really gentle";* and *"she didn't push me"*. She said: *"I felt comfortable enough around her just to cry"*. Annie described what feeling comfortable with the second therapist meant: *"I could swear, I could talk about dope, I could have talked about whatever I wanted to talk about"; "she wasn't narrow minded"; "I felt she wasn't going to judge me"; "I'd never been around anyone like her"*; and *"I just knew that I could trust her"*.

At thirty-two, this was the first time in her life she had told anyone about the CSA. She saw this therapist weekly for 3-4 months until her child was born. Annie described the way the second therapist helped her reduce the power of the flashbacks by providing her with a safe space to talk about the CSA and vent her distress. Annie was helped by:

> *Just telling her (about the abuse) almost made (the abuse effects) go away. I think all I needed to do was to get (the abuse) out of my head. By talking about it and by crying about (the abuse) …it absolutely lost its power. I think it was really important that she let me just cry until there was no crying left; she didn't interfere with the process; she just let it all come out; …then we started looking at (other issues).*

One of the issues Annie talked about a lot with her second therapist was her mother. *"I blamed my mother for lots (for lack of protection from the CSA)… my mother wasn't a sort of nurturing mother"*. Annie also began working on her inability to say "No" to others and to set healthy limits in her relationships. The second therapist helped her to realize that the CSA was not her *"fault*" and, by the time she was due to give birth, she reported that she was *"feeling a lot better"*.

Several months later Annie wanted to continue therapy but the second therapist had returned to full time tertiary education. This led Annie to see a third therapist from another feminist organization and she continued to see this therapist for almost three years. Annie felt even more comfortable with her third therapist, reporting that: *"she was the best"*. Annie reported that she *"never felt guilty about anything with her"*. With her third therapist she could smoke cigarettes and she could take her child into the therapy session if necessary, and the third therapist would *"be fine with that…(the*

therapist) would go and get the crayons. The third therapist also helped Annie with a huge obstacle to therapy – payment. This therapist did not mind if she could not pay her 'top-up' fee (above the ACC subsidy). This contrasted with another experience she had of taking her child to a family therapist and having feelings of guilt and shame when, as a beneficiary, she could not pay the ten dollars donation. She stopped going to see the family therapist because of *"the money issue …even though it was a donation"*. With her third therapist however:

> *The message was that she really wanted to help me, she didn't give a shit about the money…I really appreciated that because money was a huge issue and I really know that I needed to see her every week and 25 bucks was a lot of money.*

Annie was most impressed with her third therapist's commitment to her work and her field. She said her therapist went on lots of CSA therapy training courses and was *"really ( ) there for women who have been sexually abused, absolutely"*. Annie noticed that her therapist went *"out of her way to get all the latest information… she's intelligent… she's just amazing"*. Another aspect of the third therapist that impressed Annie was that she was able, when necessary to provide her with useful referrals for her children, family or her friends: *"she was a one stop therapist shop, she's really awesome…"* .

In their sessions Annie liked her therapist's flexibility and the fact that she *"let things flow"*. She reported that she would not have liked setting goals because: *"I would feel the pressure to get there and then if I wasn't there I would feel a failure"*. Annie liked it that her therapist listened to her talk about her background and was able to get to know her that way. She reported that her therapist: *"knows who I am…and she knows that without being intrusive because I wouldn't like if anyone got too intrusive"*.

Having a good rapport with a therapist was important to Annie. In contrast she reported that she had had an experience of two group therapists with whom she did not have rapport. She described them as authoritarian, distant and aloof. Annie complained that they: *"had their own agenda, they never listened…they'd never answer a question… they never ever gave us straight answers"*. It seems significant to note that because Annie did not experience the two group therapists as understanding, she felt the need to ask them whether they had experienced CSA, in order to establish if they really

understood issues for survivors of CSA. In contrast, she never felt the need to ask her third therapist *"because she just understood, so I didn't need to ask her"*.

Another significant issue relates to the matching of client and therapist by ethnicity. In the third therapy relationship, although her therapist was a Pakeha, it was helpful when Annie's father died that her therapist was aware of her culture's rituals and meanings surrounding death:

> *She (the therapist) actually knows more about Maori and what's Maori than I do because I've never been taught it or learnt it…so…it's almost like she knows every aspect of my life…she knew what a tangi (funeral) was*

Annie was impressed with her third therapist's availability and reported: *"I know that if I ever need to contact her…I just leave a message and she'll return it within the hour.* Furthermore, because the therapist knew that a situation would need to be serious before Annie would ring the agency's 24-hour line, she was pro-active and made sure that when she went on holiday, the agency's crisis service were alerted that if Annie rang then they should take the fact that she rang seriously.

Some of the long-term benefits of therapy for Annie, apart from having dealt with her symptoms of post-traumatic stress, were that both the second and third therapist helped her by:

> *Getting me to see that (the CSA) wasn't my fault and that… I realized that it was a terrible thing that happened and these people were listening to my story and not saying: "Oh come on it wasn't that bad"*.

Having talked about the CSA and the impact on her life Annie reported that other benefits included: *"I'm not as afraid of other people as I was";* and *"I'm okay with who I am and comfortable with who I am"*. Through therapy she had also developed her boundaries and was able to be assertive: *"If I want to say "No" to people now, I say "No"*. Because her self worth and self-esteem had increased through therapy she was now able to accept help from others: *"I can accept giving now whereas I couldn't before"*. In addition, due to therapy she reported that she was able to control her anger and was *"not as angry"* as she had been and there were huge improvements in her abilities to parent: *"I am definitely a better parent"*.

In summary Annie's first therapy experience demonstrates that when a therapist is perceived to be non-judgemental, showing openness, support and caring, a therapeutic relationship built on trust and rapport can be developed. Such a therapeutic relationship is difficult to build if a therapist is perceived to be judgemental, clinical or aloof. The lack of a trusting therapeutic relationship can be an obstacle to effective therapy work. It seems that Annie was able to achieve huge gains in her life because she was able to find two therapists that she felt comfortable with. The warmth and support from these therapists allowed Annie to reduce her self-blame about the CSA and work through the difficult and complex tasks of re-building her damaged 'self', her boundaries, self esteem and self worth. This therapy work was not only of benefit to her but also her children, her whanau (family) and her community.

Bella: Mixed Therapy Experiences (P16)

Bella's story has been selected because in her interview she described a mixture of therapy experiences. Three of her early therapy experiences were 'unhelpful' and her last one was very 'helpful'.

Twenty-nine year old Bella had experienced severe sexual abuse by both an uncle and a male friend of the family. The sexual abuse had begun when she was around two years old and had ended by age fifteen. Bella started looking for a therapist at fifteen, after the abuse stopped. She rang a rape crisis help-line thinking that she could talk to someone immediately about the abuse, but instead the service gave her another number to call. After calling five different numbers looking for counselling help and being *"fobbed off"*, she *"quit at that point"*.

Almost a year later, she was *"shocked"* and *"scared"* when two Police officers arrived at her home to talk to her. Other women witnesses to the CSA had told the Police that Bella had been abused. The Police arranged for her to see a child psychologist. When she went to the appointment the Police sat in to hear the evidence. The only thing she could remember was the psychologist saying (to her disclosure of CSA) that: *"that's the most horrible thing I've ever heard"*. This comment led Bella to think: *"oh my god, this is really bad"*. She decided: *"I don't want to talk to these people anymore"* and she *"didn't go back."*

Bella's reaction to the psychologist's comment requires an understanding of the context of the CSA. The offender had continually told Bella that she was responsible for the abuse and threatened that he would blame her if she ever told: *"he constantly told me that, if you tell anyone about this (abuse), I'm going to say it's all your fault"*. When the psychologist made the comment about the abuse having been "*horrible"*, Bella still believed what the abuser had told her and believed that the abuse was her fault; that she was *"responsible for it"*. She felt guilt and shame. Due to this unhelpful intervention, Bella did not seek therapy for another eight years.

At age 24 she sought help from a second psychologist recommended by a friend. Bella never felt comfortable with this therapist. Bella described her as clinical because she *"didn't give any feedback"*. She was also a trainee and English was her second language. Furthermore, Bella did not have her rights explained to her at the beginning of therapy so did not know that she could change therapists if she did not feel comfortable.

> *I didn't know that I could say, after one session or two sessions or even ten sessions even… "I think I need to see someone else because I'm not making any connection with you and I don't think that it's (therapy) being very helpful"*.

Over eight months of seeing the trainee psychologist, Bella reported going *"slowly down hill"*. However, because she did not have a "*personal connection"* with the therapist she was unable to tell her that she felt *"very suicidal"* throughout the eight months. Bella said that it was the responsibility she felt towards helping the psychologist learn (because she was a trainee) that kept her going twice a week to therapy. Ironically her feelings of responsibility kept her alive.

> *That's what kept me going… I didn't want her to fail because of me. That was definitely my whole life…I was responsible for everybody else – that was how I was brought up and also what the sexual abuse taught me as well.*

Bella described feeling relieved when she moved house into a new area because she could legitimately tell the psychologist that she could not come to therapy any more.

Bella saw a third therapist for nine months. At first Bella felt she had a good connection with this therapist. The therapist was *"respectful"*, *"open"* and told Bella about her

rights as a client. However, this therapist soon began to over-disclose about her own CSA and healing process. Bella felt unable to tell the therapist that having the therapist talk about her own issues was unhelpful because:

> *I firmly believed that what she had to say was a lot more important than what I had to say because I was brought up to believe that I was to shut-up and do as I was told, and the abuse reinforced that.*

Bella felt that this therapist also reinforced her *"victim role"* by suggesting it was *"okay not to cope"* – even with looking after her child. Bella was relieved when the therapist ended the therapy (because the therapist had to go back into therapy).

Some months later Bella went to her doctor for some anti-depressants in preparation for a visit to her family of origin. The doctor recommended a fourth therapist. This therapist told Bella that she was not registered with ACC because ACC were too difficult to deal with but her fees were very negotiable. The therapist immediately gave Bella an overview of her qualifications and experience and a:

> *Personal picture of herself, without giving me too much information which was really, really nice. It made me feel instantly relaxed with her, like I was in competent hands.*

Bella told the therapist of one of the difficulties she had coming to therapy. She did not want people that she knew seeing her in the waiting room (they lived in a small rural area). The therapist suggested that instead of going to the waiting room, that Bella could arrive five minutes after the therapy session time, so that she could walk straight into her office. The therapist also accommodated other obstacles that Bella had in attending therapy. For example, without needing to be asked, the therapist arranged for free child-care for each session and when Bella was struggling financially she lowered her already small fee. Furthermore the therapist:

> *Recognized instantly that I may want to make up excuses to not be there (in therapy). She said "I know that coming to therapy isn't an easy thing and there may be times when you're supposed to come here and you might have 50 excuses running through your head about what excuse you're going to give me about not coming. I know that's how it works. If that's how you feel on the day, ring me up and say I want to make an excuse about why I don't want to be at my session today". And I did that a couple of times and she, didn't talk me into it but, encouraged me through what I was feeling and I ended up going.*

Bella found this therapist *"very easy to talk to"*. She especially appreciated that this therapist hardly talked about "*her stuff*" and *"there wasn't much small talk"*. As a result Bella reported that she never ended up feeling responsible for the therapist. The therapy was solely focused on *"what was occurring for me now and what it was related to in my past, in my abuse and also my upbringing"*. This therapist was the first therapist to tell Bella that she was not responsible for the CSA. Bella's relief was enormous. She reported that she had waited all her life to hear that. Bella also felt able to talk about other difficult issues such as her suicidal feelings and her boyfriend who had introduced her to drugs:

> *I was really comfortable talking to her about feeling suicidal or taking drugs. She made no judgement on me if I said…I was smoking dope or taking speed.*

Instead, the therapist gently helped Bella to make her own decisions about taking drugs:

> *She would point out to me: how does this make you feel about being a mother, how does this relate to your child, does this effect you financially…and how did it relate to my sexual abuse and my upbringing.*

The result of this therapeutic approach was that Bella was able to make sense of the links between the CSA and her current issues: *"I knew somehow that they (her relationship with her boyfriend and her drug taking) were related to the past"*. Furthermore, although her therapist considered that Bella's current drug taking and putting up with an unhealthy relationship was related to her past, the therapist suggested that these behaviours did not need to continue.

> *She (therapist) wasn't saying that that behaviour's okay, she was saying that that behaviour is a result of this and …do you feel that you need to change it?… The onus was all on me … she helped me do it myself. It was always me doing it… I just found that remarkably helpful.*

The therapist was proactive in helping her with all challenges in front of her. For example, before Bella went to visit her family of origin, the therapist helped her set up a network of friends that she could ring and also said that she could ring her for a phone session from her family's home if she needed to. The therapist anticipated possible difficulties that Bella may have and taught her skills and strategies to deal with such situations. For example, should her family begin to speak to her in a *"derogatory manner"* the therapist said:

> *You can choose to say "I really don't appreciate you saying that to me and I won't stay here much longer if you're going to treat me like that"… or you can choose to ignore it and just remain emotionally detached.*

Bella coped well with her visit to her family and said that as a result of this therapy, her focus changed *" from caring so much about what they think, to really only caring what I think."*

Another important part of the therapy for Bella was that the therapist continually reminded her of her progress:

> *On many occasions she pointed out to me that I was actually saying "No" to people or doing what I needed to do for myself. She would say, "Hey remember when you first came you wouldn't be saying that" and "Look at the progress that you've made". She made it very clear to me. It's almost like getting gold stars, which you need…you need to know that you're doing a good job and that everything's progressing.*

As a result of this therapy Bella said that within four weeks of beginning to see this fourth therapist:

> *I went from suicidal and very depressed and having major physical symptoms ... to functioning again.*

Bella continued to see this therapist for a total of eight months and had gained sufficient skills in that time to end therapy. She knew that if she needed to go back for a few sessions she could.

In summary Bella's first therapy experience demonstrates the harm that can be done by a therapist's response to a client's disclosure of CSA. The second therapy experience highlights the difficulties when a client does not feel sufficiently safe and comfortable with her therapist to tell her about her suicidal feelings and about her need to move on to another therapist. The third therapy experience demonstrates the potential harm to a client when a therapist overdisclosed about her own issues and does not focus on the client's strengths. Fortunately Bella was finally referred to a fourth therapist who demonstrated enough openness and warmth to establish a therapeutic relationship but was also sufficiently bounded to not burden Bella with her issues. The fourth therapist

also seemed knowledgeable about the effects of CSA and was able to anticipate and cater for Bella's needs. In addition, the fourth therapist focused on her client's strengths and was able to motivate and teach Bella self-help skills for her to deal with her issues on an on-going basis.

Cathy: The 'Textbook' Therapist (P14).

Cathy's story has been selected because she was the only interviewee to rate her overall therapy experiences as 'Very unhelpful'. Her main therapy experience describes the model of a 'textbook' therapist. In this case, the term 'textbook' therapist refers to a therapist who closely follows her professional obligations so could not be faulted objectively about her practice. While some therapists reading this story may identify with Cathy's main therapist's need to strictly adhere to her professional boundaries, it is important to acknowledge that Cathy's experience of this was extremely negative.

Cathy a 32 year old, professional woman had experienced sexual abuse by a male friend of the family from age seven to nine. After the birth of her child in the late 1990s Cathy suffered postnatal psychosis, felt suicidal and was admitted to an in-patient unit. A course of anti-depressants proved to be ineffectual and Cathy cut herself while she was in the unit. Cathy reported that the staff *"told me the only way I would get better was to have shock treatment, so I did that"*. Cathy said the shock treatment did not help, instead the effect was a *"really bad headache"* and *"it cuts out your short-term memory. I can't remember that period of three weeks at all"*.

Later, in hospital, Cathy began seeing a psychologist for some brief cognitive behavioural therapy. In addition, due to her significant symptoms, she was asked if she had been sexually abused. Cathy was reluctant to disclose the CSA: *"I didn't want to tell. I've never told my husband…why would I want to tell some total stranger"*. However, to oblige the staff, Cathy left hospital briefly, told her husband about the CSA then went back to hospital and told the psychologist. Unfortunately Cathy regretted her disclosure to the hospital staff because the psychologist she disclosed to left a few weeks later. Cathy complained:

> *That's really dumb...she was a really nice lady, she did a lot of work with me and then after five weeks – "Bye". I mean, how can you do that? I didn't know*

anything about therapists, I didn't know that that's what they did (leave suddenly).

After her disclosure of CSA things got even worse for Cathy:

> *And then all these people suddenly treated me like a different human being. I was no longer just (Cathy)…their attitude towards me changed… I was no longer just a mum…with post-natal psychosis, I was a mother…and…watch out for her because…she's got borderline personality disorder.*

After she was discharged from hospital Cathy reported that she *"kept getting in trouble from the (crisis) team"*. Cathy was very critical of the crisis team because no one told her from the outset how much she could use the service. She was frustrated with the mixed messages she received from the crisis service. For example: *"they kept saying that I could ring them"* and then she was told: *"you've had this service for far too long"*. Consequently, Cathy stopped calling the crisis service but continued to self-harm. Soon after, the crisis team arranged for a male psychiatric nurse to visit her once a week. The therapeutic relationship with the nurse lasted for eighteen months and Cathy reported that:

> *He made…a huge difference…I could trust him…he was a real person, he wasn't a therapist. He cared about me…and I trusted him enough because (although) he was very busy…he would sit there…for as long as it took…A therapist can't do that because…they've got a time agenda and, I'm not saying he was perfect,… (but) I knew the things I could trust in him…(and) when he went on holiday…he didn't want to leave me without…support…(and although) it wasn't his job, it wasn't his obligation…he used to e-mail me…which is pretty awesome.*

In addition to the support from the psychiatric nurse, it was arranged that Cathy see a psychologist. Unfortunately Cathy was never able to trust this psychologist:

> *I was told a million times she is "The Best" and I'm sure that she was. I liked her a lot, (however) I didn't trust her. I never knew who she was…There was no emotional response…She wasn't empathetic…Yes, she would look empathetic. Yes, she would sound empathetic but she wasn't empathetic …She wasn't lying to me, she was just …an act… it was her job and that's what she had to do, but it wasn't real…(she was) a phoney…she was never anything. She wasn't happy, She wasn't sad…She was a persona of a therapist…She was as inanimate as you can get…you could never find out what was inside her…view on the world…*

Eventually Cathy was able to tell the therapist that she liked her but could not trust her and the therapist said: *"go away and think about something or some way that we can form a lot more trusting relationship"…so I did…and I thought about it a lot."* Cathy thought of a physical trust exercise that she and her therapist could do. Although the exercise was outside of the therapy room, it would only take an hour and it would not cost anything. When Cathy offered her idea, (that she had put a great deal of thought in to), the therapist rejected her idea outright – further more it became: *"a standard joke after this with the mental health team"*. Cathy felt hurt, rejected and humiliated.

Sadly seeing this therapist was extremely bad for Cathy. As she put it:

> *Someone who's been abused, particularly who's been raped has had every boundary crossed, spiritually, emotionally, physically…and I'm constantly looking for people that I can trust.*

Yet, she described her experience with her therapist as:

> *Like being raped…I'd go there twice a week…(and) be raped. …I didn't trust her. I didn't want to talk to her about sexual abuse. It took eighteen months for me to talk to that (psychiatric) nurse about sexual abuse, eighteen months!…I knew him…who he was…(but) I didn't want to talk to that therapist about sexual abuse.*

Cathy disliked the clinical nature of the therapist's approach to therapy: *"She used to get a white board out and draw my life out on the white board…eventually I told her that I didn't like the white board and she was quite offended…"*. Cathy also complained about the impractical nature of the therapist's suggestions, such as that Cathy should make lists everyday and tick them off. Cathy did not believe that the therapist or anyone else would live their life this way. In addition, what Cathy wanted from the therapist was for some of the focus of the therapy to be on her strengths and her professional role – that she had managed to maintain all through her mental health difficulties. Cathy wanted the therapist to remind her that she had got herself an *"education"*, and even though she and her husband were married as teenagers they had managed to make their *"marriage work"* and they had *"created a loving family"*.

To Cathy, even the therapist's extra help seemed cold and clinical. At one point Cathy said that the therapist was trying to *"wean me off (the crisis team)"*. To do this the

therapist arranged to ring Cathy at certain pre-arranged times. Cathy disliked the strictly bounded nature of the calls:

> *So she said that she would ring during that time and she did... she was really professional about it… she said "Cathy I have got ten minutes for you now, you've got ten minutes to tell me how you're feeling". It was like being in therapy again you know. It wasn't real and I know that (ringing) was above and beyond the call of duty (but) I'm just asking for realness.*

In contrast, when discussing the therapeutic relationship she had with the male psychiatric nurse she said:

> *It was a relationship and I think that's probably the bottom line. I think we heal in relationship…it was a human who caused the brokenness and in someone else's humility we find healing…*

Cathy never felt secure enough in the relationship with the main therapist to feel able to work through their difficulties. For example, Cathy gave the analogy that, although, she knew she could get angry with her husband, he would not leave her. In contrast, with the therapist: *"I knew that if I got angry with her, she would say 'the hour's up'.*

Cathy described the reasons she continued to see this therapist for six months:

> *People kept saying she is "The Best" and I guess she was. She was lovely but she was terrible too…she told me that there was no way that I could get well without a therapist…I had stayed in there because people told me that that's where I would get well.*

However, in hindsight, Cathy believed:

> *I would never have got well in that situation, I would have been dead by now…I wouldn't have survived and she would have gone to my funeral. She'd done her best.*

After six months, her therapist was about to go on holiday and things came to a head. Cathy was feeling suicidal and wanted to say "Goodbye" to the therapist. She thought it would be awful for the therapist to go on holiday and come back to find out that she had committed suicide without at least contacting her. She went to see the therapist and when telling her she was going to commit suicide she took off her wedding rings and asked her to give them to her husband later. Cathy reported: *"I realized I couldn't cope any more…"*. Later, Cathy felt angry that, although the therapist rang the crisis team to tell them that Cathy was suicidal, the therapist never rang later to see how she was: *"she*

didn't make any effort to ring …she was leaving me to die…I was in a very suicidal state…".

Cathy would have liked the therapist to have: *"rung that night to say…"Are you okay?"* Later Cathy decided she had "*asked for too much"* from the therapist, but then decided: "*you've got to believe that you're worth it, that you're worth the struggle that someone else puts in."*

Cathy did not return to therapy and believes that she healed herself through a lot of writing, physical exercise and through the support of her friends and family. She said that participating in this study and being interviewed by a therapist/researcher was part of her *"de-toxifying"* her therapy experience.

In summary Cathy's story supports the idea that, to be able to gain benefit from therapy, clients need to be able to feel a connection to their therapists and able to feel trust, safety and care. It appears that there was sufficient warmth and connection in the relationship with the first therapist Cathy saw in hospital (albeit briefly), and with the crisis nurse, but not with her main therapist. This suggests that Cathy was able to make a therapeutic connection when she was placed with a therapist that she could relate to. Nothing about the main therapist's practice seemed outstandingly neglectful if measured objectively. However, it seems that from the beginning of therapy, Cathy was unable to connect or build a therapeutic relationship with her. In addition Cathy reported feeling rejected, humiliated and abandoned by the therapist. The lack of connection to the therapist seemed to put Cathy in danger – her suicidality continued and she was unable to access any effective therapy help during this time. She was being "weaned off" the crisis team and on to accessing help only from a therapist she did not relate to. Cathy's experience suggests that therapeutic agencies need to ensure that clients are able to be placed with therapists they feel comfortable with and feel connected to.

Summary

All three of these stories suggest that unless a comfortable, safe, and connected therapeutic relationship is established, the work that a client is able to do in therapy is

likely to be limited. All three were more able to establish trusting therapeutic relationships with some therapists and not with others.

Effective therapists were reported to be those who were warm, caring, supportive, non-judgemental, open and 'real'. Being 'real' seemed to mean that therapists struck the right balance between openness and boundedness and showed their clients some of their humanness without burdening them. Therapists who provided care, warmth and connection that was beyond the professional 'paid' role were valued. When the three women felt cared for and comfortable with their therapists, they reported feeling safe enough to open up to the therapist to talk about difficult and sensitive issues such as CSA related-material, as well as feelings of suicidality, their drug use and could fully express their emotions. Therapists who provided information (about the therapy process and the client's rights and responsibilities), as well as sufficient structure, and support were appreciated. Helpful therapists focused on the participants' strengths and achievements and assisted the participants to acknowledge their progress. Therapists who were knowledgeable about the effects of CSA and proactive in anticipating, predicting and dealing with their clients' needs and therapy issues were particularly helpful. Assisting a client to overcome obstacles to accessing therapy (such as costs, child-care needs and the timing of therapy sessions) was also reported as helpful.

The three women's stories illustrate that unhelpful therapists were those who lacked warmth, empathy and caring and who were judgemental, authoritarian (or 'pushy'), non-consultative, distant, aloof and/or non-responsive. Therapists who over-disclosed about their own issues or who over-reacted in a negative way to a participant's disclosure of CSA were found to be unhelpful. Therapy approaches that were too rigid, professionally bounded (to the point of seeming like a 'text-book'), and those who were impractical were also regarded as unhelpful.

When an effective therapeutic relationship was able to be established participants reported a number of gains through therapy including: reduction of CSA effects in their lives such as symptoms of PTSD, suicidality, depression, and anger; improvements in their self esteem, relationship and parenting skills; and the acquisition of new skills in self assertion, setting personal boundaries, and in self managing the on-going effects of CSA in their lives.

CHAPTER TEN – DISCUSSION

This chapter discusses: the extent to which the aims of the present study have been achieved; the strengths and limitations of the research; the major findings of the study in relation to previous literature; recommendations for further research; and implications for practice and policy.

Achievement Of Aims

The aims of this study were to: 1) provide an opportunity for women survivors of CSA to voice their experiences of abuse-related therapy; 2) document specific aspects of the therapy that participants found helpful and unhelpful in dealing with the effects of CSA; 3) compare participants' experiences with current 'best practice' guidelines; 4) use data gathered from clients to inform therapists, funders, and therapist trainers about client therapy experiences; and 5) to work towards improving the delivery of therapy to survivors of CSA by providing a set of recommendations based on the findings from this study.

The first aim of this research – that of giving voice to women survivors' experiences of therapy – was achieved by gathering 191 postal questionnaires and a sub-sample of 20 follow-up in-depth interviews. The overwhelming enthusiasm from survivors of CSA for this study suggested that clients saw this study as a way of having their voices heard. Reasons for taking part were exemplified in one participant's response:

> *I saw it as a way of helping other CSA survivors. I also saw it as a contribution to improving therapy and bringing to therapists' attention what CSA survivors look for/don't look for in therapy. Thank you for conducting this study!*

The second aim – that of discovering what aspects of therapy clients found to be helpful and unhelpful in dealing with the effects of CSA – was achieved by analysing the participants' qualitative and quantitative responses. These findings have been outlined in Chapters Five to Nine.

The third aim – comparing participants' experiences of therapy with the template of best practice abuse-focused therapy – began in Chapter Eight and continues through to this chapter.

The fourth aim – dissemination in order to improve service delivery – began with the original literature review for this thesis being disseminated nationally and internationally as a resource (McGregor, 2000) and then a synopsis of the literature review was developed for, and published by, the ACC as guidelines for ACC-registered therapists (McGregor, 2001). In addition, presentations of preliminary findings from the pilot study have already been presented at:

- two international trauma conferences (Melbourne, Australia and Edinburgh, Scotland),
- a national trauma conference (Auckland),
- workshops for therapists, and
- lectures to psychology and counselling students.

Dissemination of the findings will continue over the next few years through journal articles and presentations to therapists and their trainers, consumer groups, and policy makers. The research findings detailed in this thesis will contribute to the national and international body of knowledge in this somewhat neglected area of therapy research. Whether any of this has an impact on actual clinical practice is as yet unknown.

The final aim – to work towards improving the delivery of therapy to survivors of CSA – has been achieved by outlining a set of recommendations to improve policy and practice (detailed later in this Chapter).

Strengths And Limitations Of The Study

A particular value of the present study is the qualitative findings – the voices of the participants. While quantitative ratings are useful, for example, in grading the overall value of therapy to the participants, therapy ratings do not provide details and specifics of what clients of therapy found helpful and unhelpful. To provide feedback so clinicians can improve their practice, qualitative information is essential.

Dale's (1999) study found that the fear of hurting their therapists' feelings was one of the obstacles to clients giving feedback to their therapists. The use of an anonymous postal questionnaire and interviews with a researcher who was not involved in the

participant's treatment enabled clients to express both their positive and negative feelings about their ex-therapists without fear of hurting their feelings.

The size of the sample gathered for this study was much larger than most previous studies (such as Amsworth (1989) (30); Feinauer (1989) (36); Frenken and Van Stolk (1990) (50); Dale et al. (1998) (40)) which all had sample groups of 50 or fewer. Only Palmer et al. (2001) had a larger sample (311) (see Table 25).

The findings that the majority (90.4%) of the sample had some therapy in the last ten years and that over half the sample (51.1.%) last saw a therapist between 1998 and 2001, adds to the relevancy of the findings, as a large proportion of the comments about therapy relates to recent therapy practices.

There are a number of limitations to the ability to generalize from this study. For example, the criteria on which it is based excluded many survivors of CSA: males; women who had not had any therapy; and women currently in therapy. Furthermore, similar to Feinauer's (1989) observation, probably some of the most seriously harmed survivors of CSA (including those involved in long-term psychiatric care) might also have been excluded. Supporting the theory that survivors of CSA who continued to feel high levels of distress about their CSA experiences would have had difficulties participating in this study are the participants who reported having some emotional difficulties completing the postal questionnaire (see Methodology Chapter). Because of these exclusions, findings from this study cannot be applied to all survivors of CSA.

The general representativeness of the present sample may further be in question given that it is a self-selected group. However, the large nationwide sample attracted to this study adds to the representativeness of the findings. Furthermore, additional indirect support for the validity of the findings is based on the present study producing similar quantitative and qualitative findings to the Dale et al. (1998) study.

Given that the postal questionnaire required a certain level of literacy, the self-selected sample had the potential to be over-represented by those who were articulate and educated. However no significant differences were found in levels of education when the present sample was compared to women in the general population in the 1996 New Zealand Census.

Although participants in the present study included women from a number of different ethnicities, such as New Zealand Europeans, Maori, Pacific people and people from a range of other ethnic backgrounds, time and spatial constraints have precluded separate analyses of these CSA and therapy experiences. Findings cannot therefore be generalized to different ethnic groups.

Given that this study is based on retrospective self-reports and self-assessments of CSA and therapy experiences, accuracy and recall factors may limit the exactness of participant reports. Any study that relies on a person's memory can never assume that memory to be 100% accurate. As one participant stated in the postal questionnaire:

> *A well-designed study, however it is still difficult to give "correct" answers as a lot of details get forgotten over time and subjective evaluations about past states in particular, are very hard to make.*

An example of details forgotten over time included the number of therapists that participants saw. During several interviews, while talking about their therapy experiences, participants remembered 'other' therapists that they had not reported on the postal questionnaire. This lack of precision would explain the discrepancy between the number of therapists that participants rated *overall* (633 therapists) and the number of therapists that participants rated (in a separate question) *individually* (553 therapists).

CSA experiences are often emotionally difficult to report objectively. Asking participants to tick boxes on a postal questionnaire to describe their CSA experiences was a somewhat crude attempt to gauge the severity of these experiences. Although the occurrence of the CSA experiences cannot be verified absolutely, there would appear to be little reward for respondents participating in this study to either lie about or exaggerate their CSA or therapy experiences. There were no inducements to enter this study and no obvious secondary gains. The assumption that research participants' disclosures of CSA are likely to be relatively reliable is supported through other studies that have attempted to verify participant's disclosures of CSA and have found high rates of supporting or corroborative evidence (Agar, Read, & Bush, 2002; Herman & Schatzow, 1987; Sorensen & Snow, 1991) or high levels of test-re-test reliability (Goodman et al., 1999).

In this study, as with Dale's (1999), it was accepted that it would be impossible to verify the accuracy of the CSA and CA (child abuse) reports, as well as ethically questionable to challenge participants about this issue. Having said this, on some occasions, verification of sorts was available. Information that verified the participants' reports were often given without being asked for, within interviews, postal questionnaires, letters and phone calls. For example, support for participants' reports of CSA were given sponteneously in three follow-up interviews. When participants were describing memory difficulties they had had with their CSA experiences – without being asked or prompted – they went on to make a comment (sometimes much later in the interview) that they had either an acknowledgement of the CSA experience from the offender, a witness, or physical confirmation from a doctor.

Only five participants (2.6%) reported that the CSA ended before the age of five. Because questions could be raised about how this group could remember the abuse, these five postal questionnaires were reviewed. Only one of the five said that the abuse ended before four years old. This was a 70 year old woman who reported that she had been abused by a male friend of the family at around two to three years old. In her postal questionnaire she added that she had experienced *"full"* penetration and that she tried to tell her mother at the time but was unable to be understood. In questions about disclosure she reported that her mother did not believe her and smacked her for *"saying nasty things about the nice man"*. The remaining four participants who reported the CSA ended around the age of four were all abused by their fathers. One of the four participants reported that her father had also sexually abused her older sister. Of the four, another participant reported that her father served six months in jail for the sexual abuse of one of her sisters.

Additional verification of participants' reports of CSA in this study was based on the fact that over 70% of the sample had their claims of CSA accepted by the ACC. In order to have a claim of sexual abuse accepted by the ACC claimants must have clear memories of the abuse occurring and be able to provide exact details of the abuse. Both the therapist and the ACC assessors must accept their claim. Furthermore, the abuse must be sufficiently serious to be covered by the Crimes Act, and in some cases corroboration is sought.

A further limitation of this study was the absence of a control group. The absence of an untreated control group of women means that some or all of the improvements reported by the sample may have been produced by a range of factors unrelated to therapy.

The other voices excluded from this study were those of the therapists. Although an original plan for the present study was to include a sample of therapists, time and resource constraints forced a choice to be made. The decision was to give pre-eminence to the voices of survivors of CSA. It is acknowledged, however, that therapists who work with survivors of interpersonal trauma such as CSA, do some of the most complex and taxing therapy work that therapists may ever be asked to do (van der Kolk, McFarlane et al., 1996). There has been no desire to ignore or undermine this valuable work.

Another limitation of this study was my dual role as a therapist/researcher. Given that the study originated from questions I had from my own work as a therapist, it was essential that I tried to suspend or 'bracket off' my therapist role when necessary to avoid bias. It could be argued that as a therapist I would wish to uphold the positive view of my profession. Counter to this argument however, I would offer that my desire to conduct this study suggests that I am open to critical feedback from clients about therapy practices. For example, if my bias were to 'prove' that therapy was 'helpful' I would have designed a study that focused solely on what participants found to be helpful in therapy. One of my primary motivations for the study was to enhance the quality of therapy. This motivation rendered me equally 'biased' towards what had helped and what had harmed.

Despite my openness to participants' feedback, I did experience the need to 'bracket off' some of my responses when reading or hearing participants' accounts of poor or harmful therapy practices. The dominant responses that I needed to bracket off were my strong feelings of sadness, anger, and the desire to refer the participant on to a colleague that I trusted. In these situations I bracketed-off my therapist role and did not offer a referral. Instead, towards the end of the interview I enquired if the participant would ever consider approaching a therapist again and if so what sort of therapist they would consider. This approach was designed to help the participant clarify these issues in their own mind. I refrained from offering a referral unless one was requested of me.

Before discussing the main findings of this study (clients' experiences of therapy), participants' CSA and disclosure experiences will be compared with other studies. A comparison of these variables will help to further establish the extent to which the main findings are generalisable.

CSA And Disclosure Experiences

A range of factors has been used to measure the severity of abuse. These variables appear to contribute to poor psychological outcomes (Beitchman et al., 1992). Factors that appear to impact negatively on a child's development and long-term outcomes include: the younger the child at the age of onset; the longer the duration of the CSA; the more severe the nature of the CSA; the closer the relationship of the offender; the presence of additional child abuses or neglect; the longer the delay in disclosure; and the more unsupportive the post-disclosure responses (Beitchman et al., 1992; Green, 1993; Kendall-Tackett et al., 1993).

These variables permit a comparison of the present sample with the samples of other studies (Table 24). However, because other studies may be based on different populations (such as: general or clinical populations; males and females, children and adult participants; and CSA or incest experiences), the comparisons are less than perfect (see Briere (1992b) for discussion).

Age and duration of CSA: This present study was focused on a post-clinical population of women survivors of CSA. The mean age of onset of CSA for the present sample, (6.3 years) appeared to be a slightly younger age of onset compared with studies based on Aotearoa/New Zealand and international literature of CSA and incest found in general and clinical populations where the age of onset of CSA has been found to be approximately seven to nine years old (Anderson et al., 1993; Armsworth, 1989; Beitchman et al., 1992; Feinauer, 1989; Finkelhor et al., 1990; Matthews, 1998; Polusny & Follette, 1995). It was closest to two clinical samples of incest survivors Frenken and Van Stolk, (1990) (6.9 years) and Palmer et al., (2001) (6.3 years). However, although the mean age of onset appeared to be slightly younger than several studies, the mean age the CSA ended in the present study (12.9 years) appeared to be a younger age than the mean age incest ended in Armsworth's (1989) study (13.9 years)

and the Palmer et al., study (16.3 years), but within the range (age of greatest risk 7-13 years) reported by Finkelhor (1994) and Gomes-Schwartz, et al. (1985).

Table 24. Comparison of Present Study with Other Studies by CSA Severity Factors.

Severity Factors of CSA	*Other Studies	Present Study: Women survivors of CSA (Clinical population)
Age of onset	**Mean age 6.3 years** Palmer et al. (2001) **Mean age 6.9 years** Frenken & Van Stolk (1990) **Mean ages between 7-9 years:** ACC SCU (1998) Anderson et al. (1993) Armsworth (1989) Beitchman et al. (1992) Feinauer (1989) Finkelhor et al. (1990) Polusny & Follette (1995)	**Mean age 6.3 years**
Age of ending	**Mean age 13.9 years** Armsworth (1989) **Mean age 16.3 years** Palmer et al. (2001) **Age of greatest risk 7-13 years** Finkelhor (1994) Gomes-Schwartz et al. (1985)	**Mean age 12.9 years**
Duration	**Average 6 years** Armsworth (1989) **Average 4 years** Frenken & Van Stolk (1989)	**Average 6.1 years**
Nature	**Approx 50% attempted/ completed penetration** Elliot & Briere (1994) Gomes-Schwartz et al. (1990) Ruggiero et al. (2000) **70-74% genital contact or attempted/completed penetration** Anderson et al. (1993) Frenken & Van Stolk (1990)	**63.7% attempted or completed penetration** **27.4% genital contact**
Offenders	**Approx 50% were relatives** Elliot & Briere (1994) Gomes-Schwartz et al. (1990) Ruggiero et al. (2000)	**52.2% male relatives**
Additional Child Abuses	**83% Physical, verbal and emotional abuse (intrafamilial)** Armsworth (1989) **56% Physical abuse** Briere & Runtz (1987)	**79.9% child physical abuse, emotional abuse and neglect** **41.9% child physical abuse**

* 'Other Studies' include those based on national and international research and samples of both CSA and incest in general and clinical populations.

Despite this latter finding, the average duration of CSA and incest in the present study (6.1 years), was the same (6 years) as Armsworth's study that focused on incest and higher than the average duration of incest of four years in Frenken and Van Stolk's study.

Nature of CSA: In terms of severity of CSA, the present sample findings of 63.7% reporting attempted or completed penetration appeared higher than international, clinical populations that have found about half of their samples reported attempted or completed penetration (Elliott & Briere, 1994; Gomes-Schwartz et al., 1990; Ruggiero et al., 2000). In addition, 91% of the present sample reported genital contact or attempted or completed penetration. This figure appears higher than the 70% of survivors of CSA in a general population, who reported some genital contact or attempted or completed penetration (Anderson, et al. 1993); and of a sample of incest survivors that reported 74% sexual abuse to this level (Frenken & Van Stolk, 1990).

Offenders: In the present sample, the finding that over half (52.2%) of offenders were male relatives, was comparable with international clinical samples that reported approximately one-half of the offenders were relatives (Elliott & Briere, 1994; Gomes-Schwartz et al., 1990; Ruggiero et al., 2000).

Additional Child Abuses: The findings that – in addition to their CSA experiences 41.9% of the present sample had experienced child physical abuse and that most (79.9%) reported experiencing child physical abuse, emotional abuse or neglect – were comparable with international clinical populations of women who had experienced incest and CSA (Armsworth, 1989; Briere & Runtz, 1987).

In summary, the present sample (see Table 24) demonstrates that the level of severity of CSA in the present sample is broadly comparable with other national and international studies. However the delay in reporting CSA in the present sample (on average 16.3 years) was considerably longer on average than the Frenken and Van Stolk (1990) study of incest survivors from a clinical population who took an average of 9.5 years to disclose the incest. In addition, the present sample took longer on average to disclose the CSA than the Anderson et al. (1993), Aotearoa/New Zealand general population study that found that over a third (37%) of the sample disclosed the CSA within one year, (compared with the present study of 12.9%); and ten percent delayed their

disclosure of CSA to between one and ten years (compared with the present sample of 33%).

Overall, findings suggest that the present sample represents a group of women who experienced relatively severe levels of CSA and coped alone with their childhood traumas without therapeutic interventions or any other help to make sense of the impact on their lives throughout much of their childhood, adolescence and adult development. Consequently, the long-term negative outcomes for this sample would likely be significant and require significant therapeutic support.

In the present study, the majority of first disclosures (71.6%) were to family, friends or partners. When asked in an open-ended question to describe the responses of the people to whom they disclosed the CSA, participants reported that 44% of the responses included being believed, listened to, made safe or that therapy support was suggested. It is of concern however, that a third (32.6%) of responses to CSA disclosures included: not helping the participant in any way; becoming angry (including being verbally or physically abusive to the participant); or disbelieving the disclosure, minimizing the CSA or attempting to silence the participant.

The finding that 14.9% of the present sample at some point (as child or adult) reported their CSA experiences to the authorities (child protection workers or police) is higher than the Aotearoa/New Zealand study (Anderson et al., 1993) where only 7.5% of women survivors of CSA in the general population reported their CSA to the authorities. It is also higher than a national USA survey that found that 11.9% of child rapes were reported to authorities (Saunders et al., 1999). However the finding that 82.5% of the present sample did not report their CSA experiences to the authorities is of concern – especially when 91.1% of the present sample experienced CSA to the level of genital contact, or attempted penetration or penetration.

Ratings Of Therapy

There are a number of limitations when comparing therapy ratings in the present study with the consumer studies in (Table 25) because each study used different rating scales, processes and questions. Nevertheless, although the comparisons are inevitably somewhat tortuous, it is important to place the current study in the context of these

important studies. Chapter Five sets out two processes by which participants rated their therapy experiences (*individual* therapists and their therapy experiences *overall*). The process of rating therapists individually was used by four of the five studies summarized in Chapter Five, the exception being Feinauer (1989) who used one overall rating.

Armsworth used questionnaires to collect data from 30 women incest survivors with an average age of 31.2 years. The number of professionals seen was four. Armsworth's participants were asked to rate their therapists individually. Her scale (see Table 25) (5=Very Helpful, 3=Helpful, 1=Not much help and 0=More harm than good) had no neutral point and was not strictly comparable with the present study. Her participants' mean rating of therapy was 3.02 (slightly above 'Helpful'). Armsworth provided insufficient data to convert her mean rating to percentages. The mean for the present study was 2.47 a point, between 'Somewhat helpful' and 'Made no difference' on the rating scale: 1=Very helpful; 2=Somewhat helpful; 3=Made no difference; 4=Somewhat unhelpful; and 5=Very unhelpful. Participants in Armsworth's study rated therapy between Helpful and Very helpful. It is not possible to compare these two findings because the rating scales are so different, however there is no strong evidence to suggest that there is a large difference between the two studies.

Feinauer used questionnaires and interviews to collect data on 36 women survivors of CSA with an average age of 31 years. Feinauer used an *overall* rating scale and found: 28% 'Very Helpful'; 36% 'Quite Helpful'; 17% 'Somewhat Helpful'; 14% 'Not Very Helpful'; and 6% 'Not Helpful'. The only similar rating between Feinauer's scale and the present study is that of 'Very Helpful' and 56% of the present sample rated therapy as 'Very Helpful' which is twice that of Feinauer's similar rating. If Feinauer's 'Very helpful', 'Quite helpful' and 'Somewhat helpful' are combined the rating is 81%. In contrast, if 'Very helpful' and 'Somewhat helpful' are combined, the present study found 86%. When Feinauer's 'Not very helpful' and 'Not helpful' are combined the rate is 20%. In the present study when the ratings 'No difference', 'Somewhat Unhelpful' and 'Very unhelpful' are combined, then the total is 15%. Overall, given the limited comparability of the two scales, the findings in the present study might best be described as slightly more positive than those of Feinauer. In both studies the majority (over 80%) found therapy, in general, to be helpful.

Table 25. Sample, Methods, Number Of Professionals Seen And Therapy Ratings Of Six Studies.

Armsworth (1989)	**Feinauer** (1989)	**Frenken and Van Stolk** (1990)	**Dale et al.** (1998)	**Palmer et al.** (2001)	**McGregor** (2003)
Sample					
30 women incest survivors	36 women survivors CSA	50 adult incest survivors	40 adult survivors of child sexual, physical abuse or neglect	311 adult survivors of sexual, physical, or emotional, child abuse, by family	191women CSA survivors
Average age					
31.2	31	33	-	38.7	42.5
Methods					
Questionnaires	Questionnaire/ 25 interviews	Interviews	Interviews	Questionnaires/ 50 interviews	Questionnaires/ 20 interviews
Number of professionals seen					
Mode=4	-	Mean=3.5	Mean=3.25	Mean=3.2	Mean=3.4
Overall therapy ratings					
	28% Very helpful 36% Quite helpful 17% Somewhat helpful 14% Not very helpful 6% Not helpful				56% Very helpful 30% Somewhat helpful 8.0% Made No difference 4% Somewhat unhelpful 3% Very unhelpful (Mean 1.67)
Individual therapists' ratings					
(Mean=3.02) 5 Very helpful 3 Helpful 1 Not much help 0 More harm than good		31% Very satisfied 9% Satisfied 16% Partly dissatisfied 10% Dissatisfied 34% Very dissatisfied (First four professionals)	37%Yes- a great deal 32% Yes- to some extent 8% Uncertain 13% No did not really help 10% No seemed to make things worse/was harmful	(Mean range types of helpers 2.3-3.4) 4 Very helpful 3 Somewhat helpful 2 No help 1 Made it worse	32% Very helpful 30% Somewhat helpful 14% Made No difference 9% Somewhat unhelpful 16%Very unhelpful (Mean 2.47) 1 Very Helpful 2 Somewhat helpful 3 Made No difference 4 Somewhat unhelpful 5 Very unhelpful

Frenken and Van Stolk interviewed 50 male and female incest survivors. Table 25 shows that they only provided ratings for the first four professionals seen and in their paper they concluded that eventually just over half of the sample found satisfactory contact. It is difficult to contrast Frenken and Van Stolk's rating scale, which uses the term 'satisfaction', in contrast to the present study's term 'helpfulness'. However if the rating 'Very Satisfied' (31%) is compared with the present study's 'Very helpful' (32%) the percentages are very similar. If the two satisfied points on Frenken and Van Stolk's scale are combined then 40% of their sample found therapy to be of some satisfaction. This compares less favourably with the two 'helpful' points from the present study of 62%. Frenken and Van Stolk do not have an equivalent neutral point (No difference) on their scale. If comparing Frenken and Van Stolk's combined three 'dissatisfied' points (60%) with the present study's, two 'unhelpful' points (25%), then Frenken and Van Stolk's therapists can be considered to have been rated more negatively than the present study's. Despite the limited comparability of the two scales, the findings in the present study do appear to be more positive than those of Frenken and Van Stolk.

Dale et al. (1998) used interviews to collect data from 40 male and female survivors of child sexual abuse, physical abuse or neglect. Dale et al. asked their participants: "Has the counselling/therapy you have received helped you to deal more effectively with the problems that led you to seek counselling/therapy?" Their rating scale is the closest to the present study although the scales are still not exactly equivalent. If the first and second points on the Dale et al. scale (37% 'Yes – a great deal'; 32% 'Yes to some extent') are compared with the present study (32% 'Very Helpful'; 30% 'Somewhat Helpful'), the findings are similar. In addition if the two points on the Dale et al. scale relating to unhelpfulness (13% 'No – did not really help'; 10% 'No – seemed to make things worse/was harmful') are compared with similar points from the present study (9% 'Somewhat unhelpful' and 16% 'Very unhelpful') then these findings are roughly equivalent. Overall the present study findings seem to be quite similar to the Dale et al. findings.

Palmer et al. (2001) collected data using questionnaires and interviews from 311 male and female survivors of sexual, physical, or emotional child abuse perpetrated by family. They provided a mean rating for nine categories of professionals. The mean finding on their scale of (4=Very helpful, 3=Somewhat helpful, 2=No help and 1=Made

it worse) was between 2.3–3.4 (between ‘No help’ and ‘Very helpful’). It was difficult to make a comparison between the Palmer et al. findings and the present study because there was insufficient data to convert Palmer’s study to percentages (although in their paper Palmer et al. reported that 70% of participants reported finding at least one professional who they rated as very helpful) and their scale was a four-point scale and did not contain a neutral point. The mean for the present study on a five-point scale was 2.47; a point between ‘Somewhat helpful’ and ‘Made no difference’ (on the rating scale 1=Very helpful; 2=Somewhat helpful; 3=Made no difference; 4=Somewhat unhelpful; and 5=Very unhelpful). The two scales are quite different, however there is no evidence to suggest that there is a difference between the two studies.

In summary, the present study sample seemed to rate therapy as slightly more helpful than the Feinauer (1989) and the Frenken and Van Stolk studies (1990) and found no large difference to the findings of Armsworth (1989), Dale et al. (1998), and Palmer et al. (2001).

It is of interest that the mean rating in the present study dropped from 1.67 (between ‘Very Helpful’ and ‘Somewhat helpful’) when participants rated therapy overall, to 2.47 (between ‘Somewhat helpful’ and ‘Made no difference’) when participants rated therapists individually. Perhaps the lower ratings, (when therapists were rated individually), is not surprising considering the likely averaging out effect that takes place when participants are asked to assess the overall effects of therapy. In addition, it seems that many participants moved on from unhelpful therapists to find more helpful therapists and thereby had a good overall outcome. This hypothesis is supported by the positive overall ratings of therapy as well as findings in the interview data that described how many participants moved on from unhelpful to helpful therapists.

Impact Of Therapy

Of the five consumer studies in Table 25, only Feinauer (1989) gave a report of participants’ psychological well-being before therapy, after therapy and at the time of the study. Feinauer (1989) found that before therapy, 87% of participants reported their self-assessed psychological distress to be ‘extreme’ or ‘severe’. After therapy these percentages dropped to 25%, and at the time of the study they had dropped further to 17%. A similar pattern of improvement in well-being was found in the present study.

Participants' self-assessed ratings of their Emotional Well-Being (EWB) before therapy found a mean rating of 2.2 (on a Likert scale where 1=Emotionally unwell and 7=Emotionally well) and after therapy their self-assessed EWB mean rating increased to 4.9. Furthermore, more participants' self-assessed EWB at the time of the study had increased to a mean rating of 5.4.

The finding that the EWB of some participants in the present study continued to improve after therapy ended replicates Feinauer's (1989) finding. Explanations, for both studies, for participants' improvements post-therapy may be associated with the work carried out in therapy. In the present sample for example, given the lengthy delays in disclosures of CSA, qualitative findings suggest it was possible that some of the on-going improvements in EWB were due to the participants': relief of breaking the silence about CSA; the reduction of self-blaming thoughts, and behaviours; and learning skills and strategies to deal with the effects of CSA in their lives, as well as relapse prevention. In addition the on-going maturity of the sample and the ability to develop more satisfying lives could also be associated with gains in EWB. However, the absence of an untreated control group makes it impossible to be certain that the improvement in EWB, during or after therapy, was due to therapy.

The finding that those at the lower end of EWB scale prior to therapy improved significantly more than those at the higher end of the scale, suggests that therapy for CSA was effective for some of the most seriously impacted participants.

It is important to note that participants who had more than 50 sessions of therapy were more likely to report a positive change of four or more on the scale of Emotional Well-Being compared to those who had fewer than 50 sessions.

Therapy Experiences

In this section, participants' reports about accessing therapy, and what they found helpful and unhelpful are discussed in relation to other studies in Table 25 and the therapy guidelines in Chapter Two.

Access issues

In Chapter One questions were raised about the ease of access to therapy for survivors of CSA. These questions were based on clinical observations of survivors of CSA having difficulties paying for therapy, therapy sessions being limited due to the lack of availability of therapists, and restrictions in the allocation of therapy hours by the ACC. Findings from the present study suggest that these issues are indeed important for a significant proportion of CSA survivors. For example, more than half of the present sample reported being unable to have therapy due to cost at some point, and more than one-quarter of the sample described the number of therapy sessions allocated to them by ACC as inadequate. Furthermore, almost one-third of responses about unhelpful therapy related to difficulties securing on-going access to therapy. Obstacles to accessing sufficient therapy included: the lack of on-going availability of therapists over the extended time that some participants required; therapy mostly being limited to one hour, once a week when the participants' needs were greater; and the lack of after-work and weekend sessions.

In addition, when asked why therapy ended, almost one-third of responses referred to therapy ending because on-going access became problematic. Of these, almost half (14.9%) of the reasons were due to the cost of therapy or that the ACC funding ended. These findings suggest that even for survivors of CSA who had managed to overcome the internal and external difficulties of initially accessing therapy (Dale, 1999; Morrow & Smith, 1995), on-going access to therapy continued to be difficult for some. Most of the consumer studies in Table 25 supported these findings, with the Palmer et al.'s (2001) study in particular, which reported complaints about limited access to affordable and specifically trained abuse-focused therapists.

Despite complaints about on-going access to therapy, it would seem that most of the participants were able to access reasonable amounts of therapy in comparison with other studies (although comparisons are difficult due to insufficient data provided by the other studies). For example, more than half of the participants in the present study reported having the equivalent of one year of weekly therapy (51 sessions) or more. This compares favourably to Armsworth's (1989) sample of incest survivors who reported having an average of 36 sessions. Two-thirds of Feinauer's (1989) sample of CSA

survivors reported having had twenty sessions or less; and Palmer et al. (2001) reported that therapy continued for more than ten sessions for most of the sample.

Length of therapy does not always equate with benefits to the client however. For example, Feinauer's study found that the length of time in therapy had no significant relationship with the participants' perception of adjustment post-therapy. However, in the present study those who had long-term therapy (over 50 sessions) were significantly more likely to report a positive change in their well-being compared with those who had 50 sessions or fewer.

Finding therapists knowledgeable about abuse-focused therapy

In Chapter One the hypothesis was put forward that, in comparison with two of the older client evaluation studies (Armsworth 1989; Frenken & van Stolk, 1990), that reported that a number of therapists disbelieved, ignored or minimized reports of CSA, participants in this present study would report fewer such difficulties. The hypothesis was based on two factors: 1) the increased awareness of the issues of CSA that had grown over the last decade or more (Finkelhor, 2002; McDowell & Saphira, 1989), and 2) the large group of specialist therapists in Aotearoa/New Zealand registered to work with survivors of sexual assault. The hypothesis was partially supported in as much as when asked what was unhelpful, participants in the present study rarely seemed to comment that their therapists disbelieved their accounts of CSA to the same extent as those in the Armsworth or Frenken and Van Stolk studies.

This hypothesis was undermined a little however, in Chapters Seven, Eight and Nine, when a few participants complained that some therapists seemed uncomfortable with the subject of CSA and either changed the subject or ignored their disclosure. Some participants also reported that some therapists lacked the specialist knowledge to fully assess the effects of CSA. It may be that many of these experiences related to therapists other than those who were registered by ACC to work with CSA (only 70% of participants received some ACC-funded therapy). Although data from the postal questionnaire are unable to answer this question, examples from the face-to-face interviews would support this theory. For example, a trend that emerged from the interview data, (Chapters Eight and Nine) suggested that a number of participants had not made the connection between their present difficulties and their histories of CSA.

Therefore, many had initially seen non-registered ACC therapists, such as mental health workers, crisis teams and student counselling services for the difficulties in their lives.

Once they had made the connection between their childhood abuse and current difficulties, some were then able to be referred to an ACC-registered therapist. Many participants who were supported as they made sense of their lives reported the relief of finally understanding themselves and their reactions. Having been supported as they put their lives into context, a number of participants rated poorly those previously-seen therapists who had not helped them to acknowledge or deal with their abuse experiences.

Are therapists asking repeatedly about CSA or 'implanting false memories'?

Another issue outlined in Chapter One was whether any survivors of CSA had felt any impact from the "false memory" debate and climate of minimisation and denial that continues to surround this field of work. Even though the questionnaire contained no direct questions, some participants made poignant comments on how this particular debate had affected them. For example, one participant commented:

> *The huge burst of publicity in the early 90s led not to recovered memories but the inability to ignore them.*

The fact that the participant felt the need to qualify that her memories of CSA were not "recovered memories" suggests that the participant considered that her "inability to ignore" her memories of CSA could be interpreted by some to mean they were false.

As mentioned in Chapter One, a popular view emanating from the proponents of "false memory" has been that therapists implant false memories of CSA where there are no such histories by repeatedly asking if their clients had experienced CSA. If this practice does exist in Aotearoa/New Zealand, it is surprising (given that the sample included those who not only saw specialist abuse-focused therapists such as those registered with ACC but also saw a number of non-ACC-registered therapists, sometimes before they were aware of the connection between their current difficulties and their CSA histories) that, when asked what was unhelpful in therapy, not one of the 191 participants in the present study complained that any of the 633 therapists they saw had questioned them about CSA in a leading or repetitive manner. In addition, during several of the face-to-face interviews when some participants had described their processes of coming to

terms with their memories of CSA, I asked them if they experienced any of their therapists attempting to influence their memories in any way. None reported that a therapist had attempted to influence their memories or had repeatedly asked them if they had experienced CSA.

In fact the opposite was the case. Some participants were annoyed that therapists had not asked them if they had a history of abuse and complained that if someone had asked they would not have wasted so many years of their lives not understanding themselves (such as their 'seemingly irrational' fears of men and/or certain situations, their depressions and sleep disturbances and so forth).

Therefore findings from this study suggest that in contrast to the allegations that therapists constantly question their clients about the possibility of a CSA history, some participants complained that the opposite was true. The strongest example of this trend was when a 56 year old woman (P18) who had seen over 20 therapists from 1963 until 1997, and complained that, over those 24 years, not one of the 20 had ever asked her if she had experienced CSA.

Furthermore, fewer than one-quarter (21.7%) of those who had been in contact with mental health services had been asked by staff if they had a history of CSA. This finding suggests that professionals in the mental health field tend to avoid a client's history of CSA, rather than insist upon such a history being present. This finding is consistent with other studies from Aotearoa/New Zealand (Agar et al., 2002; Read & Fraser, 1998a) and elsewhere (Briere & Zaidi, 1989; Lanktree et al., 1991). For instance only 32% of psychiatric in-patients were asked about abuse even when the assessment form explicitly included a section on trauma and abuse (Read & Fraser, 1998a).

Beginning therapy

Findings from the present study confirm those studies (Chapter Two) which found that a number of survivors of CSA approach therapy due to a crisis, and others approach therapy with a vague notion that the effects of CSA were impacting on their lives (Courtois, 1988; Meiselman, 1994; Mullen et al., 1996). Only 5.7% of responses in the present study indicated that one of the reasons the participant entered therapy was due to their need to talk about the CSA. This finding is similar to Frenken and Van Stolk's

(1990) finding that only ten percent of sample sought therapy directly to talk about their experiences of incest. In the present study the most common reasons given for seeking therapy were depression, suicidality, post-traumatic stress and/or relationship issues. Interview data suggests that sometimes participants were vaguely aware that there might be a connection between their CSA histories and their reasons for seeking therapy.

Morrow and Smith (1995) found that entering therapy takes courage. This finding was borne out by some participants in the present study who commented on their need to overcome their fear of therapy. Their fear was often based on not knowing what was involved in the therapy process. Abuse-focused therapy guidelines (Chapter Two) and two consumer studies (Dale, 1999; Feinauer, 1989) highlighted the need for therapists to help their clients to engage in therapy, in a way that offered clients as much control over the process as possible. From the beginning of therapy Dale and the therapy guidelines reviewed in Chapter Two encourage therapists to make the effort to build rapport and assist clients to deal with their fears of therapy by educating them about: 1) their rights within therapy (including their right to leave therapy or change therapists if they wish and the conditions under which they can contact the therapist) and 2) the structure and process of therapy including predicting possible difficulties (such as how talking about trauma can have an effect on current well-being and how a number of aspects of therapy can trigger strong feelings). Findings from the present study suggest that participants valued therapists who followed these practices. Participants reported that when they encountered therapists who treated them as equals, told them of their rights in therapy, and described the therapy process, they felt empowered, respected and safe. Other participants who had not been helped in this way when they entered therapy were sometimes critical of therapists who neglected these practices.

The therapy relationship

The title of this thesis “It’s a Two-Way Thing” is an acknowledgement of the importance of the therapy relationship. The title is taken from an interview with a participant who described helpful therapy as a collaborative venture between therapist and client. In most abuse-focused therapy guidelines (Chapter Two) the therapy relationship is described as the crux of therapy. The main reason for survivors of CSA beginning therapy is to seek help to deal with the current effects of CSA in their lives (often without having made the connection between their CSA history and their current

difficulties). Finding a therapist that they feel comfortable to work with seems to be crucial to this goal. For example, in the postal questionnaire, when participants were asked what was helpful in therapy the second largest number of responses – over one-third – were about 'the therapy relationship'.

Participants reported the powerful healing aspect of the therapy relationship, when they were able to form a positive working relationship. Counter to this were reports of the less than helpful and sometimes harmful power of the therapy relationship when a working relationship could not be formed.

Therapists can unknowingly cause hurt simply by being insufficiently attentive (Dalenberg, 2000). When participants in the present study encountered therapists who listened to them and were attentive, non-judgemental, accepting, understanding, caring, and supportive, participants reported feeling safe, heard, consulted, understood, and able to talk about their issues at their own pace. Key differences in therapy relationships between helpful and unhelpful therapists were that helpful therapists were: interactive rather than non-communicative; warm and open to being known (within limits), rather than cold, clinical and aloof; involved with the client but not over-involved; supportive and able to manage the process of therapy but not pushy or overly directive; affirming rather than judgemental; encouraging but not impatient; and empowering rather than disempowering.

A strong finding from this study was the need for therapists to consult their clients about all aspects of the therapy rather than make assumptions (for example, about what the client means) or act in the role of expert. Clients need to be consulted over the focus, pace and techniques used in therapy as well as the meaning of the trauma and the on-going impact of therapy on the participant.

Although a positive therapeutic relationship can be key to therapy goals being achieved, findings from this study (Chapters Eight and Nine) suggest that a positive, safe and caring therapy relationship, on its own, is not enough. Participants reported that specific training in abuse-focused therapy was also essential to their ability to work effectively with a therapist. Too many participants encountered therapists who were *"sweet"* and

"nice", but also: *"we weren't getting anywhere because she didn't know how to help me" and "she couldn't take me deep enough"*.

Based on participant descriptions of helpful therapists, a composite model of a helpful therapist would be one who was *both* interactive and knowledgeable about abuse-focused therapy. Such an interactive and knowledgeable therapist would be: warm; caring; understanding; assessing and attending to a client's needs; supportive; open with safe boundaries; an active listener; *and* knowledgeable about abuse-focused therapy philosophy and practice.

When participants in the present study encountered therapists who did not listen, treat them respectfully, or have the skills and knowledge to help them, many left. Of equal concern is the finding that some participants stayed and blamed themselves for failing in therapy. This finding is a replication of Dale's finding. A problem, identified by both Dale (1999) and this study, (but not covered at length in the therapy guidelines summarized in Chapter Two), was how to help clients who were disempowered, lacking in confidence in their own judgements or who deferred to the authority of the therapist and stayed in therapy that was not particularly helpful to them.

Working with the effects of CSA

The largest number of responses to the question concerning what was helpful and unhelpful in therapy related to 'the work' carried out in therapy. The size of response about therapy work is understandable – many participants described feeling desperate to be rid of the effects on their lives.

Focus on helpful therapy work

Findings in Chapters Six, Seven, Eight and Nine suggested that to help a participant work through the effects of CSA required adherence to many of the recommendations of the abuse-focused therapy guidelines (Chapter Two).

Assessment process: Helpful therapy began with good assessments of all areas of the participants' lives, including: most importantly, an assessment of their current safety and stability (in their living environments and interpersonal relationships); the participants' abilities to emotionally and financially sustain the therapy work; and the

need for referrals (when necessary) to access additional therapies such as group therapy, couple therapy, and/or psychopharmaceutical therapies. In Chapter Nine, one participant described the best therapist she had ever had, one who worked holistically with her and was a *"one stop therapist shop"*. This therapist was able to provide referrals to group therapy, couple therapy, as well as providing a referral for her child's behavioural difficulties.

Working with current functioning: Participants described helpful therapy work as being thorough and assisting them to work through a wide range of issues, such as dealing with current functioning difficulties including: learning to be aware of and regulate thoughts and feelings; ways of dealing with depression, symptoms of PTSD including panic attacks, flashbacks, fears and anxieties, and dissociation; learning self-care and assertion; and how to cope with relationships as a partner, worker, parent and/or friend.

Working through traumatic material: Helpful therapists contracted with and consulted participants over the pace and focus of the therapy and of the techniques used. Participants were encouraged to give feedback about the process and progress of the therapy. When participants disclosed sensitive material, they described helpful therapists as acknowledging their disclosures without over- or under-reacting. Helpful therapists were able to provide participants with the support to talk as much or as little as they felt able, about all aspects of the CSA. In addition, helpful therapists supported participants as they worked through the meaning of the CSA and helped them to de-stigmatize the CSA by supporting them to understand that things they considered proof of their 'badness' or 'madness' were common effects of CSA.

Focus on unhelpful therapy work

Unhelpful therapy practices included a range of therapy errors including omissions and commissions. Serious errors in either category could be described as harmful practices. These errors seemed to reflect Dalenberg's (2000) descriptions of therapeutic errors along the withdrawal/intrusion continuum.

Omissions included: a lack of focus on CSA; participants not being supported or encouraged to return to therapy; and therapists not providing sufficient structure, direction, progress, information, guidance, or referrals. Other omission errors (Chapters

Eight and Nine) included therapists who: did not seem to know how to proceed in therapy after hearing a disclosure of CSA; appeared unable to cope with painful disclosures of CSA; and ignored CSA disclosures or changed the subject.

Commissions included: inadequate assessments and abuse-focused therapy work. For example, in their assessments, some therapists did not seem to include a number of participants' current difficulties (such as interpersonal difficulties, problems with alcohol, anger, or parenting), as part of the therapy. This latter finding suggests that either the therapists viewed abuse-focused therapy work as solely focusing on issues directly related to the disclosures of CSA, or that they did not recognize many of the common long-term effects of CSA as part of the therapy work. If either suggestion is correct, another question could be raised about whether these situations have occurred due to therapists' lacking training in abuse-focused therapy or whether their narrow focus was sometimes influenced by pressures from agencies, waiting lists, or ACC. Given one pattern found (in Chapters Eight and Nine) – where a few interviewees were given three or four sessions with a therapist and then told there was no more that could be done for them, and that they should come back if they had a crisis – a lack of knowledge of abuse-focused therapy seems likely in this case.

Other commissions included therapists being: poor at managing the therapy sessions; poorly attuned to a participant's needs; too interventionist; and/or poor at providing helpful information or advice.

Harmful practices included practices that the therapy guidelines (Chapter Two) warned therapists to avoid, such as: therapists being blaming, angry, shouting; insulting and/or describing clients in derogatory ways including using psychiatric labels. In addition some described harmful therapists as those who: over-stepped therapeutic boundaries; did not maintain confidentiality; over-disclosed their own issues; made their clients leave therapy before they were ready (by putting up therapy fees or refusing to continue the therapy); and did not act responsibly (such as not taking suicidality seriously).

Two interview participants in Chapter Eight described therapists' failures to assess their current safety issues leading to their therapists' recommendations to be assertive in situations that were potentially dangerous. One participant was at increased danger of

further abuse had she followed her therapist's advice to say "No" to sex with her husband – whom she had already told the therapist had "pushed" her "around". She left therapy instead. The other participant did in fact experience further abuse after she followed her therapist's advice to be assertive in a violent home situation.

Some participants described unwanted hugs from male therapists (after they had disclosed their experiences of CSA) as harmful, insulting and signalling a lack of understanding. Furthermore, three participants (two interviewees and one participant who phoned after sending her postal questionnaire) spontaneously reported sexual abuse by a therapist. The most extreme of the three reports in the present study were the violent rapes of one interviewee over three days after she had sought therapy for incest in the 1980s from a male church-counsellor. Another interviewee reported sexual abuse by a female church-counsellor and one participant reported "becoming sexually involved" with a male psychologist and later felt violated by the involvement.

The three reports represent 1.6% of the sample of 191 participants, or 0.5% of the 633 therapists seen by the sample. In comparison, a review of the literature up until 1990 reported 1.9-3.5% of female therapists and 7.1-10.9% of male therapists had admitted to intimate contact with clients (Carr et al., 1990). Doubts must be raised in relation to the accuracy of the low level of reporting in the present study however, given that none of these accounts were reported in the postal questionnaire. Perhaps a better estimate of the level of sexual abuse by professionals of this sample is based on the two interviewees in the sub-sample of 20 (10%) who spontaneously disclosed abuse. (The sub-sample of interviewees saw 112 therapists and reported two abusing therapists making the rate 1.8%).

A mix of helpful and unhelpful therapy work

Many aspects of therapy were helpful for some participants and the same approaches were unhelpful for others. Due to space considerations only a few key issues will be noted here.

Structure and goals: Some participants reported that more structured therapy, such as setting goals, could lead them to feel pressured to achieve their goals and fearful of

failure. Others felt that therapy without clear goals and structures left them feeling dissatisfied about their direction and progress in therapy.

Pace of therapy: When designing this study it was hypothesized (Chapter One) that participants would not make comments about the helpfulness of well-paced or staged therapy. For example, despite therapy guidelines (Chapter Two) advocating that carefully paced therapy was vital, it was not expected that participants would comment that this aspect of therapy was helpful. However, although participants did not directly state that it was helpful when, for example, therapists assisted them to gain safety in their lives first and helped them build their ability to cope with their feelings 'before' talking about CSA at a deep level, some certainly complained when there was an absence of carefully titrated therapy. For example, there were some complaints (Chapters Seven and Eight) when the therapist left participants in a distressed state at the end of therapy sessions.

Therapist self-disclosures: Given that participants were expected to share personal and sensitive information with the therapist (to avoid being labelled as resistant), the therapist/client power relationship seemed particularly unequal to some participants. Similar to Dale's (1999) findings, at the beginning of therapy when the therapy relationship was being established, some self-disclosures by therapists could reduce participants' anxieties. For example, a participant who was a parent commented that she felt that her therapist understood her better when she found that her therapist was also a parent. Knowing a little about their therapists helped some participants with rapport building, feelings of safety, and stopped them from needing to seek confirmation that their therapists understood them. In contrast, some participants reported that therapists who refused to give any personal information seemed untrusting, cold, aloof and withholding. However, also consistent with Dale's study was the finding that large amounts of therapist disclosures was often reported as unhelpful, unwanted, burdensome, disrespectful and wasteful of clients' time and money.

Given that abuse-focused therapy is not a one-size-fits-all endeavour, findings from this study support therapy guidelines (Chapter Two) that encourage therapists to consult their clients about the therapy process and progress.

Therapy models

Comments about particular therapy models and techniques drew very few responses. Most were mentioned only once or twice. The only types of therapy models or techniques to attract a number of responses were creative techniques and group therapy.

Creative techniques that included role-play, writing and drawing were described as both unhelpful and helpful. However within these categories role-play/psychodrama was described as unhelpful twice as often (6.3%) as helpful (3.0%). This finding from the postal questionnaire was supported in the interview sample. A number of interviewees described feeling that psychodrama split them into parts and they were not helped to feel whole again at the end of the session. Furthermore, replicating Dale's (1999) finding, some participants in the present study reported feeling pushed to express anger through action methods and to produce a catharsis of emotion. Some participants reported feeling 'stupid' or 'silly' when asked to talk to empty chairs or to hit cushions. In contrast, some participants described 'talk therapy' as ineffectual for them and reported that the most valuable and effective therapy they encountered was role-play and psychodrama. These findings support the therapy guidelines (Chapter Two) that suggest that, as with any therapeutic tool, it is important to consult the client about their preferences rather than a therapist following a model they prefer, without such consultation.

Group therapy was also described as both helpful (2.3%) and unhelpful (1.9%). The small number of responses in this category should be seen in context of the study being focused on one-to-one therapy. The value in group therapy was found in the process of normalisation and reducing feelings of isolation. Group therapy was reported to be unhelpful when there was poor facilitation and participants felt unsafe from other group members. Again the need to consult is highlighted.

Conclusions

There was a potential for this study to attract a large number of dissatisfied clients wanting to use the study as a vehicle through which to vent their complaints about therapy. To the extent that this did not happen (in fact the opposite was found) seems to be a tribute to therapists in this country.

Focus on the positive

The finding that the majority (85.7%) of participants rated their therapy experiences overall as either 'Somewhat or Very Helpful' is impressive especially given the size of the sample and the severity of the CSA experiences. Participants contributed almost twice as many responses (606) when describing what they found helpful in therapy in comparison to their descriptions of unhelpful therapy (364 responses).

The findings that the participants' Emotional Well-Being (EWB) mean ratings improved from 2.2 to 4.9 (Likert scale 1= Emotionally unwell to 7 = Emotionally Well) from before therapy to after therapy and continued to increase after therapy ended, was also remarkable. Similarly, the finding that those at the lower end (closer to 1) of the EWB scale moved significantly more than those at the higher end of the scale suggests that the therapy provided was particularly effective for the more distressed survivors of CSA.

The finding that participants in the present study rated their therapy experiences so positively overall, supports the hypothesis at the beginning of this study, that the 600-800 therapists in this country registered with ACC specifically to provide therapy for survivors of sexual trauma have been providing relatively 'helpful' therapy over the last decade or more. Support for this hypothesis came with the finding that over 70% of the present sample had at least some of their therapy funded by ACC.

Nevertheless, participants' descriptions of helpful and unhelpful therapy experiences in the present study were similar to the consumer studies listed in Table 25 in that therapy experiences were often mixed and could range from being vital and life saving to distressing and harmful.

Helpful therapy was when participants were:

- Able to access therapy at the time they needed assistance.
- Easily able to find a therapist with whom they felt comfortable and who was knowledgeable about abuse-focused therapy.
- Able to have access to this therapist for as long as they needed.

Helpful therapists were:

- Affectively available, non judgemental and interactive.
- Open and 'real' as well as bounded and safe.
- Knowledgeable about the dynamics and effects of CSA.
- Knowledgeable about abuse-focused therapy.
- Able to provide an overview of the process of therapy and the client's rights and responsibilities from the beginning of therapy (especially the client's right to move on to another therapist if the therapeutic relationship was not able to be established).
- Able to cope with hearing about CSA and about the effects of CSA.
- Able to support participants as they talked about their CSA experiences.
- Able to conduct a full and on-going assessment of participants issues and needs.
- Able to assist participants to begin to work through the effects of CSA in their lives.
- Flexible and consultative about the focus and pace of therapy work.
- Focused on adding to the client's skills, self-management abilities, self esteem and self worth.
- Able to remind the participant of their progress through therapy.

Helpful work in therapy included participants being assisted to:

- Establish some safety and stability in their lives.
- Understand the effects of CSA on their lives.
- Reduce self-blame and effects such as depression, suicidality, symptoms of PTSD.
- Improve their relationships.
- Learn to feel and/or control strong emotions such as anger.
- Understand their thoughts, and behaviours.
- Deal with some of the issues of responsibility and forgiveness.

Focus on the negative

Virtually everything that the participants from this present study reported to be helpful in therapy was described as 'best practice' in the abuse-focused therapy guidelines as (outlined in Chapter Two). Participants' descriptions of unhelpful therapy were mostly the opposite of the template of 'best practice'. However, because the abuse-focused therapy guidelines are mostly written for therapists already engaged in therapy work, the guidelines reviewed in Chapter Two did not seem to devote a great deal of attention to advising therapists how to help (especially new) clients through the process of finding a therapist to work with.

An alarming number of participants reported staying in therapy relationships (for months and sometimes years) that were not particularly helpful to them. Their reasons for staying in these relationships were similar to findings in Dale's (1999) study and included that: they did not know it was their right to leave the therapist; they did not want to hurt the therapist's feelings; and/or because their experiences of child abuse had taught them to be deferent and put the needs of others (therapists included) before their own needs.

It is of concern that when participants rated their therapists individually, one-quarter (24.5%) rated their therapy experiences as either 'Somewhat or Very unhelpful'.

When therapy was described as unhelpful key complaints were that sometimes some therapists:

- Were not sufficiently available or did not provide enough therapy.
- Lacked knowledge of abuse-focused therapy and philosophy.
- Did not conduct on-going assessments of the effects of CSA throughout therapy.
- Did not provide information about rights and responsibilities at the beginning of therapy including the right to be referred on to another therapist should there be difficulties forming a safe and effective working therapeutic relationship.
- Did not focus on all of the effects of CSA (not for example just PTSD, but also relationship and parenting difficulties, problems with anger, sexuality, and substances).
- Did not focus sufficiently on the CSA experiences or were unable to cope with disclosures or descriptions of CSA.

- Did not consult their clients about the pace, focus or techniques used in therapy.
- Did not find the optimal balance to manage therapy sessions, the therapy framework, or therapeutic boundaries so that there was sufficient flexibility and openness as well as enough structure, boundedness, and progress through the therapy.
- Were poor at carrying out techniques, interventions or giving information.
- Were passive, non-interactive, cold, clinical, 'a blank screen' and/or did not assess or cater for client's needs.
- Were judgemental, insensitive, insulting and a few were harmful.

Therefore, although overall participants gave therapists in this country remarkably positive ratings, there are concerns that:

- On-going access to therapy was a problem for many.
- Almost one-third of the reasons why therapy ended were due to problems with the on-going access to therapy and of these, almost half of the reasons were due to the cost of therapy or that the ACC funding ended.
- More than half of the overall sample reported being unable to afford therapy at some point.
- Over one-quarter of the participants who had therapy funded by ACC described the therapy sessions allocated by ACC as inadequate.
- Almost two-thirds of those in contact with mental health services prior to one-to-one therapy were not asked about their histories of CSA.
- There were three reports of rape or sexual abuse by professionals.
- There were some reports of other harmful practices including shouting at participants.

Suggestions For Future Research

By this present study solely focusing on the experiences of clients, their therapists have been excluded. Conducting a study focusing on the therapists who do this work would be a useful contribution to this field. For example a similar study format of all therapists who work with survivors of CSA (particularly ACC-registered therapists) to assess what therapy practices they consider are effective and non-effective with this population would collect a great deal of valuable data.

This study has focused on women survivors of CSA. Further research is required to explore CSA and therapy experiences of male survivors. A study with a similar format to the present study could provide valuable data that may be compared with this study.

Due to time and spatial constraints, this study has not analysed the different CSA and therapy experiences of the different ethnic groups represented in this study. It is intended that, following the completion of this thesis, the analysis of Maori experiences will be conducted in collaboration with a Maori researcher and the findings will be disseminated to Maori, as well as therapists, therapy trainers, policy makers, and scientific journals and conferences. Unfortunately this study failed to attract sufficient Pacific participants to permit meaningful analysis so findings from this study cannot be generalized to Pacific people. Further research by a Pacific researcher would be a valuable contribution to this field.

Similarly, time and spatial constraints did not permit analysis of five questions (Qns 31-35) asking participants to 1) give advice to: other survivors about what to look for in a therapist; therapists to improve their practice; and government about the funding of therapy for survivors of CSA; 2) say what they thought would be helpful to prevent CSA; and 3) comment on anything not covered in the study. A cursory examination of the responses to the first three questions asking for advice (Qns 31-33) suggests that they largely reproduced similar responses to earlier questions about what was helpful and unhelpful in therapy. Nevertheless these five questions will be analysed and included in papers submitted for publication in scientific journals.

Over 70% of the present sample had some of their therapy funded by ACC. Due to time and spatial constraints a great deal of data from participants about their views of, and interactions with, the ACC have been unable to be included. It is intended that following the completion of this thesis further analysis and dissemination to ACC, policy makers, therapists and consumers will be undertaken.

Due to time and spatial constraints participants' views of how they would like to be approached to contribute to the on-going evaluation of their therapists has been unable

to be included. It is intended that these data will be analysed and disseminated to ACC, and professional bodies following the completion of this thesis.

Advice for possible replication of the study

There are other methodological approaches to the questions addressed in this study, including studies using standarized outcome measures and matched control groups of untreated women, and similar comparisons of different treatment models. For those researchers who prefer to ask the survivors themselves, this study provides a few useful suggestions.

In the process of designing the postal questionnaire there were extensive deliberations about the optimal length of the questionnaire to gather sufficient data while maximizing the return rate. The compromise reached may have been too conservative. A number of participants complained about the lack of space to write fuller responses. Similar future studies should anticipate an articulate, and enthusiastic group of participants who are likely to want to contribute fully. However, any such future research designs that include open-ended questions will also need to allow a substantial amount of time and resources for data analysis. When this present study was designed, the four earlier consumer evaluation studies (in Table 25) each had attracted less than 50 survivors of child abuse as participants. The more than 250 initial responses to this present study were unexpected and consequently produced an enormous amount of quantitative and qualitative data.

When the postal questionnaire was designed, it was anticipated that the open-ended question about unhelpful therapy would allow participants to disclose any sexual abuse by therapists. It became clear that at least three participants did not report sexual abuse by their therapists on the postal questionnaires. Two participants reported rape and sexual harassment during their follow-up interviews and one participant reported unwanted sexual involvement with a male therapist during a telephone conversation following her postal questionnaire being sent into the study. Given that participants in Armsworth's (1989) postal questionnaire disclosed sexual abuse by professionals when asked directly, it is recommended that future research in this area that uses a postal questionnaire, ask participants directly if there has been any sexual involvement with professionals.

It became clear from the postal questionnaire that participants experienced a great deal of re-victimisation following their CSA and other child abuse experiences. Spontaneous additional comments about rape, gang rape and beatings as adolescents and as adults were included in a number of postal questionnaires. The absence of questions about later re-victimization in the postal questionnaire precluded the gathering of further details on these abuses. It is recommended that any similar future studies ask about re-victimization experiences in order to provide a broader picture of abuse experienced.

Policy And Practice Implications

This study asked consumers about some of the obstacles to accessing therapy. It seems that it is difficult enough for some survivors to find the courage and self-worth required to ask for help, overcome internal (denial and fear) and external barriers (climate of 'backlash' and social stigma associated with therapy for CSA) to ask for help. Then there are the practical obstacles such as applying to a bureaucracy such as ACC for funding and the search for an available, knowledgeable, empathetic, affordable therapist, which can be complex and draining. For these reasons, policies associated with providing abuse-focused therapy need to facilitate the ready availability of knowledgeable, empathetic, and affordable therapists.

Furthermore considerations should be made to make it easy for clients to change therapists when necessary. This study has found that participants needed to be able to trust and feel safe and comfortable with a therapist before they were able to complete their therapy work. Without the ability to establish a positive therapeutic relationship survivors and funders of therapy may be wasting their precious time and resources on therapy that is not helpful and in some cases may be harmful to survivors of CSA.

This thesis replicates many of the findings of Dale et al. (1998) and supports their calls for the specialized training and monitoring of therapists who work with this vulnerable population. This study has found that survivors of CSA want to be involved in evaluating their therapists and they want improvements in the quality, availability and monitoring of therapy for survivors of CSA. Findings from this study would support bodies such as the ACC and/or other professional bodies developing a system where survivors of CSA could contribute to the evaluation of their therapy.

It seems that a large part of the attraction of participants to this study was to help other survivors by reinforcing that the availability of good quality, affordable therapy is essential. Many of the messages to government agencies (the findings of which are unable to be included due to spatial considerations) are summed up in the comment from one participant who wanted the government to know that the cost of therapy was *"worth it"*. In addition, a phone call from a participant who had begun therapy for CSA after she had turned 60 wanted ACC to know that therapy can be beneficial for older people too, and that *"ACC didn't waste their money"* on her because she and her family had experienced huge benefits from her having had therapy for the CSA effects she experienced.

Recommendations

The following set of recommendations is based on findings from this study. The recommendations are directed at those who may be able to implement changes to their policies and/or practices.

Therapists

Therapists who work with survivors of CSA need to be:

- Knowledgeable about the dynamics of CSA (including how children can be entrapped and take a long time to disclose CSA).
- Knowledgeable about the wide-range of effects of CSA.
- Able to provide clients with a description of the therapy process, the limits of their availability and the client's rights and responsibilities (including the right to move on to another therapist if a therapeutic relationship is not able to be established).
- Able to cope with hearing accounts of CSA (including aspects of humiliation, and helplessness) and the sometimes debilitating and chronic effects of CSA (including deeply entrenched self-harming behaviours, suicidality and/or rage).
- Able to be warm, caring, supportive, non-judgemental, an active listener, sufficiently open and interactive as well as bounded and safe.
- Willing to assist clients to access all appropriate supports and services.
- Able to provide an on-going assessment of each survivor of CSA (that includes their current safety and ability to sustain the therapy work).

- Able to provide flexible, well-paced therapy for all effects of CSA (not just post-traumatic stress, but also depression; substance abuses; eating and sleeping disorders; mood and thought disturbances; and relationship and parenting difficulties).
- Willing to consult clients about the focus and pace of therapy as well as techniques used.
- Able to focus on the clients' strengths and remind them of their progress.
- Able to add to the clients' skill-building and self-management abilities.
- Able to develop open relationships with clients that support and encourage them to give feedback about what parts of the therapy are helpful and unhelpful; and
- Able to find sensitive ways to discuss how to deal with therapy relationships that do not seem to be benefiting the client.

Those involved in supervizing and monitoring therapy

Because survivors of CSA seem to be particularly vulnerable to poor practice, supervisors, professional bodies, and those involved in monitoring therapy (such as ACC) need to work towards:

- Educating CSA survivors about therapy by providing survivors of CSA with information (at the beginning of therapy) about the process of therapy (what to expect) and about their rights in therapy – especially their right to leave therapy if they are not comfortable with the therapist;
- Finding a non-intrusive, transparent, on-going process to evaluate abuse-focused therapy that empowers both the client and the therapist;
- Assisting consumers to be part of the process of evaluating their therapy and – given the vulnerability of survivors of CSA to further revictimization – any evaluation should include an assessment of how safe the client feels with the therapist (including from sexual and financial exploitation).

ACC

As the largest funder of therapy for CSA in the country, ACC needs to:

- Assist the increased access to knowledgeable and well-trained abuse-focused therapists.

- Ensure therapy is affordable for survivors of CSA (perhaps by increasing the ACC fee to therapists to reduce the 'top-up' fees paid by participants).
- Ensure survivors of CSA can access sufficient therapy for their needs (sometimes more than once a week, over the length of time survivors consider they need such support).
- Develop a system to consult the client about the amount of therapy they consider they need.
- Acknowledge from the outset of therapy any limitations of treatment provision so that survivors and therapists can co-ordinate a continuum of care based on treatment availability.
- Minimize the extent to which bureaucratic requirements become obstacles to survivors of CSA accessing sufficient therapy for their individual needs. For example – given the amount of anxiety participants described when considering approaching therapy – it may assist survivors if only the minimum amount of information about the CSA be required to establish the initial claim
- Support therapists who are able and committed to work with survivors of CSA (perhaps by providing affordable on-going specialist training to increase the availability of knowledgeable abuse-focused therapists).
- Ensure that all the ACC personnel who interact with survivors of CSA are sufficiently sensitive and have some specialist knowledge about the effects of CSA and the complexities of abuse-focused therapy.
- Ensure survivors in rural areas have financial support to access a range of therapists and support services (for reasons of confidentiality or the need to find a therapist they feel comfortable with, they may need to travel outside of their community).
- Support the inclusion of consumers in the development of ACC SCU policy and practices.

Health and mental health professionals

Given that some participants in this study have suggested that they would have benefited from professionals helping them to understand the links between being a victim of crime and the effects on their lives, it is recommended that:

- Screening for child and adult abuse is incorporated into routine health checks.

- Routine screening for abuse is incorporated into all mental health and health services.
- Health and mental health professionals are provided with training about a) the wide-ranging effects of CSA, b) when and how to ask about CSA, and c) how to respond sensitively to survivors of CSA and to disclosures of CSA including being sufficiently knowledgeable about local resources (and funding processes) to be able to offer appropriate referrals.

Clients' rights

Clients need to be reminded that:

- They have the right to good quality therapy and have the right to 'shop around' when looking for a therapist to work with.
- They do not need to stay with a therapist that they cannot form a working relationship with.
- They are the experts on their own experiences and are entitled to work with therapists who will treat them with respect and compassion.
- They do not have to put up with therapists who shout at them, humiliate them or abuse them in any way.
- There are supervisors, professional bodies and complaint procedures that they can access.

APPENDIX 1 - CRIMES ACT

APPENDIX 2 – STUDY BROCHURE

APPENDIX 3 – POSTAL QUESTIONNAIRE

APPENDIX 4 – FINAL COMMENTS SHEET

APPENDIX 5 – PRESS RELEASE

APPENDIX 6 – SEMI-STRUCTURED INTERVIEW SCHEDULE

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