REALITY THERAPY WITHIN A FEMINIST FRAMEWORK:

INDIVIDUAL THERAPY WITH SEXUAL ABUSE SURVIVORS

BY

MAUREEN P. FLAHERTY

A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

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THE CAGE

It's there.
You can't see it
But I can feel it.
It drags me everywhere it's told to go
EVERY DAY
A cage on wheels it is.
Someday soon I'm going to break the cage
And only take the wheels
And I'll go, go,go
Maybe I'll never come back.

" Penny",1988

1. Introduction and Plan for Therapeutic Intervention.

1.1 Introduction.

My real interest in the area of child sexual abuse began when I started my career in social work in rural Alberta in 1975. Within the first two weeks on the job, I was introduced to two little girls aged nine and eleven, both of whom had been taken into temporary custody of the social service agency for which I worked. They had both been raped, sometimes at knife point, over a period of years by their father. My job was to be 'their worker',which meant representative guardian, continuing investigator (other children remained in the home), and counsellor. Fresh out of theatre school, with some added background in psychology, I had plenty of desire and good intentions, but little idea how to help these young children heal from their trauma. Available literature on the subject of child sexual abuse was not of much use as it was generally believed at the time that sexual abuse was very rare, or an aberration of the 'client' or 'patient' and her psyche(Masson,1984; Rush,1977). I floundered in my work, using a good deal of empathy with the girls, but little else. Jobs changed, I moved out of the province, and out of child welfare work.

In 1981, within a month of returning to work, and of acquiring a caseload of permanent children in care, I met a suicidal eleven year old and her 'acting out' thirteen year old sister. As I worked with the eleven year old, my concerns about her caregivers increased. It was soon discovered that both girls were being sexually abused by their foster father and his son-in-law. Available literature to help the counsellor aide the victim was still virtually nonexistent. Child sexual abuse was still thought of as a fairly rare phenomenon. I wondered what would happen to the bruised children as they grew into adulthood, and I hoped that my work and study would

eventually afford me the opportunity to be a much more actively involved in the healing of survivors in general.

Research since the early 1980's has revealed a glimpse of what now appears to be an astonishing number of women who have experienced sexual abuse as children. What was, until recently thought to be a rare occurrence, is now seen to be of epidemic proportions.

One study based on a random sample of the entire population of the United States (Lewis, 1985), a telephone interview survey, found that some form of sexual abuse during childhood was reported by 27% of the 1,374 females interviewed. A random sample of 930 San Francisco women was completed by Russell (1983, 1986), with a 50% response rate. In Russell's survey, (1983,1986) 54% of the responding women reported experiencing childhood sexual abuse. Fifty-three percent of women in a similar study by Wyatt and Peters (1985) in Los Angeles reported experiencing some form of childhood sexual abuse. In this study, 55% of the women surveyed responded.

A random sample of 1,006 women drawn from the national population in Canada completed a questionnaire. With a response rate of 94%, 23% of the women surveyed reported unwanted touching of a 'sex part' of their bodies and 22% said someone had either attempted to have or actually had unwanted sex with the respondents. The unwanted acts reported by these women occurred before the age of eighteen for two thirds of the women and prior to the age of fourteen for one third of the women (Jehu, 1988).

Despite the variation in numbers, a history of child sexual abuse is common among females in the general population of North America.

Finkelhor (1979), Jehu and Gazan (1983), Jehu, Gazan and Klassen (1988) are among the many researchers and therapists who have found that adult survivors of child sexual abuse often share a sense of lack of control and low self-esteem. These feelings have

been found to be played out in behaviors which include isolation, self-mutilation, prostitution, alcohol and drug dependence--or extreme passivity and lack of assertiveness. Curtois (1988) in a study of 30 women victims of incest, found 87% reported their self-esteem had been moderately to severely affected. Those studied reported that the incest experience formed the core of their identity and set them apart from others.

Curtois (1988) labelled the therapeutic process for incest survivors as "the victim/survivor paradox", since victims of childhood abuse survive through their own efforts but often continue to perceive themselves as victims--without power, and at the mercy of those around them. Therapy, ideally, is focussed to illuminate the paradox and facilitate change from victim to survivor and beyond. Curtois (1988) stressed that therapy provides an opportunity to address the past with a supportive ally, to grieve and make up for the childhood losses,and to find meaning in the experience.

This report is an attempt to outline from start to finish my work with seven individual women who are adult survivors of childhood sexual abuse. I endeavor to reflect my process from the initial stages of planning the therapeutic intervention for and then with the women. I will outline the therapy itself with each client, the evaluation of the work by each woman, and a summary of their evaluations. I will describe as clearly as possible the different components that are used in therapy, reflecting the method with which they are used. I then will conclude with an analysis of what I found to be most helpful in the therapeutic process.

1.2 Plan for Therapeutic Intervention.

In summer of 1991, as part of my studies toward a Masters degree in social work, I proposed a practicum involving work with individual women who have identified themselves as survivors of childhood sexual abuse. This therapy was designed to stand on its own or become a stepping stone for women who wanted to enter group therapy but do not feel strong or prepared enough to participate without first doing some individual work.

1.2(a)The Interventive Goals of the Practicum :

i. To provide individual therapy to six to eight women who have experienced the trauma of childhood sexual abuse. The time commitment to therapy set out at the beginning of counselling was for weekly one hour sessions over a period of eight months. (September,1991 through April,1992).

ii. To develop a commitment to therapy and the establishment of a therapeutic alliance between client and counsellor.

iii. To aid the client to acknowledge and accept the occurrence of incest in her life.

iv. To help the client recount the incest inasmuch as she needs to recognize and talk through the experience.

v. To aid the client in the recognition, labelling and expression of feelings.

vi. To aid the client in the resolution of responsibility toward herself as well as issues in facilitating her own survival.

vii. To facilitate the client in grieving for lost/changed childhood, family relationships, etc.

viii. To aid the client in cognitive restructuring of beliefs previously distorted by childhood trauma- to accept and re-nurture her inner child.

ix. To aid the client in empowering self-determination and behavior change through gaining a sense of personal control over her own life -- a control which has often been denied by sex role socialization and the sexual assault traumas in her life as a child.

x. To promote further empowerment and sense of self-esteem through education. This includes open teaching of the therapeutic tools used, and openly connecting the client to the issues of sexual abuse as a social problem which can be changed through social action.

1.2(b) The Education Goals for this Practicum:

i. To review the relevant literature related to child sexual abuse, intervention with adult survivors of child sexual abuse, feminist counselling, control theory as presented through reality therapy, and evaluative research.

ii. To further develop counselling skills from a feminist perspective.

iii. To incorporate the techniques used in brief models such as reality therapy, within a feminist framework.

iv. To develop a basic understanding and application of feminist research methodology.

v. To develop a better understanding of single system design research.

1.2(c)The Evaluation Goals of this Practicum:

i. To administer standardized measures of self esteem, providing clients with feedback regarding their progress through therapy.

ii. To administer a self-anchored goals scale, created by and for each individual client to aid in a sense of control in her life.

iii. To administer an unstructured follow-up interview one month after the therapy ends to evaluate the effectiveness of the treatment from the clients point of view. This interview was to be conducted by a third party with prearranged permission from the client.

2.0 Literature Review

2.1 The Phenomena of Child Sexual Abuse

Sgroi (1975) and Finkelhor (1979) pioneered the exploration of sexual abuse of children as adults, when they found that many clients, usually female, disclosed experiences of such trauma in childhood. Later studies, such as those of Pierce (1987) and Sibold (1987) found an increasing number of males sexually abused as children, but being perhaps even more reluctant than females to report the abuse.

Until quite recently, the sexual abuse of children was regarded as a rare occurrence, and reports of it happening tended to be attributed to Oedipal fantasies (Masson,1984; Rush,1977,1980).

Russell (1983) defined extrafamilial child sexual abuse as one or more unwanted sexual experiences with persons unrelated by blood of marriage, ranging from petting (touching of breasts or genitals, or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted forcible rape experiences from ages 13 to 17 years (inclusive). Intrafamilial child sexual abuse, also defined by Russell (1983), was seen as any kind of exploitive sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old. Non-exploitive experiences were described as those such as 'wanted' play between cousins or siblings with less than 5 years age difference (1983, pp. 135 - 136). Wyatt and Peters (1986) adopted Russell's definition.

Another useful, and commonly accepted definition of incest was described by Benward and Densen-Gerber (1975). This report will adopt the definitions of incest as portrayed by Benward and Densen-Gerber (1975) unless otherwise stated.

"...[incest] refers to sexual contact with a person who would be considered an ineligible partner because of his blood and/or social ties (ie. kin) to the subject and her family. The term encompasses, then, several categories of partners, including father, stepfather, grandfather, uncles, siblings, cousins, in-laws, and what we call 'quasi-family'. The last category includes parental and family friends (eg. mother's sexual partner). Our feeling is that the most taboo applies in a weakened form to all these categories in that the 'partner' represents someone from whom the female child should rightfully expect warmth or protection and sexual distance. Sexual behavior recorded as incest ranged from intercourse with consent; intercourse by force; attempted intercourse or seduction; molestation, primarily fondling of the breasts and genitals, and exposure. We included other behaviors as intercourse , namely penetration, anal, oral, and vaginal, both passive and active. Cunnilingus and fellatio were not uncommon activities, nor was sodomy. " (p. 326)

Definitions may not have been as clearly outlined in other surveys on the incidence of child sexual abuse. However, Russell (1983) found that 54% of women surveyed in the U.S. reported incidents of child sexual abuse. Wyatt and Peters (1986) found that 53% of women surveyed reported experiencing the phenomena, while 27% of the women who reported in the Lewis (1985) survey reported child sexual abuse.

In Canada, 23% of women surveyed at random reported unwanted touching of a 'sex part' of their body, while 22% of the respondents said that they had experienced at least one unwanted attempt at sex with them -- or that they had been sexually attacked. The unwanted acts on both these categories occurred in approximately two-thirds of the cases when the victims were under 18 years, and in one-third when they aged 14 or under. (Sexual Offenses Against Children in Canada,1984) This report, otherwise known as the Badgely report, states that one in four women in Canada and one in ten men in Canada were sexually abused as children.

Despite the variation in reported prevalence rates, it is evident that child sexual abuse is commonly experienced by females in the general population in North America. One result is that clinicians are virtually certain to encounter, among their clients, women who have had such experiences. While child sexual abuse may not be the clients presenting issue, it is now understood that past abuse is often a causative factor in current difficulties. Jehu, Gazan and Klassen (1988) proposed that past sexual abuse may contribute to current problems and therefore must be openly addressed to resolve the present difficulties. Jehu et al (1988) connected childhood sexual abuse to some adult experienced difficulties including mood disturbances, substance abuse, self-injurious or suicidal behavior, dissociative phenomena, marital conflict and sexual dysfunctions. This was not to say that all of these difficulties are necessarily a product of childhood sexual abuse, ,but there was a notable correlation of experiences for many women. Jehu et al (1988) provide a table outlining the prevalence of child sexual abuse found among women in clinical samples.(See Table 1 on page 14.)

Table 1: Prevalence of Child Sexual Abuse Among Women in Clinical Samples

Source	Country	Description of Sample	Size of Sample (n)	Proportion Abused (%)
Herman (1986)	USA	Psychiatric outpatients	105	13
Friedman 7 Harrison (1984)	USA	Schizophrenic inpatients	20	60
Briere (1984)	Canada	'Walkins' for counselling	153	43
Bliss (1984)	USA	Multiple personality disorder	70	90
Coors and Milstein (1986)	USA	Multiple personality disorder	17	82
Benward & Densen-Gerber (1975)	USA	"Drug abuse"	118	44
Baisden & Baisden (1979)	USA	Sexual dysfunction	240	90
Oppenheim et al (1985)	UK	Anorexia/ bulimia	78	51
Gross et al (1980)	USA	Psychogenic pelvic pain	25	36

[From Jehu,(1988). Beyond Sexual Abuse. Toronto:John Wiley and Sons. p.7.]

This table reflects the large numbers of women who seek help with what they may consider a behavior or mood problem, and, in the assessment phase of therapy, when or if appropriately asked, disclose a history of child sexual abuse. It is evident from the above table that the origin of many clients pain may be be easily overlooked in a focus on treating only the presenting problem(s).

2.2 The Initial Effects of Child Sexual Abuse

Brown and Finkelhor (1986) describe initial incest aftereffects and their symptoms as developing at the time of the abuse or up to two years after the termination of the abuse. These affects may be transient and remit over time either spontaneously or with assistance. They may, alternatively, persist and become long term or may develop in a delayed fashion. The impact of incest, then, has been found in both the intrapsychic and interpersonal presentation of the victim. Curtois (1988) categorized these effects into six groupings: (1) emotional reactions; (2) self-perceptions: (3) physical/somatic effects; (4) sexual effects; (5) interpersonal relating and functioning, and (6) social functioning.

Curtois (1988) summarized and briefly elaborated upon the initial effects of child sexual abuse as follows.

1) Emotional reactions. Anxiety, fear, confusion, guilt, anger and depression along with loss and grief reactions are common emotional effects associated with ongoing incest of it's immediate aftermath. Anxiety and fear may show up in compulsive or ritualized behavior and phobia, nightmares, dissociative reactions, mood swings, hypervigilance and hyperactivity. According to Curtois(1988), the victim will probably show symptoms of depression (including sadness), lethargy, concentration and memory impairment, and feelings of guilt and confusion. Children may also emotionally shut down in order to protect themselves from further hurt.

2) Self-perceptions. Curtois (1988) relates that erosion of positive self-esteem and the development of a negative identity is usually the result of the secrecy, entrapment, and betrayal of trusted family members, coupled with feelings of guilt and complicity. Shame and stigma reactions are reported to be common. (Brown and Finkelhor, 1986) (Curtois, 1988)

Emotional and social withdrawal, carelessness, and risk-taking behaviors and self-defeating and self-injurious behavior may be the most obvious, immediate manifestations of negative self-esteem(Curtois, 1988).

3) Physical/Somatic Effects. These may include regressive behavior (eg. bed-wetting), the sudden onset of diffuse aches and pains, gastrointestinal, genitourinary discomfort or pain, eating disorders, loss or gain of appetite and weight, signs of physical and genital trauma and infection, pregnancy, frozen watchfulness, the repetition of the trauma in dreams, fantasies, play with others, and/or sudden personality changes (Curtois,1988).

4) Sexual Effects. Children may attempt to resolve feelings through age-inappropriate sexual activities. Yates (1982) discussed the way some children involved in long-term incest become eroticized by the experience, are easily aroused and find sexual activity pleasurable. This may in itself pose a problem in psychosexual development and interpersonal relationships when children seek out, initiate, or participate in age inappropriate sexual behaviours with peers, older or younger children, in attempts to emulate pleasant feeling activities they have been taught.

Other children react with feelings of disgust over their bodies, thinking something about them has caused the abuse (Curtois,1988). These children may react by blunting or dissociating from their bodily sensations or by engaging in self-injurious behavior to hurt themselves or to call attention to their plight.

5) Interpersonal Relating. Many victims suffer a marked impairment in their ability to trust others within and outside of their families as a result of the behavior inherent in incest (Curtois,1988). The child is likely to withdraw but be needy and dependent (possibly making her a target for further victimization). The eroticized child may have interpersonal relationships typified by others keeping their distance due to discomfort with her behaviour. Alternatively, the eroticized child is more easily revictimized

sexually by those who will take advantage of her more 'aware' sexual behaviour.

The neediness of the victim may be masked by motherly or overly helpful behavior. According to Curtois (1988) and Malma et al (1991), the taking on of a parental or parent's helper role may give the victim a much needed sense of control.

Some children act out their distrust by withdrawing from interpersonal and social contact or by becoming hostile, aggressive, and unmanageable. These behaviors may be directed at the perpetrator, the family, or outside the family (Curtois,1988) often result on the family turning on the victim instead of helping her or recognizing their family situation.

6) Social Functioning. The psychological overload involved in chronic abuse may result in cognitive developmental distortions (memory and learning difficulties, concentration problems, and shortened attention span). Curtois(1988) found there may be associated problems in school and socializing with other children. In contrast, some children excel in school - finding a place which is a haven from the abuse.

2.3 Long-Term Effects of Child Sexual Abuse

Long-term effects and their symptoms have been defined by Brown and Finkelhor (1986), as those effects which develop two or more years after the cessation of the abuse. These effects are described as chronic manifestations of acute after-effects or may develop in a delayed manner. Some effects appear and remit sporadically and rather spontaneously. It might be more useful to define long term effects simply as those lasting beyond childhood. They may be any coping mechanism the victim develops to help her survive the abuse, and may change as she changes developmentally or situationally.

Emotional Reactions. As stated earlier, emotions initially associated with incest have been found to often persist over time, but may fluctuate in continuity and intensity. Anxiety and fear generally continue for many survivors who report apprehension, anxiety attacks, sleep disturbances and nightmares. Curtois (1988) noted that anxiety and apprehension may be especially pronounced around issues of sexuality and sexual functioning.

Depression may be seen in self-damaging behavior and suicidal ideation and attempts. Briere and Runtz (1986), in an empirical study, found that while rates of depression of abuse victims may not differ greatly from depression in the general population, abuse victims are much more likely to consider an attempt at suicide or to use self-mutilatory behaviors.

Self-Perceptions. Curtois (1988) again summarizes findings that most survivors perceive themselves negatively, feeling stigmatized and marked by the incest experience. Jehu et al (1988) found 78% of his clients reported themselves to be at least partly "worthless and bad"-- blaming themselves and their very existence for somehow having caused the incest.

Physical and Somatic Effects. Somatic effects are experienced by victims when negative feelings of self are contained in, or projected onto the body. Physical effects may be related to the type and focus of the abuse and directly or indirectly manifested. Curtois (1988) states these can include discomfort in the abused areas, chronic pain, infection, unpredictable and unexplained feelings of stimulation, and fears and phobias about genitourinary organs and functioning.

Nausea, choking reactions, gagging, and vomiting are some gastrointestinal and respiratory effects which may be related to being choked, forced to have oral sex, or swallow semen (Curtois,1988).

Bass and Davis (1988), Curtois (1988), and Dolan (1991) also report more generalized physical effects which are usually anxiety and fear related. These include gastrointestinal problems, respiratory distress, muscular tension, and stress problems. Substance abuse, obesity and anorexia nervosa have also been found to be used by victims to either blunt, or intensify the pain-- attempts to gain a sense of control. Sometimes these coping mechanisms can work well for years.

Effects on Social Functioning. Maltz and Holman (1987) find that sexual repercussions of incest are evident in three major areas: (1) sexual emergence in early adulthood; (2) sexual orientation and preference; and (3) sexual arousal, response, and satisfaction.

In terms of sexual emergence, Curtois (1988) describes sexual abuse survivors as largely tending to become socially and sexually withdrawn, indiscriminately sexually active, or alternating between the two. Both styles are seen as a way for the victim to gain some control over her body.

The effects of sexual abuse on a survivor's sexual orientation and preference is unclear. Some survivors report that the sexual abuse has affected their orientation while others reporting no such after effects. Curtois (1988) argues that some women may view all men as unsafe and choose same sex partners. Other women are lesbian and happen to be incest survivors. Bass and Davis (1988), Curtois (1988), and Dolan (1991) put forth that incest treatment should help resolve sexual fears and allow the survivor a sexual preference based on choice rather than fear and avoidance.

Sprei and Curtois (1988) find that sexual difficulties for survivors often present as the following: (1) desire complications, (2) arousal problems, (3) orgasmic disorders, (4) coital pain, (5) frequency and satisfaction dysfunctions. The terms disorder and dysfunction here refer to a response to traumatic sexualization and are to be understood as effects associated with trauma or as survivor skills that once were functional for the victim.

Interpersonal Relating and Social Effects. Difficulty trusting others due to the past betrayal by one or more family members is the core problem in interpersonal relating. Incest survivors seem to have particular difficulty in intimate or committed relationships.

After affects of abuse, often leaving women with fear for any children they might have, or rivalries towards them for affection from other family members, often makes parenting quite difficult.

"Emotional deadness" (Curtois, 1988, p. 113) may leave women to be viewed as paranoid, hostile, anti-social and/or eccentric.

To summarize, Curtois (1988) states:

"...child sexual abuse has been found to affect the victim's personality development and every major life system, either at the time of incest or later in life. The severity and after-effects [are] not uniform and [vary] by individual circumstances. In a clinical sample, the after-effects are by definition more serious than in the population in general and have become symptoms associated with an array of mental health disturbances. Therapeutically, these disturbances need to be recognized as consequences of the untreated original effects of the abuse. Treatment must therefore be directed towards addressing the original trauma as well as its initial and chronic after-effects." (p. 117.)

2.4 Theoretical Perspectives on Child Sexual Abuse.

In this section four dominant perspectives will be briefly outlined and compared. These perspectives are: a)feminist theories in general, b)traumatic stress theory, c)self-development theory, and d)loss theory. These perspectives have been chosen for the insight they offer in treatment.

2.4 a))Feminist Theories

Feminism has brought male violence in the family and violence against women to public awareness with rape being the first

form of violence against women to be addressed. Prior to the revival of the feminist movement in the 1970's, these abuses tended to remain hidden, with victims suffering in the pain of their isolation. After the revival of feminism, power and degradation were identified as the predominant motivations of rape with sexual violation providing the modus operandi (Brownmiller, 1975). As rape issues brought women into counselling, other forms of sexual violence were divulged revealing that a majority of the violence being perpetrated within the family was by male relatives or acquaintances.

A feminist perspective extends beyond the family unit to examine the social perspectives and influences on the development of incest. The high prevalence of female children victimized by adult males (Russell, 1986) has led feminists to conclude that child sexual abuse is a social manifestation of the power imbalance between the sexes as well as the power imbalances between ages and positions in families. From this perspective, men are conditioned into roles of power and domination with regard to females, who are conditioned to be passive and dependent. As Brickman (1984) states:

"The immediate effects of incest as described by.victims is that they are driven out of their bodies.....In this manner their bodies become the property of men, and females are deeply and seriously alienated from one piece of territory every human being possesses, her own body....Incest victims learn at an early age that sex is for male pleasure, for the benefit of men. For her, sexuality is connected to pain and humiliation; it is something to endure." (p. 66).

Feminists argue against the sexism of traditional psychoanalysis which tends to blame the child and the colluding mother for the development of incest, while exonerating the father (Rush, 1977). With the social analysis intrinsic in feminist philosophy, comes a recognition of the child as much less powerful than parent by virtue of size, sex, and role in the family. This social analysis reveals that the family hierarchy, and therefore order of power, is traditionally father, then mother, then children. With

power should come responsibility. Feminists acknowledge the imbalance of power and often misuse of responsibility in parent child relationships as well as the traditional imbalance of power between male and female partners in most societies.

Curtois (1988) states:

"Incest was reconceptualized as victimization with high traumatic potential for the exploited child. A form of rape, it was and is viewed as as the ultimate violation of the self short of homicide. Its occurrence within the family, by a supposedly trustworthy individual, was seen as compounding its traumatic impact and its potential to seriously injure the developing child." (p. 119).

Feminism focuses on woman's reality, stressing the subjective reality of the woman and seeking to validate a woman's experience in a world where the experience of men has been held as the standard (Brickman, 1984). Feminists conceptualize symptom formation as a creative adaptation to negative circumstances rather than as pathology. While these mechanisms allowed the victim to cope with the incest, these same coping mechanisms may have become maladaptive, once the victim is older. The work of therapy is to validate the reality of the original injury, to identify survival skills, and to re-adapt the survival skills and the survivor's use of them so that the injury may be healed and development completed. The survivor is seen as an expert in her own experience which she is assisted to explore in therapy. Because control was negated through her incest experience, treatment is geared to help the client re-establish a sense of personal power in her life through acknowledgement and readaptation of her already present strengths. (Nomme-Russell, 1984).

2.4 b))Traumatic Stress Theory

Figley (1985) reminds us that trauma is an emotional state of discomfort or stress resulting from memories of an extraordinary, catastrophic experience which has shattered the survivor's sense of

invulnerability to harm. A catastrophe is the situational prerequisite for the emergence of trauma. Figley (1985) defined catastrophe as an extraordinary event or series of events which is sudden, or overwhelming, and often dangerous, either to one self, or significant others. A traumatic stress reaction is made up of the natural consequent behaviors and emotions of a trauma during a catastrophe -- a set of conscious or unconscious actions or emotions associated with dealing with the stresses of the catastrophe and the period immediately after.

Symptoms experienced by incest survivors have been found to closely resemble those found in rape survivors, including fear, guilt, sleep and eating disorders, genitourinary difficulties, anxiety and depression (Ruch and Chandler, 1983) (Goodwin, 1985). Loss of control (or sense of control) is also central (Bassuk, 1980) (Ruch and Chandler, 1983) (Goodwin, 1985). These symptoms have often been labeled rape trauma syndrome or sexual assault trauma (Ruch and Chandler,1983) (Goodwin,1985). The symptoms are parallel , in that incest, like rape, is human-induced, premeditated, involves sexual violation and is ultimately a violation of the victims selfhood. However, incest involves assault or rape repeated by the same individual(s). Herman (1987) has likened the incest experience to concentration camp internment where the victim is victimized and reduced to emotional and physical dependency on the captor.

Traumatic stress theory, like feminist theory, recognizes symptomatology as adaptive survival mechanisms. Traumatic stress theory usually suggests long term treatment due to the impact of the incest on the victims personality development. The goal of treatment is " ...the abreaction of the trauma and the improvement of associated problems, including the development of positive affiliative bonds and the resumption of development arrested by the abuse." (Curtios, 1988, p. 123).

2.4 c))Self-development Theory

Van der Kolk (1987) states :

" The earliest and possibly most damaging psychological trauma is the loss of a secure base. When caregivers who are supposed to be sources of protection and nurturance become simultaneously the main sources of danger, a child must maneuver psychologically to re-establish some sense of safety, often becoming fearfully and hungrily attached, unwillingly or anxiously obedient, and apprehensive lest the caregiver be unavailable when needed." (p.32).

Incest and other forms of chronic child abuse interfere with the completion of developmental tasks associated with each life stage (Erikson,1980) beginning with the first and most basic stage, trust vs. mistrust. According to the self-development theory, at subsequent stages, children are prone to develop a sense of shame, low self-esteem, identity diffusion, and difficulties in intimate relationships and productivity.

Treatment involves a search for the 'true self' and gradual dissolution of the 'false self' that developed as protection. This work can be conceptualized as finding 'the child within' (Curtois, 1988). The survivor is urged to remember the trauma and the emotions which were split off in order to survive the abuse ordeal. She looks at family rules and messages which disconfirmed her experience. The abuse is recontextualized (Reiker and Carmen, 1986), allowing the survivor to restore accurate meanings and emotions to past experience.

2.4(d)Loss Theory

Benedek (1985), in discussing children and trauma, noted that losses in human induced violence may be overlooked because they are personal rather than property losses. That is, a loss of self-esteem, of sense of personal worth and body integrity. The incest survivor loses a sense of possibilities, often telling clinicians that she

mourns for what might have been (Curtois, 1988). She is unable to transform her family to the supportive people she needs. Accepting the loss means admitting to the inability to control the circumstances. Paradoxically, attempts to control contribute to more loss.

Following the loss theory, individuals are led through an acknowledgement of loss, through grieving which, though painful, leads to healing. With grieving often comes anger and outrage over the past abuse and neglect as the client then refocuses her energies into separating from her family and proceeds with her own self development.

Four different theoretical models have been briefly reviewed. Each provides a distinct perspective in the understanding and treatment of the victim/survivor of incest. These four perspectives are just a sampling of the approaches available. They have been described here because they all allow for work that is client centred and doesn't blame the victim. These theoretical perspectives have all moved beyond a victim blaming stance and acknowledge that the victim has been 'acted upon' by a trusted individual. These perspectives also look beyond the victim as a 'patient who is sick' and focus instead on a person who has been hurt (acted upon in a hurtful way). The focus in healing is not in rearranging the psyche of the victim, but in helping her acknowledge the very real hurts, to express herself, and to work toward her own strength.

The above four theories have been chosen for description because they do not pathologize the victim, and while different have some value in understanding the needs of the victim/survivor.

The next section, will look at the advantages and disadvantages of individual and group treatment methods, acknowledging the possibilities for each method.

2.5 Individual vs. Group Therapy for Incest Survivors

Curtois (1988) and Sprei (1986) outline the benefits of group therapy for incest survivors as being an experience where the individual can re-experience herself as useful to others. She shares and vents feelings which others have experienced and is accepted by the group as the individual she is. The secret is out. Her experience is normalized. Shame usually lessens as she meets and shares with women who have similar experiences. She can become empowered by active participation in a group and learn again to trust others, as well as see others trust and enjoy her. The group can become a surrogate family where she can challenge the beliefs and messages of childhood.

While group work is usually recommended, it is usually offered in addition, either consecutively or concurrently, with individual therapy. Some survivors find group therapy too threatening to consider initially because of shame, secrecy, or denial surrounding the incest. Reluctance to join a group may also be based in a fear of losing control in the group and a fear of unknown consequences. (Curtois, 1988). For many women, individual therapy is a precursor to group participation. Many individuals, on first acknowledgement or disclosure of the incest, chose/prefer to do individual work prior to making themselves vulnerable in group. Self-esteem and a sense of personal control must first become at least minimally acceptable to the client before she can join as a group participant. There are many women who have worked through some of these issues on their own and choose to move into group work as their preferred method of therapy.

3.0 Approach and Methodology of this Practicum

3.1 Treatment Approach

Giaretto (1976) commented that, in working with incest survivors, a particular school or discipline not be rigidly adhered to, but rather a variety of techniques may be implemented in therapy, none being used for their own sake, but as they approach or meet the clients needs. Curtois (1988) states that a multimodal approach often is used. Curtois (1988) reminds the therapist to keep in mind that a 'shamed client' is being treated. Thus, it is important in therapy to avoid techniques or behaviors which reinforce the clients sense of unworthiness. The therapist must keep in mind the survivor's need for control and her tendency toward self-blame and punishment.

While incest therapy most frequently is conducted with an individual or in a group, couple/ marital therapy, as described by Jehu (1988), has been found to be helpful. Family therapy may also be utilized, especially when the victim still is living at home. When applied to incest, however, traditional family models are inadequate since they tend to rebalance families in traditional roles (Brickman, 1984) without addressing the power, gender, and social issues which support the continuation of incest (Goodrich, et al, 1988).

Therapy may be brief or longer term, but it is strongly recommended (Brickman, 1984) (Curtois, 1988) that the duration and focus of therapy be contracted very specifically with the client in order to best meet her needs (Nomme-Russell, 1989) and encourage her to take back some control.

Next, I will address the rationale for a feminist perspective as a theoretical base in working with individual incest survivors. As noted earlier, loss theory, self-development theory, traumatic stress theory, and feminist theory all offer some insight into the needs of the child sexual abuse survivor. A feminist perspective allows for

the use of the best of all these theories with added insight and direction.

3.2 A Feminist Perspective as a Theoretical Base

A feminist perspective appears to offer the the survivor the hope of reconnection with her own personal power. A feminist perspective also clearly removes any blame from the victim and places responsibility squarely upon the individual perpetrator and the society which allows and supports this type of abuse. A feminist perspective in therapy not only promotes the healing of the individual as an individual, but in the very fact that social analysis is an integral part of the perspective of the therapy, feminist therapy promotes the reconnection of the individual to society in a strong, active way. This reconnection encourages the survivor to join with other survivors to not only promote each individuals healing, but the healing eventually of all survivors, and, ideally of society as a whole.

In her analysis of therapy from a feminist perspective, Brickman (1984) has summarized and outlined the following goals of treatment. (1) development of a commitment to treatment and the establishment of a therapeutic alliance, (2) acknowledgement and acceptance of the occurrence of incest, (3) recounting the incest, (4) breaking down the feelings of isolation and stigma, (5) recognition, labelling, and expressing of feelings, (6) resolution of responsibility and survival issues, (7) grieving, (8) cognitive restructuring of distorted beliefs and stress responses, (9) self-determination and behavior change, (10) education and skill building.

In short, then, the goals of therapy are to aid the individual to move from a position of weakness/a sense of lack of control, to a position of strength. This happens through a process of the individual acknowledging her traumatic experiences, the skills she used to cope with the experiences, and accessing again those strengths to her own benefit, placing her in a position of power and control in her own life.

In working with adult survivors of child sexual abuse, family issues are central. Who was the perpetrator? What was the child's role and position in the family? Were there any other direct victims in the family? Who were the child's supports, if any? What were the family messages about loyalty? secrets? Who had the most power in the family? What were the family dynamics? To work without a family or ecological background would be to work in a very false vacuum. The abuse happened not as the result of individual 'illness' or individual intrapsychic difficulties. A feminist perspective acknowledges the reality of the abuse which has been experienced and places it in a larger context, thus opening the channels for the victim to come out of isolation to stand with other victims/survivors, removing responsibility for her victimization away from herself and placing it where it belongs -- on the perpetrator, and on the patriarchal society which supports the conditions encouraging and allowing her victimization. This work can be done within a group or with individuals. At times it may be of benefit for the survivor to do work in dyads and tryads of people who are important to her in order to try to heal these relationships and gather further support for the client.

Goodrich et al (1988) remind that ".feminist therapy is not a set of techniques, but a political & philosophical viewpoint." (p. 21) Feminist counselling goals include the promotion of independence, autonomy and personal effectiveness, simultaneously with the goal of providing a feminist social perspective. As Nomme-Russell (1988) states, providing a feminist perspective aids clients not only in dealing with their particular situation, but also in recognizing social change. Rather than adjusting to the situation, women are aided in redefining the situation and women's place in it. It is this social analysis that separates feminist therapies from others with a humanistic philosophy. In feminist therapies, the counsellor is ally, resource person and advisor for/to the client -- accessible and involved.

Because feminist counselling does not ascribe to or offer a set of specific techniques or methodology, but rather a philosophy, I have sought out a practical base from Reality Therapy/ Control Theory (Glasser,1965,1984) to carry out the goals of the client in feminist therapy.

3.3 Control Theory/Reality Therapy

Control theory (Glasser, 1984), an extension of reality therapy, (Glasser, 1965) was designed to assist a client or any individual to gain control over her life, thus raising her self-esteem and sense of personal power. Reality therapy provides a cognitive/behavioral approach which requires openly teaching the client to reconnect with and acknowledge her own strengths and creativity.

Glasser (1965,1984) outlines four components of behavior: action, thinking, feeling and physiology. Reality therapy/control theory teaches the client that she is a control system, that she has almost complete control over her actions, barring physical handicaps. There is moderate control over thoughts through the process of thought substitution. That is, the individual cannot stop a thought, but can replace it with another thought. The individual has indirect control at the physiological level by using behaviors such as taking medication or doing exercise. Gossen (1986) explained that we can change our own feelings by the following processes: (1) action on the external world to get what we want -- therefore reducing frustration, (2) action on our own physiology to change the chemical balance to change feelings, (3) thought substitution, (4) thinking to change a perception, (5) exposing the self to another control system which can directly affect our system through the use of positive or negative feeling behaviors. Control theory teaches that behaviors are not dealt with in isolation from each other because they make up the total behavior of the individual (or system). However, this method or theory, which is taught to the client, can help a client to understand where she can gain greater control. The client can learn

to emphasize one aspect of the system to turn the balance of the system.

Control theory also teaches that a 'system', or an individual always chooses the best behavior that she can at the time (Glasser, 1984), using whatever creativity available -- all behavior is purposeful. When certain behaviors are not working, or getting the individual what she needs (eg. safety), education or exploration of new ways will allow her to make better choices, or use behaviors in more effective ways.

Glasser (1984) shows that the ground work in reality therapy, control theory is laid by helping the client to become her own best friend--to be self accepting, to see her strengths, and to recognize how her choices of behaviors have worked for her in the past. Control theory is actively taught to the client--including the tenets of the theory. These state that all individuals have four basic needs besides physical survival: 1) a need for love or belonging; 2) a need for personal power or control; 3) a need for freedom (choices); and 4) a need for fun. Control theory teaches that we are internally motivated and that we cannot know what another person wants. Each person is an expert in her own life. The therapist can be an ally and a guide, but the client is the expert on what her needs are. The counsellor negotiates her role with the client. She becomes involved with the client in a warm, supportive and challenging relationship.

Reality therapy offers techniques to help the client get out of or through the feeling mode when feeling may paralyze the individual, keeping her from acting for herself. Feelings are acknowledged but the individual is encouraged to go on to positive thinking and action. This is done partially by helping her access positive "pictures" for herself. The individual shares with the therapist her definition, or her 'picture' of belonging, self-control, freedom and fun, and the therapist helps the client to flesh out and evaluate the 'picture' so that it becomes something that may be attainable for the client.

Glasser (1965,1984), E.P.Good (1986) and Gossen (1986) outline an approach which has the client and therapist design specific tasks or exercises which the client then contracts to do. The client chooses or designs tasks with an action component which will bring her closer to her goals. In reality therapy/control theory these goals are labelled as wants and needs.

Brierly (1986) offers even more help to the therapist in fine-tuning task-oriented exercises, aiding the client to identify her own needs, her 'ideal picture' as well as an acceptable/realistic picture if it differs from the ideal. Once the need and want are identified, specific tasks are outlined by the client. The client, in setting her tasks, includes possible complications as well as their solutions, and a reward for herself. The client returns to therapy at the specified time,usually a week later, and recounts her experience. If the task was not successful, the client assesses the reasons, ie. perhaps it was not really what she wanted/needed - perhaps it was too big a task, etc. She then sets another task and approaches it as previously described. The key here is that the client does her own evaluating. The therapist provides support.

Reality therapy/control theory is reportedly being used with incest survivors with success.(Puteran, 1991; Brierly, 1986) However, a fairly extensive literature review and consultation with individual therapists using reality therapy (Puteran and Puteran, 1991), revealed no written material specifically geared to this population.

Puteran (1991), however,explained that in addition to the techniques of reality therapy outlined here, additional work is being done. Reality therapists are apparently working with the client to recount/acknowledge the incest experience more fully and help her to grieve in a healing fashion. This work has not been found in the reality therapy/control theory literature, but may be an adaptation found necessary for fuller healing. Guided imagery is used as well to help the client reconstruct an inner safer place.(Brierly, 1986) Again,

this type of work has not been found in the written literature of reality therapy to date, but seems to be an addition of those wanting to do more ecclectic, and perhaps more complete work. (Brierly,1986)(Gossen,1986).

In my opinion the work in Reality Therapy since the mid 1980's reflects a necessary addition to the therapy as it was initially described. The initial written work (Glasser,1968,1984) tended to down play the role of clients' social and cultural experience in shaping their behaviour. The rather quick brushing over of feelings could also give the client a message that feelings were unimportant or easily handled. The early work of Glasser(1965,1984) also tended to use some terms which I consider blaming, and therefore harmful. For example, a client would be asked to chose between a 'failure' and a 'success' identity, not taking into account the social context of the client.

3.4 A Feminist Perspective of Reality Therapy

Reality therapy appears to offer some strong techniques for empowering the client, including validating her experience. It does, however, lack a social analysis of power dynamics in relationships. This is offered by a feminist perspective. Reality therapy addresses the reality of the individual but does not formally address the context in which she lives. The shortcoming, therefore, is that the individual client may learn to "take charge" of her feelings/thoughts/actions, but, if the larger context in which she is living is not addressed, the fear is that she will be left wondering why she feels so "out of control" in her larger world --including her specific social system and family.

Psychology and social work literature do not indicate that there has been any attempt at meshing reality therapy with a feminist perspective. Verbal consultation by the author with Puteran (1991) confirmed a lack of written or even verbal communication on work with this approach.

Logically, however, control theory techniques within a feminist perspective should provide powerful tools for aiding the healing of incest survivors. I will now again address the goals of therapy outlined by Brickman (1984) and reiterated by Curtois (1988). This time the goals will be matched with the tools provided by control theory/ reality therapy. The goals of therapy with incest survivors are as follows:

1) Developing a commitment to treatment and the establishment of a therapeutic alliance. Both reality therapy (Gossen,1986) and a feminist approach to therapy stress the importance of the therapeutic alliance with the client being an expert on her own life (Brickman,1984; Curtois,1988).
2) Acknowledgement of and the acceptance of incest.
3) Recounting the incest.
4) Breaking down the feelings of isolation. Reality therapy (Glasser,1986) and feminist perspectives (Goodrich et al,1988) stress the importance of acknowledging the client's reality. A feminist perspective places the experience in a social context.
5) Recognizing, labelling and expressing feelings. Again, both a feminist perspective and reality therapy theory stress the importance of the individual's experience. Reality therapy offers specific exercises and techniques to help the client access her feelings, identify and own them (Brierly,1986;Gossen,1986)
6) Resolution of responsibility and survival issues. Both feminist perspective and reality therapy focus on the client's perspective/reality. Reality therapy teaches the client ways of trying out new/safer ways of coping when her old survival mechanisms are not as healthy for her as they could be. The client learns to identify her needs; acknowledge her strength in her old choices, and practices/learns new ways she may want to better meet her needs (Gossen,1986).
7) Grieving. A feminist perspective acknowledges the responsibility of society for much of the client's pain. Reality

therapy, through guided imagery and other tasks (Brierly, 1986; Gossen,1986), provides a safe mechanism for grieving.

8) Cognitive restructuring of distorted beliefs and stress responses.

9) Self-determination and behavior change. One of the purposes of reality therapy is to teach the clients to acknowledge that their choices in the past were the best they could manage at the time. Now that these responses no longer meet their needs, the client again reaches into her own creative base to find more useful behaviors/thoughts which will eventually affect her feelings about herself.

10) Education and skill building. A feminist perspective addresses the importance of the client learning about the social context of her incest experience - and the reality that changing her own behavior is not enough to keep her or others safe in our society. This perspective also offers the connection with other abused women to join to work for social changes should the survivor feel able. Reality therapy provides specific education for the client about how to take control over her own life, building on the strength and creativity she already has. Within both reality therapy (Brierly,1986; Glasser,1968,1984; Gossen,1986), and various feminist perspectives (Brickman,1984; Butler,1978; Goodrich et al, 1988; Nomme-Russell, 1984) client and therapist work together constantly dialoguing and re-evaluating to meet the clients needs.

Feminist therapy offers a philosophical base for healing which supports all the above goals of therapy for incest survivors. Reality therapy/control theory offers an action plan to help the women move from victim to survivor . Therefore, I have chosen to apply reality therapy within a feminist framework in my work with incest survivors. As noted earlier, reality therapy literature does not describe work specifically with incest survivors. Also, reality therapists such as Brierly (1986),Gossen(1986) and Puteran (1991) have noted that they use other tools besides reality therapy when working with survivors.

A feminist perspective allows and encourages the therapist and the client to look to whatever means possible within a philosophy of self-empowerment to work towards the clients goals. Thus, in undertaking the client work in this practicum, this author,while choosing to use reality therapy/control theory as a tool within a feminist framework, acknowledged that client needs came first and methodology second. That is, there was the understanding that other tools may be employed to augment reality therapy/control theory if healing would be facilitated with some other tool readily apparent. The ultimate goal is the health of the client .

3.5 Methodology of the Practicum

3.5(a)Setting

It was important in choosing a setting for a practicum working with incest survivors to keep in mind the therapists goals of therapy which are very briefly summarized (1) to improve the clients sense of self, (2) to empower her helping her rediscover her sense of self control within a very controlling society.

Therefore, work in a setting where treatment is mandated was less than optimum. The sense of client control would, by definition, be limited.

A setting which is easily accessible to people of varying physical abilities was important. A setting which is known for other than incest work would be helpful-- aiding in keeping the clients issues confidential, where she would not be visibly identified as an incest client merely by the fact that she attends sessions at the agency.

Ideally, a setting where the client has the choice of individual or group therapy would aid in supporting the client in her sense of control--she has options!

It was important to find a setting which offers support for the individual counsellor or therapist ie. other counsellors working on similar issues supporting professional autonomy and an agency which understands the issues.

A setting which supports a feminist philosophy was also necessary.

3.5(b)Proposed Intervention

The setting for this practicum was Klinic Community Health Centre, Inc. Klinic is easily accessible geographically in Winnipeg, Manitoba. This centre has a reputation for medical and community health programs and offers a variety of counselling services. Klinic also houses twenty-four hour crisis and sexual assault lines.

All of these factors help, I believe, to ensure the client's confidential treatment, as well as provide emergency back-up (crisis lines) should the client need the service. Klinic espouses a feminist philosophy.

The actual research design was labelled 'AB' (Corcoran, Fischer,1987) with the both the 'A' and the 'B' components components being addressed in this practicum. The A phase was unfortunately quite short comprised of the assessment information gathered during the first few interviews. Because Klinic does not keep a waiting list for clients, and resources are limited in Winnipeg, it would seemed unethical to keep the clients on a longer wait in order to gather data. Also, in keeping with a feminist philosophy, to impose a longer baseline, when the client has presented as ready for therapy would be contraindicated. The A or assessment phase was to be followed by the B or treatment phase which is the intervention described in this proposal, as follows.

The therapy (B phase) was individual work with six to eight women eighteen years or older. The proposed length of therapy was to meet once weekly with each individual for a one hour session.

There was some flexibility according to client need. The actual time period of this practicum was from September 1,1991, to April 30, 1992. Intake was by referral through clients coming into the intake process at Klinic. The only restriction on clients was that the individuals not be presenting as actively suicidal at the time of referral. Also because of the relatively brief nature of the therapy period, I preferred that the clients referred not be diagnosed (self or otherwise) as suffering with Multiple Personality Disorder. (The rationale for having these two conditions was an understanding that work related to multiple personalities or active suicidal tendencies would require more lengthy involvement with the clients than could be offered in the parameters of this practicum.) The therapy used was a feminist perspective which in turn utilized, primarily, the tools of control theory in reality therapy. As suggested by Curtois (1988) and Giaretto (1976), other models were called upon as the need arose. However, any strategy used for healing was used only within a feminist perspective as earlier outlined.

At the end of the eight month period, clients were to be encouraged to consider entering a group for survivors to further personal strengths and social supports.

3.5(c)Evaluation

i. Recording

In the A phase, at the point of the initial interview (early September,1991) each client was to be provided with an Incest History Questionnaire (modified version of Curtois (1988, p.360 ff) (See Appendix 1) as a means of assessment for the client and for the therapist.

Following each therapy session, in a client file I recorded the focus of the interview, client goals, therapist goals, assessment, and short-term plan. I also kept a separate log of my own observations

and reflections of the therapeutic process and other practicum experiences for the purposes of supervision and later analysis.

ii. Evaluation Tools and Measures:

Near the beginning of therapy (within the first few sessions) each woman was asked to outline her goals for therapy, and then to construct, with the therapist a self anchored goal scale.(Corcoran, Fischer,1987).

After completion of the contracted time in therapy, each woman was asked to complete an evaluation form, assessing her satisfaction with therapy, both the outcome, and the process itself.

(1) Self Anchored Scale of Client Goals

Each client, at the end of the initial interview or second interview, was to develop with the therapist a ten item goal scale, with zero (0) being the lowest number possible associated with goal attainment, and nine (9) being the highest. The client was then asked to anchor each number with a self-prescribed goal for action or behavior. The client was also asked to state how well is 'well enough' to be in order to complete individual therapy sessions. While the client might not reach her goal for optimum well being (behavior, and feelings about that behavior, feelings about herself), the client was requested to describe what would be 'good enough ' behaviour'. That is the client was asked to describe satisfactory, as well as optimum behavior. She was asked to describe behavior which would be acceptable for leaving therapy. This described behavior was also be rated on the clients personal goal attainment scale. Prior to leaving the first (or second) session, the client was asked to rate her present behavior on her goal attainment scale and to describe how she felt about both the scale and her present behavior. The client was then to be asked to continue to rate her goals and goal attainment on this scale monthly throughout the B or treatment phase. This data was to be graphed with the client.

(2) Client Satisfaction Interview/Report

Within two weeks after termination of treatment, the client was contacted for a pre-scheduled client satisfaction interview. The client was be asked to review the therapeutic process with an interviewer other than the therapist. The client was be asked to review her own goal attainment as established. She was asked to use a Likert scale to rate the therapy process for several criteria: ease of access, appropriate amount of time spent in sessions, amount of client involvement. She was also asked to describe in her own terms what she found beneficial as well as what elements she might have changed, increased or decreased in therapy.

iii. Plan for Data Analysis

The self anchored goal scales were graphed individually on a line graph to facilitate visual inspection of the data by both the client and the therapist. While causality cannot be shown, the data on the goal scale should predictably increase in magnitude if therapy was, indeed successful. The client had previously established at what point treatment will be considered successful (above the minimally acceptable point set by each client). The graphing of the information gathered proved enlightening and empowering for the client.

A final piece of analysis was done through the client satisfaction interview. This is a means of subjectively discussing success of the process of therapy for the client. In the philosophy of the type of intervention suggested, process is very important. The client satisfaction interview was conducted by an individual other than the therapist, for ethical reasons.

iv. Informed Consent and Confidentiality Issues

The issues surrounding confidentiality were discussed at the initial interview with the client. The setting was described, clarifying that the client was not identified as an incest survivor merely by attending the agency (other programs are available there as well).

The client was advised of the nature of the practicum, as well as the fact that the client was also considered a regular Klinic client with all the advantages and parameters of confidentiality being observed. The client was advised that a file must be kept and access to the file was be described-- including the fact that that the client had access to her own file upon request.

Also on initial interview, a consent form was presented to the client, describing the nature of the practicum/research. A form requesting permission to tape sessions for supervision purposes was also presented to the client. Treatment would not have been withheld, regardless of the signing of these documents.(See Appendices A and B.)

The client was also be advised that all information discussed would be held confidential within the therapeutic supervision team, with the exceptions as provided by regular Klinic and Child and Family Services guidelines. That is, information regarding threats to safety of either the client or another individual must be addressed by the proper reporting and follow-up procedures in order to maintain the safety of all individuals.

The identity of the client was masked for practicum report and any other purposes other than that directly involved with the treatment of the client or as stated above.

In summary, then, the client file contained the following:

1)-a consent form as outlined above.

2)-a form requesting permission to tape for supervision purposes.

3)-Incest History Questionnaire

4)-data and graphs of the clients personal goal scale

5)-post sessional recordings

6)-client satisfaction interview information

7)-termination summary

Summary of Practicum

The practicum involved individual therapy with seven women who are adult survivors of child sexual abuse. The intervention proposed used a feminist perspective first and foremost. Within the feminist framework, the primary tools were those of reality therapy/control theory. Other tools were borrowed from other therapies,as the need arose and if they fit within a feminist framework. The site for this practicum was Klinic Community Health Centre, Inc. The major interventive responsibilities the therapist were weekly hour long sessions with each client, planning , facilitating and evaluating with each client her progress, as well as evaluating the overall effectiveness of this treatment/intervention plan.

The purpose of the interventive strategy was to aide each client in raising her self-esteem and sense of control or empowerment while reducing her sense of isolation through a social analysis provided by feminist philosophy.

Someone hit me
hit me hard
"No pain, No gain
Knock the bad girl down
Put away your sympathy
Let's duke it out.

Someone smack me
Kick me hard
I should be punished

I Am Rubbish
I was bad.

Get out the bottle, hammer, nails
Create some pain
It's pay back day
Innocence invade
Get laid
You're paid.

"Penny",1990

4.0 The Client Work

Referrals for the actual client work were first received in September. Women went through the formal intake process at Klinic Community Health Center in Winnipeg. While referral sources to Klinic varied, each woman was seen for a standard intake assessment, as is any new client requesting long term counselling. In the intake process at Klinic, each new client has a 'one time assessment interview' where a brief history is taken and the client is asked to outline her main counselling goals. An assessment is done with the intake counsellor, looking at the degree of crisis the client is in, as well as her main presenting issues. The client information is then presented at an intake meeting with recommendations as per treatment. Referrals are then made to counsellors within Klinic, or to other agencies.

Through the intake process, I was referred seven women who identified themselves as incest survivors. As a result of their intake sessions , these women were identified also as not being actively suicidal, and not showing evidence of multiple personalities, or extreme dissociation. Each agreed to work with me, a student, prior to meeting me in person.

In the initial telephone contact I had with each of the women, I again advised them that I was a student, and that I would be keeping a counselling journal as well as writing up a report regarding our work at the end of counselling/therapy.

First sessions--my first in person contacts with the women--were opportunities to again explain the nature of my practicum, provide a letter of introduction (Appendix A) to the women, and to have them sign a consent form(Appendix B) which again outlined the work as well as the written records and confidentiality to which we would adhere. The consent forms were then placed on file and the women kept the letter of introduction.

In this section I shall first describe each client, using pseudonyms. A later section will describe, as much as possible, the commonalties in the way I worked with all of the women. All of these women had suggested that as much detail as necessary could be used with the hope that the work that they have done might be of help to other survivors, and to therapists working with survivors. In honoring the work that they have done, I have disguised their identity for their own privacy and the privacy of friends and family. Some of the pseudonyms and disguising details that I will use have been chose by the women themselves. The reader should note that the detail covered in this report could in no way approximate the valiant and painful work carried on by all the women in this group. Instead, I shall attempt to reflect some of my own process in working with the women, noting what they found most helpful and also noting some of the pitfalls. The women will be known as Penny, Laura, Marilee, Elise, Amanda, Myrna, and Joanne.

4.1 PENNY

Penny is a woman in her late teens, raised as the younger of two children in a professional, urban family. Penny spoke of her childhood as privileged, generally comfortable, with father more 'warm' in manner than mother, and older brother a good friend, but tending to be very physical when angry. Penny said that she was often the focus of the anger, being the little sister, and selfidentified peacemaker in the family (following in her fathers footsteps). Penny presented as a very sad, quiet, inward young woman.

Penny revealed that her experiences of sexual abuse started at a very young age. At about three years of age, her babysitter would molest Penny, making a game out of it. Penny suspects that her brother was also molested in this manner. The brother and sister team also witnessed the babysitter and her boyfriend having intercourse. They never told their parents about either set of occurrences, but Penny suspected that her brother somehow

managed to convey to their parents that a new babysitter was needed.

At age eight , Penny was fondled on a couple of occasions by her brother, several years older. Penny said that she did not tell anyone about the incidents because she was afraid of her brother's anger, and also that her parents would be angry at her brother, who was apparently often in trouble because of his temper. The fondling incidents stopped, Penny said, when she threatened to tell her parents.

At age seventeen, when the family had moved to a new community, and Penny had not yet bonded with new friends, a teacher of Penny's sought her out, and began 'dating ' her in secret. This relationship soon turned into a sexual one, with Penny feeling frightened, alone, and flattered all at the same time. Penny had never had a real boyfriend. Penny ended this contact as soon as she could, moving thousands of miles away the day after graduation.

Penny began therapy, identifying that she had very low self esteem, great difficulty concentrating...to the point that she was unable to hold down a full time job, and unable to continue with the university classes that she had started. She stated that she had anxiety attacks--times when her heart would race, she would become dizzy and then at times would feel 'unreal' or blackout. She also reluctantly admitted that she would slash or 'carve' her arms when her pain or despair became too great. Her goals on entering counselling were largely focussed on raising her self esteem which she noted would be operationalized through better concentration, enabling her to work and/or go to university, enjoying having friends, both male and female, possibly having a boyfriend, and stopping slashing or carving her arms. Note that Penny identified early on that the cutting was a way of expressing or releasing some of her pain. She was able to portray it in a visible way, a way that she did not initially show to other people, but which she could at least see.

Initially, Penny was unable to place herself on her goal line, feeling that she was, initially lower than zero. Her goal was to be able to reach a seven out of nine.

Work with Penny was initially fairly slow, with Penny needing time to assess whether I was indeed trustworthy. We began by talking less about feelings, than actual history, as Penny seemed to feel safer doing concrete work. Penny showed no hesitation in filling out the Incest History (Appendix C) and while the information about the molestation by her brother could not be ignored here, there was also room to normalize the loyalty she felt for her family and celebrate some of the positives she felt that she had shared with them. Because Penny was in late adolescence, and in the process of separating or individuating from family, the discussion which ensued from the Incest History and matters related gave Penny a chance to look at the different roles, expectations and relationships within the family.This work also began to highlight the fact that Penny had learned from her family that members were to "take on the chin" whatever came their way...no complaining or feeling sorry for oneself, and no indulgence in other than reasonable happy emotions.

Included in the initial phases of work with Penny was the learning of relaxation and anxiety reduction techniques, including breath consciousness, grounding in the present , and positive self talk. Penny read the book "Why Me" (Daugherty,1984))and began to write in reaction about the sad/angry feelings that she had buried in childhood and adolescence. As these feelings began to surface, Penny began to cut herself more, and suicidal ideation increased. Penny contracted to keep herself safe, using friends and the crisis lines as backups. In contracting to use her friends as supports, Penny had to look at what friendship meant to her, and whether she could indeed trust the people she wanted. After about a month and a half of work with Penny, I began to gently confront Penny around her belief that she really had no supports...no people with whom she could actually be herself. At one point, I simply asked her if she really believed that the people she spent time with were there out of a sense of

obligation or because they really wanted to be. Penny and I constructed some questions that she could ask her friends in order to help her gauge their trustworthiness. With discussion with friends and reflection on the actions of these friends in session, as well as her own feelings about the friends, Penny was able to ascertain the depth and some of the boundaries around the relationships.

Using the principles of Reality Therapy/Control Theory, I asked Penny whether she felt that more power, sense of belonging, fun or freedom would be most beneficial at this point. She identified that she would like more fun... a break from the sadness. She then chose some activities which she contracted to do daily to keep her in contact with others, and provide some fun. The activities chosen were volunteer activities which involved her with other people, and were fun for her, as well as eventually helping her find work on a paid basis, perhaps heightening her sense of control in her life in a positive way.

Sadness was the predominant emotion expressed, until two things happened. When Penny had been working with me for several weeks, I brought to her attention the fact that,as mentioned by the other counsellor in the intake session, by law we had to report the teacher who had abused her to Child and Family Services. An earlier contact had been made after the intake, providing Child and Family Services the very sketchy scenario Penny had mentioned at intake, but no names, as the CFS worker advised that there was insufficient information for a formal report, at that time. Because Penny had been a minor when the incidents occurred, and because her perpetrator was still teaching there was definite concern. I voiced the concern and information about the reporting requirements to Penny, reminding her that she had provided more identifying information during sessions after being advised on intake of the need to report (this also being stated in our contract) . I advised Penny that I could report with what little information that I had, or that she could choose to provide information to CFS. Penny opted, after thinking things over, to make a formal complaint to CFS

and the police herself. This choice, along with the suggestion on my part that the sadness that she was expressing might be the flipside of some powerful anger she was housing , seemed to be a turning point for some of the work. These reports Penny chose to carry through on her own, advising me about them after the fact, although the initial phone call made to CFS was done jointly, at her request, from my office.

From this report ensued an out of province investigation, a preliminary trial, and at the time of this writing, a formal hearing with judge and jury was to follow at the time of writing.

Work with Penny took on a slightly different focus, with her becoming quite open and expressive, starting to write quite prolifically, and doing art work which clearly showed the anger, anguish, sadness and despair, as well as confusion which she experienced. The writing and drawing was shared with me first when I asked Penny, who seemed to be overwhelmed with sadness, to do an exercise in writing with her dominant hand writing to her nondominant hand (child within) asking her what she was needing in order to feel safe enough to do the work that she was setting out to do in counselling. This took place just prior to Penny's decision to report to CFS.

Work with Penny then continued, including debriefing after contacts with the police, lots of stroking for the work that she had chosen to do here. Besides actual court preparation work, providing information, connecting her up with a lawyer, and noting the kinds of questions she might be asked as well as looking at the worst case/best case scenario regarding court, there was a major focus on helping Penny to just be more comfortable and appreciative of herself.

Penny began to monitor sleep with a sleep diary as well as set up a nurturing nighttime routine. She also began to write down her dreams and bring them to session. She continued to work on anxiety reduction through physical activity, self talk, and focus on breathing.

Penny actively sought work which would not be too stressful and found herself a part time job as well as some volunteer work, finding that she was better able to keep herself safe when doing 'meaningful work, which to her involved often helping other people.

Penny visited her family during this time, initially at Christmas, not telling them about the abuse, and later,just prior to court, advising them about all of the abuse except that by her brother. Initially, her family was quite blaming, asking her why they had not been told earlier. This was very painful to Penny, whose ideal career path has been called 'flaky' by her family.

Counselling ended for Penny earlier than either of us thought was optimum, but Penny was hired for a 'dream' job which necessitated her moving far away from Winnipeg. The job began only a few weeks after Penny's appearance in court, with just enough time to debrief that experience, and refer her to another therapist closer to her work. Penny left placing herself at three on her goal line, no longer slashing, and committed to see the work through. Before she left the city her poetry reflected some joy and wonder at the world as well as the anger that she must fight and work so hard to enjoy it.

My work with Penny was sometimes excruciatingly slow (building trust), often exiting, sometimes frightening. At several points she dropped off very explicit writing and drawings expressing her despair and suicidal thoughts, and at one point later on in counselling, she left me, in a brown envelope, the knife she had used to carve her arm. I discovered on reading the accompanying note that she had decided to keep herself safe, but the initial shock of seeing the knife was very powerful. My desire to be the rescuer or parent screamed out here for a few days. This, of course was worked through internally and with some serious debriefing with my supervisor! Sessions always ended with a contract for safety....until the last few weeks when she would smilingly volunteer that she would keep herself safe, and her plans as to how she would look

after herself. Penny continues to fight and write her way to the discovery and enjoyment of her strength. She has contacted me once by letter since ending therapy to let me know that her strength and optimism grows as she becomes more involved in her chosen field of work.

4.2 LAURA

Laura, a woman in her late twenties, was self-referred, having seen a private therapist for a brief term about a year prior to deal with depression following a miscarriage. It was during this time, having also then only recently moved far away from her family, and into a new somewhat 'safe' relationship, that she began to experience flashback(abreactions) to abuse in her childhood, as well as body memories of the same abuse.

Laura was also from a professional family ,but raised in the eastern part of Canada. She had a couple of siblings, and her mother was now in her third marriage. Laura's birth father was divorced from Laura's mother when Laura was about twelve. Laura was able to piece together from her memory that sexual abuse by her birth father began when she was about one year of age. She had no recollection of when the sexual abuse stopped, or the extent of it. She did know, however, that she had coped by becoming an overachiever in school, and later, for a while, a workaholic. She also recounted that her mother's second husband was an alcoholic, and that he and her mother both neglected and emotionally abused the children. At the time that Laura presented for therapy, her mother had married for a third time, to a man who Laura felt was nurturing and kind, and Laura was beginning to feel that she might one day be able to trust her mother.

On entering therapy, Laura stated that her goals were to be able to 'live her life'. She noted that even working at a part time job for her was now extremely draining. She also noted that she had

some periods of time where she thought she would 'space out', returning to a room not knowing what she had been doing there. Laura wanted to be able to reduce her nightmares and be able to sleep restfully. She wanted to be able to work full time, or, preferably, be able to go to college or university. Initially, she knew her concentration and exhaustion would not allow it. She wanted to be able to raise her self esteem to be able to do the above and she wanted to be able to eventually confront her father, her abuser, for whom she had very ambivalent feelings.

Laura was anxious to 'get to work', very open with her feelings. She immediately took home an Incest History Questionnaire (Appendix C) and brought it back the following week , completed in great detail. This became the jumping off point for exploring family relationships, history, and feelings about family. Laura began to access and express a lot of anger which she found was not only tied to family of origin and her abuser(s) but also to some abuse that she began to identify in her present relationship. She began to speak about intimidating sexual behavior by her partner, and rehearsed what she wanted to say to him in writing. She worked on other areas of their relationship this way as well, in writing, because he refused her invitation to join her for a few sessions, or to see any other counsellor with her.

As Laura began to trust me more, she identified that her partner was now and had been abusive physically as well as emotionally and sexually. With concern for her actual physical safety, Laura constructed a safety plan in counselling, rehearsed the plan, and decided to stay with her partner unless things got worse, because she had great hope for the relationship. We did some work around the cycle of violence(Walker, 1979), as well as her own protection plan. Laura did leave her partner briefly ,at one point during counselling, returning just prior to the first planned visit by her mother. It was during this visit that Laura hoped and planned to disclose the abuse but later chose not to because her mother apparently remained intoxicated for much of the visit. Laura had

sought the support of her partner during this very tough time. Laura revealed that the violence on the part of her partner increased after her mother left. She tended to blame his escalation on herself because she felt that she was more demanding emotionally, at this time.

Following her mother's departure, and her partner's increased violence, Laura came into sessions admitting that she was unable to focus on anything else but maintaining the relationship with her partner. She said that she felt stuck, and indeed, it was difficult to note other than fear and sadness on her part. In an effort to get at or past this,I asked Laura to do some left hand /right hand writing, hoping to tap into the needs of her inner child. Safety was obviously a large issue. Laura found, however, in this writing in session that the writing was taking place not between her present self and her inner child, but between her present self, and a third part of herself.The writing between these parts was about a small child within her which she could name.The child was considered to be 'bad', and somewhat worrisome to the two writing parts. We explored this, again with a focus on safety, concerned that Laura might be feeling pressured to leave her partner in order to 'please 'the therapist. Laura assigned herself a written exercise to get at what she needed from her environment, herself and me in order to facilitate her healing. By this point I had begun to have some suspicions that Laura might be experiencing some splitting of personality or identity, because there were times when it seemed that she would draw up into herself physically and her voice would soften and she would speak almost in the manner of a small petulant child. She had also noted that she often had bad headaches and had times when she seemed to sit for hours and could remember doing nothing. On occasion,she mentioned that she felt extremely drained working the few hours a day that she worked. The headaches could have been tension headaches. The fatigue might have been caused by stress related to job and her relationship with her partner. These were other possible explanations for all of this so I just kept my eyes and mind open. Laura had seemed to be integrating all that we were

doing in therapy, and was working very hard, especially through reading and writing between sessions. I also had to take into account the fact that she was living in what seemed to be a lot of turmoil at home besides just dealing with the work on the abuse, which in itself can be exhausting.

Laura returned the following week, just before Christmas, stating that she had had more blank periods during the week, had found herself 'waking' out of one of them in the process of physically attacking her partner. Laura presented to me some writing which revealed that she had four identifiable parts or personalities within her: a small child, a protector(male), an angel/observer, and the person I saw most often in session. In this session I was also privileged to share time with the small child(about four years old) . Laura felt, she said, both frightened, and more dominantly, peaceful at the discovery of this information about herself. She was frightened at what this all meant and concerned that I would think her crazy. She stated that she believed that she felt peaceful at letting down what she thought were some inner barriers. She noted that she felt that the four year old knew the secrets of all the details of the abuse, and that finally, being able to identify all these parts, she did not feel so 'spacey' or pulled apart. In this rather lengthy session, we spent some time normalizing this 'new' phenomena looking at what it might mean that she had felt safe enough or had so needed to be able to access these parts, and looked at contracting for safety with all the parts. She gave herself some assignments for self care, and to think about the information shared in this session fit for her. As stated, during this particular session, Laura switched several times in voice, physical demeanor, and manner of speech to that of a little girl of about four years.

From here the focus in therapy became continued normalizing of the experience of the "parts" of Laura, celebrating that she now had access to more of her thoughts and emotions. Continuing with this was work with all of the parts around Laura's safety, since Laura was identifying an increase in violence by her partner...at least she

remembered more abuse as it was happening. As she started to feel stronger through writing exercises and discussion, Laura advised her partner that she would stay with him if he attended Alcoholics Anonymous and saw a counsellor on his own. He agreed verbally, but after a couple of weeks, the violence and drinking reportedly increased,leaving Laura sad,confused at his mixed messages, but increasingly certain that she had to put her own safety first and would probably have to make a move in order to be able to start to focus on her own healing. In my last session with her, Laura advised me that she was certain that she would have to leave, and that meant leave the province, to be with a good friend she felt would be supportive. She did not know when the move would take place, but completed a detailed safety/escape plan. Laura ended up fleeing the province prior to our last planned session. Laura's friend who had accompanied her to one session, and had been introduced to me advised me a month later of Laura's settlement elsewhere. She had relocated and was working at a full time job.

Work with Laura was exiting and challenging. She was an articulate and insightful client, willing to work hard, and demanding of herself. She also left counselling before either of us would have chosen had the circumstances been optimum. I do not know unequivocally whether Laura would have been 'officially' diagnosed as having multiple personalities. I do know that the use of the model for working with disassociation as described by Ross (1989) and Bloch (1991) was useful to some extent. Both of these writers note that we all operate on a continuum of dissociation. Both also note that it is not unusual for survivors of childhood abuse to 'split off' fragments of personality, giving them their own identity, as a way of coping with the traumatic memories. Ross (1989) and Bloch (1991) also propose that integration of the various personalities is one of the goals for healing of the individual.

In working with Laura, I chose not to try to isolate personalities other that to contract though Laura's writing the safety of all of Laura, and to try to begin to ascertain what needs might be hidden within the different 'parts'. Laura was able to vouch verbally and take responsibility for the safety of all her parts. We were really only in the beginning stages of ascertaining with any certainty the meaning and extent of dissociation for Laura when she left the area.

As a counsellor or therapist, my most challenging moments with Laura came when Laura felt 'stuck' choosing between working on her relationship issues versus her healing issues and when she shared with me in session for the first time,information which revealed her internal split. I had suspected, but had had no real confirmation regarding her alternative parts or personalities. With regards to the issue of violence towards her by her partner, and her self defence...her choice to wait for things to change in the relationship, I was aware that my concern for Laura might be misread as lack of confidence in her own healing , decision making, and protective processes. My desire to help Laura find both her memories and her emotions and to integrate them need to be tempered with an awareness and respect for the speed and depth at which Laura herself was ready and able to work. Once I was able to address these issues for myself outside sessions, my conviction again became clear that Laura indeed has all that is needed within to heal and that I have been privileged enough to be one of her guides,or resource people. In looking at what might best help Laura, I again searched the literature, focusing especially on the work of Bloch (1991)and Ross (1989), and realized that Laura was functioning as we all do along a continuum of integration or knowledge of all the parts or facets to our personality, and that she had now come to a point where she would begin to be able to look at all the memories and feelings that her experience housed. I must trust that along with the strength she had to remove herself from an abusive and violent partner, she carries the strength she has had all along to continue to

keep herself safe and seek help with another counsellor to continue on her healing journey.

4.3 JOANNE

Joanne was referred to Klinic by a social worker who had been working with her for a number of years in the capacity of education and development coordinator. This woman was also considered by Joanne to be a good friend, and Joanne had confided that she felt that one stumbling block to her independence was a lot of fear and mistrust of herself and others arising out of years of sexual abuse by and uncle. Joanne was 28 years old when I met her. She had been orphaned as an infant and adopted by a couple who than adopted two other children. It was apparently discovered in her early schooling that Joanne appeared to be cognitively challenged. When we met, however, Joanne had managed to completed grade twelve, graduate, and was working in a workshop setting. She had recently moved into her own apartment, not far from her parents home, and continued to take night classes to improve her reading. Joanne presented as a quiet, but well spoken young woman, who had a curiosity for life and an interest in people.

Joanne confided that she had been sexually abused through her adolescence by an uncle. Joanne found that she relied very heavily on other people for strokes or validation of her self worth. She had one suicide attempt one year prior to counselling, when she had had a disagreement with a female friend and overdosed on some medication. Joanne related that while this was a first attempt, her self esteem was generally quite low, and that she felt that she had to go to many different people for validation rather relying on herself for her sense of worth. Consequently, Joanne found that she seldom wanted to spend time alone, that any ups and downs in relationships left her feeling worthless, and that, in relationships with males, she

felt that she had no right to say 'no' when sexual involvement was required. Joanne had also suffered a brutal rape a few years earlier by a male she was dating.

Joanne's goals for counselling were to talk about the sexual abuse and sexual assault and the feelings involved. She wanted to gain a liking and appreciation for herself, to raise her self esteem, to learn to trust her own judgement more, to be more assertive (that is to be able to say 'no ' when she wanted to), to be able to feel calmer, have fewer nightmares, and to feel that she did not need to go to many other people to gain approval and validation. Joanne wanted to be able to rely on her own judgement of the merit of her deeds. She also wanted to be able to ask for help when she really needed it. Joanne also stated that she wanted to learn different coping mechanisms for when she was feeling low rather than hurting herself. She wanted to be able to value and treat herself well. Joanne also felt very strongly that she be able to keep safe any child in her care, whether her own child, sometime in the future, of any child at all in even her temporary care. Joanne noted that she was quite exited about being a part of a practicum,because, she said, she wanted others to be able to learn something or gain something from what she had been through.

Work with Joanne began by establishing who her supports were, and expanding her ways of self care. She began to see the crisis lines as an option to hurting herself if she were not able to access someone else with whom to talk when feeling very frustrated or upset. Joanne then began verbally going over the Incest History (Appendix C) since she has some difficulty with written presentation of the material,and because she stated that she wanted to do the work on the form in session. The material covered on the form gave Joanne a good opportunity to share 'her story', as she put it. This was a very important piece for Joanne because she said that she had never felt that she could safely speak of all that had happened. In relaying the factual pieces , Joanne also spoke of and acknowledged

some of the emotions attached to her history, as well as how some of the feelings translate into everyday present behavior.

Once this information was initially covered, Joanne began to focus more on her present day relationships with people at work, her friends and her family members. Christmas time was a time of testing for Joanne as a family function brought Joanne in contact with her abusive uncle. At this time Joanne was able to confront him on some inappropriate touching and inappropriate comments, and to keep herself out of his presence as much as possible . Joanne reported feeling very good about this work, which was initiated through verbal rehearsal of different possible scenarios in counseling sessions in anticipation of the event.

Work with Joanne continued largely in a very practical vein. Joanne would bring up a real life relationship which was posing some dilemmas and we would look at how she could possibly handle the situation, examining what she hoped to happen, what she would gain, what she would risk by trying certain behaviors, the other individuals possible reactions,etc. In short we became quite behaviorally focussed, but with a cognitive aspect. Joanne would look at how much control of responsibility she had in a certain situation, rehearse different scenarios with the focus of trying to change a situation so that she would feel stronger or more in control of herself, or be able to share something she wanted to share. We would look at the other individual's possible responses, and Joanne would assign herself a task with which she felt comfortable in order to try out a new behavior in a relationship. Joanne would then report back the following week on the results of her work. She would then explore what had taken place, her own feelings,actions and the responses of the other individuals involved.

Joanne began to clarify and cement relationships, to let go of some relationships she found were not healthy for her and to advocate for herself with friends and at work. Doing some of this work was quite hard for Joanne because, of course, Joanne began to

act in a much more assertive manner than those around her had become accustomed.Joanne's friends, family, and supervisors at work found Joanne challenging them where she had never before questioned openly. Joanne looked at these conflicts in session, evaluated again what she had to gain versus the risks and then decided whether to continue to challenge herself and others and the manner in which she would present herself. During this time period Joanne also took a communications class at work, and the information she took in here certainly reinforced that which she was working upon in sessions. She was then able to share her work, and receive some validation for it with her supervisors at work.

Joanne also was faced with some sexual harassment in the work place by a co-worker. She shared this in session, and worked out both a safe method of confronting the issue with her supervisors, and with the man in question. When she accomplished this successfully, with again more validation from staff and another co-worker, Joanne was able to affirm her own value, her ability to access appropriate supports when needed, as well as her perception of herself as a woman able to stand up for herself.

April came closer and Joanne found that she was able to deal with almost any situation on her own, or with the supports she had put in place for herself. Joanne was much more in touch with her feelings, and they were generally very positive about herself. She found that she needed fewer people's opinions in order to make decisions for herself, and she was acting very responsibly in relationships at work and outside. Ending became a more often discussed subject. Joanne began to experience some anxiety both at work and in her life in general. It was discovered that prior to counselling and discovering that she could set some boundaries in relationships, Joanne had experienced very few positive endings in her life. Further complicating matters was the occurrence of a verbal assault on Joanne by a stranger at a bus stop. More work was done reinforcing the importance and validity of the work Joanne had done, rechecking her supports, and discussing what the ending of our

sessions would actually mean to Joanne. We started to leave more time between sessions. Joanne and I went over her goals, and 'yes', she felt that she had accomplished all that she had set out to do . In fact she had done more. She had advocated for herself at work and then been given a work situation more appropriate to her personal preference and style of learning.

Joanne and I constructed a small graduation ritual during which she audio-taped her original goals and her response to how she had accomplished them, as well as other things that she had learned about herself. Joanne then received a symbol of her blossoming and advised that she would let me know in a couple of months how her summer had gone.

Work with Joanne was again different in that Joanne did not relate well to written work,and so written assignments were seldom useful. This took me a while to learn because Joanne wanted to do any task that she thought might help her in healing and she had heard about Courage to Heal (Bass and Davis,1988) and other written tools. Joanne worked laboriously on a small part of this book, but found that the written words did not make as much sense to her as she had hoped. Instead, practical, well discussed, self assigned tasks regarding behaviors were the most effective in Joanne discovering her own strengths and feelings. Joanne shared fairly openly both her struggles and her triumphs!

4.4 MYRNA

Myrna, a woman in her early thirties was referred to Klinic from an employment counselling service in the city. A young mother of two small children, she had decided that she wanted to reenter the workforce, but found on doing some of the explorations involved in

beginning to look for work, that she had many memories of childhood sexual abuse with which she had not dealt. Myrna had been sexually abused at preschool age by one uncle who was a child himself at the time. This man had later spent time in jail for sexual offenses against another family member, and, apparently is currently in treatment. Myrna had also been sexually abused by another adult uncle who had married into the family. This abuse had occurred when Myrna was in early adolescence and her midteens. Her response at the time had been to return to school at the end of the summer, change to less challenging courses, and drop the creative activities and sports in which she had become involved. Myrna did not tell her parents of the abuse because there had been deaths of siblings from a genetically transmitted diseases, and she did not want to further burden them. She had given up much , but completed highschool and some technical school and married the young man she was dating, sharing with him alone some of the details of the abuse. With the endorsement of her husband, the only other individual with whom Myrna had shared this information, years later Myrna sought individual counselling.

Myrna's goals for counselling included being able to tell her parents about the abuse, addressing her feelings for the abuse, raising her self esteem, feeling more confident both in her relationship with her husband and with her children, and eventually being able to tap her own creativity for her own enjoyment , possibly moving into a job of some sort outside the home. Myrna also spoke of a desire to confront the uncles with the abuse and to support her niece whom she knew had also been sexually abused.

One of Myrna's first challenges was getting time away from her children during the day to come to counselling. She arranged for childcare,at first feeling guilty about taking time for herself. She then set herself the task of assuring that she have one hour a day for her own reading and study. This she negotiated with her husband. Myrna had already picked up a copy of Courage to Heal (Bass and Davis,1988)) and began to read, bringing topics to our sessions.

Shortly after establishing the above, Myrna took home the Incest History and attempted to do it at home, but found the work too sensitive for her, so we then, with her permission, used it as a vehicle to facilitate work in sessions.

After about a month in counselling, it was noticeable that quite a bit of the focus in sessions was related to parenting and to couple work. I shared some information around parenting, in particular 'Children the Challenge '(Dreikurs,R.,Soltz,V.,1984)) and 'How to Talk to Kids so Kids Will Listen and Listen So Kids Will Talk' (Faber,A.,Mazlish,E.1982). I also suggested some groups in the city for parenting. We addressed the idea of couple counselling, a referral for couple counselling was given,but Myrna presented this idea to her husband and the idea was dropped. Myrna did negotiate to spend more time with her husband alone, and this in itself seemed to help. Christmas approached, and family events loomed. Myrna decided that she wanted to share the information about her abuse with her mother. We rehearsed possible scenarios and responses, checked again on inner and outer supports, and prior to Christmas, she disclosed to both parents and her surviving brother. The response was overwhelmingly supportive!

With this positive outcome and support, Myrna then disclosed to a brother of one of the offenders , who then, with Myrna's permission, confronted his brother and set up a telephone confrontation between Myrna and her youngest abuser. This uncle acknowledged the hurt he must have caused her and apologized and opened the door for further discussion. He also advised Myrna that he is continuing in treatment. After this incident Myrna decided that the abuse no longer need to be a secret at all and she told a few other female friends and relatives , a couple of whom disclosed similar abuse to Myrna. This was the beginning of an informal support group.

Myrna then found that she was doing a lot but feeling that there was a lot of anger trapped inside. In looking at her own

children, she acknowledged the unfairness s of the abuse and her own helplessness at the time. She decided to do some inner child work, and through some nondominant hand writing she accessed some more memories and feelings attached. She was able to mourn for her losses and comfort and validate her experience. She was able to express some anger before well hidden. And Myrna, in looking at her earlier childhood was able to look at herself before the abuse and to find some qualities that she still had and wanted to further develop. Myrna acknowledged that her life is much richer than her experience of the abuse.

Myrna began to focus on further developing her own creativity...some of the performance arts and some of the crafts that she loved. She also became even more open with her husband on her needs and participation in the relationship. She began to give herself credit for all that she does at home. She also began to be more open with her husband on her need to remain focussed on the two of them in their intimate encounters, and so practised ways of grounding herself in order to be more present in their sexual contact.

Myrna sailed along working hard between sessions on clarifying relationships and cementing them. She became much more expressive about her feelings, and learned to honour them. She worked on self care, taking time for herself and continue to develop her talents. She worked hard on her relationship with her husband as partner and parent to their children, including challenging roles and perceptions.

Myrna terminated in early April, after some exploration of her fear at having done so much so fast. On ending counselling, Myrna had began her own business out of her home -a business in which she could use some of her creativity and still be with her small children, and have some income! Myrna had deepened her relationships with parents, sibling, and husband. She had furthered relationships with friends, and formed her own support group. She

was exited about having reached a higher than aimed for position on her goal line and she was exited about her life!

Work with Myrna included components of cognitive/behavioral work, written self assignments, work on the inner child, work on parenting and some exploration of spirituality as this was also very important for Myrna. One book that she particularly liked was When Bad Things Happen to Good People (Kushner,1981). Myrna was so motivated and focussed on her work that one of my roles was to help her to pace herself so that she worked at a rate which she judged as most safe for herself.

4.5 ELISE

Elise was a self-referred woman in her late twenties. On intake, she stated that she was suffering from depression and she could not understand the source. She related that she was the youngest in a large family and that for as long as she could recall she had felt almost as though she had to apologize for her own existence. She related that her mother had been and still was a perfectionist, and that when Elise was a youngster she would not be allowed to go out on family outings because her 'appearance would be an embarrassment.' (I found Elise to be an attractive well groomed young woman.) Elise reported being sexually assaulted in her early teens by an extended family member. She had not been told anything about sex or even her own body functions such as menstruation, so was doubly traumatized by the event. She did not disclose until adulthood. At fourteen Elise moved out of home with her boyfriend who was a number of years older. At fifteen she married, and continued to go to school, finishing her grade twelve. The couple had two children. Elise left the relationship after being physically, emotionally and sexually abused for a number of years by her husband. Her parents apparently were against the divorce!

At the time of our sessions, Elise had been in a committed relationship with a man for three years and they were looking to be married once her divorce became final. She had been unemployed for several months, and was finding the insecurity of income also very difficult.

Elise related that her goals for counselling were to improve her self esteem so that she could be in her relationship with more confidence and be able to go out without feeling that everyone was watching her. She wanted to be able to run her house to her own satisfaction, not feeling totally intimidated by her mother. She wanted to feel good about herself, and decrease her suicidal thoughts. Elise related that thoughts of suicide had increased, and that she had attempted before by overdose. She had a tentative suicide date in mind... a specific day at the end of December. Our initial meeting took place in September. Elise also noted that she felt that she had very little time for herself, even though she was at home by herself much of the day. She had been taught as a child that at home one had to be in productive motion at all times and that the house had to be spotless.

Work with Elise began with a contract that she would not hurt herself during our contracted counselling period, and that she would use the crisis lines if she needed to talk to someone between session, and found that journalling was not helpful . We than began work on the Incest History with Elise doing some work in writing and some in sessions verbally. Elise was able to make many connections about beliefs about herself to both family behavior and patterns and the sexual abuse, as well as some of the later abuse by her ex-husband.

Elise began to self assign practical tasks including a daily reading of the job ads in the paper and putting out some resumes as well as setting aside one hour a day to watch a soap opera that she had wanted to watch but hadn't allowed herself because her mother would have thought it slothful. Within a month Elise landed a job full time job. She eventually decided to take a break from counseling

advising that suicidal thoughts had all but ceased, and she did not have time to come to sessions and reorganize the tasks to be completed at home including, of course, childcare. She contracted to keep herself safe and to continue to do some written work at home.

In early February Elise returned to counselling , having developed an easier routine at home and ready to do more work. She related that she had passed her planned date for suicide with a strange realization that this was a choice, and very mixed accompanying feelings including anxiety, fear and triumph! She reviewed and revised her goals, finding that she had already accomplished the ones around work and establishing her home as her own place with a good deal of work and self talk.

As we looked at her new goals, it became clear the Elise still blamed herself for the abuse at home, and the sexual abuse as a preteen . She had done a lot of work around the abuse in her marriage and was able to acknowledge the part her husband played and 'forgive' herself for being as passive as she was. She also was able to credit herself with doing the best that she could at the time ,staying in a relationship that was damaging to herself because she was told that she could do no better, by both her parents and her husband. Once she realized that her children were also affected in the relationship, that her older child was starting to act out some of the aggression he had witnessed, she immediately left the relationship. Work continued with Elise challenging her own beliefs about herself, realizing that she did have many strengths and beginning to act this way.

As Elise made changes in the manner in which she related to people, at work and at home, at first her partner was very supportive. However, once it became clear that her change in behavior changed also the balance of the relationship, he began to react with objection to the changes. He did not wish to go to couple counselling with Elise, so reading material was provided for him. Elise continued to work on communication, perception checking with

him and in sessions, and sharing her reading and writing with him. At the time of the writing of this report, the allotted time for the practicum had elapsed, and Elise reviewed her goals, having almost reached them as set out both in the beginning and at the middle of counselling. Her self esteem and sense of personal control are much higher.She stated that she is certain that she will not seriously consider suicide again. There are problems in her present relationship, but she is taking responsibility to change her behaviour to benefit the relationship. She is certain that her self esteem must come first in order to truly participate in any relationship.

Elise contracted to continue to work with me for three more months after the end of practicum as a client of Klinic proper. We continue in a solution focused vein, as I write.

Work with Elise continues to be challenging as she is an avid reader and writer, and also a very concrete, often black or white thinker, reflecting, I believe, that taught her in childhood.

My own style tends to lean toward more abstract thinking and use of metaphor. Elise challenged me to stretch my way of presenting ideas in order to relate to her the very real belief that she is a survivor...and to help her navigate her own path towards healing. Elise has opened up enough to risk and set herself tasks which she would have initially have considered even 'silly' in an effort to discover and tap more of her potential. She has, I believe, discovered her delightful sense of humour along with many of the qualities within that she thought she did not have..qualities such as perseverance, insight, compassion and very real and valuable playfulness.

4.6 AMANDA

Amanda was referred to Klinic intake through Osborne House after spending a few days there retreating from a battering male partner, whom she had considered to be a boyfriend. Amanda was twenty two years old. She had had a tumultuous childhood, having been placed in foster care at age three after her mother and father broke up.Amanda was sexually abused by the 'grandpa"of the home while she lived there. It appears that she was about a year in care before her mother remarried and 'rescued' her , taking her to live in what appears to have been an often very dangerous situation. Amanda reported that her mother was battered by her new husband, and that Amanda herself witnessed this and was sometimes beaten. She advised that she was sexually abused by a brother of her new stepfather, and that she did not feel safe enough to tell anyone. Amanda was left caring for a mother who was labelled as clinically depressed and a very young sister when her stepfather abandoned them. She had difficulty at home and at school,and eventually left both at sixteen to move in with an older man who sexually and physically abused her. Amanda's younger sister became a ward of the court when their mother died, Amanda having reached her late teens was on her own, and tried to take over a sort of parent role with her sister, meanwhile attempting to establish healthier relationships with male and female peers, often ending up with older men who seemed to want to possess her. Amanda reported two suicide attempts:one with a knife at four years, and one overdose at thirteen.

When we met I was struck by both Amanda's youthful appearance and her incredible ability to think analytically. Her goals for counselling were to be able to tell her story and place it in some sort of framework that made sense. She wanted to raise her self esteem so that she would have the confidence to again work at a job. She wanted to be able to find some friends with whom she could spend some time and 'have fun' without worry of interference from

a possessive boyfriend, and she wanted to be able to learn to take care of herself in a more nurturing way so that she in turn might be better able to nurture her sister. Amanda wanted to put into perspective her feelings about her mother and to learn what a healthy relationship with a male would be.

At the time of our meeting Amanda was receiving financial assistance from the city and having a very difficult time managing and navigating the system. This in itself became a difficulty in her life as she had to struggle for bus fare to come to sessions, to put together the money to pay her utility bills because she was living in an apartment that was twenty or more dollars above the allotment and she had to pay this out of her food money-and then berated herself for being a poor manager. In addition, Amanda's 'ex' was not an 'ex' in his eyes and kept showing up on her doorstep. Negotiating the legal system, including information on restraining orders became very important.

Work with Amanda was a walk between telling and acknowledging the pain and the strengths of her young self in her past and navigating the very real problems in her everyday life in the welfare system and as the not so ex-partner who had battered her. There was also the attempt to piece together the possible dreams Amanda had for her own life. Interestingly enough, it soon became clear that Amanda was much more focussed on providing a healthy future for her younger sister than for herself. Amanda stated very clearly that she had never had a long term goal for herself, so even looking at concretizing her goals for counselling was a challenge. She had been used to having to survive for the moment.

Arriving at her counselling appointments on the right day,and at the right time was a new thing for Amanda. She had experienced work situations in the past, but they usually involved a lesser focus on promptness. Amanda was used to navigating from crisis to crisis--surviving as best she could and with as much grace as she could. Through exploration, it became clear that Amanda was a deeply

spiritual person, and this became an important key for her as she allowed that she had a right to happiness, and that she also , as a child could not have brought the abuse upon herself. Amanda began to contract for her own safety,as she realized that she owed it to herself to treat herself well. Another important piece for Amanda was acknowledging that she had been a child, like the sister she loved so dearly. As we explored some of her childhood, using the Incest History in session and going forward from infancy up through her memories, Amanda discovered that she had been overtly valued by her mother at times, and by a school teacher, and by a junior high friend. She looked at her experience of good in a relationship and began to explore and build a model or picture for herself for new relationships. In order to break out of the isolation she had been experiencing, Amanda moved apartments, sought out her old friend and began to write some letters to distant relatives to flesh out her own history and present contacts. She saved enough money out of her allowance to join a local health club .In both situations she met new people. Amanda also began to attend a women's employment counselling service, to meet new people in another setting and look at the possibilities of work and/or education.

Amanda did this work through a combination of reality therapy analysis and other methods of behavioral/cognitive self assigned tasks. She would first do some ground work on feelings regarding past and present situations and them arrange a task or situation which would allow her to test a theory about herself, or just to make connections with people in a positive way. In the middle of this work Amanda became quite depressed and even had difficulty getting herself out of the apartment. This seemed to happen when she was deep in exploring her anger towards her abusers and her mother who was unable to protect her. Amanda sought mild tranquillizers from a general practitioner who was in contact with me . She used the medication for about a month and then was able to function again without. In this month, Amanda was also able to acknowledge that her mother did give her some positives, such as some of her spiritual values, and many of her good homemaking

skills, including cooking, which she loved. (She hoped to be able to pass these on to her sister.)

Throughout our work together, Amanda continued to have difficulty with regular attendance at appointments. When confronted on whether this was indeed something she wanted to pursue at the time, she always replied in the affirmative. Amanda was always exited to share her week experiences in sessions, and she made some big steps. When our contract ended in April, Amanda admitted that this was the longest time she had committed to anything, and that she wished that she had attended more conscientiously. She also realized that she was 'playing the field' in her dating life, and was getting to be fairly quick at addressing a relationship which was harmful to her, and then gaining some distance. Amanda had greatly broadened her social contacts, and reconnected with a very good friend..the friend from junior high. She was becoming a fairly strong advocate for herself and her sister within both the financial aide and the child welfare system, and she continues to follow up on her contact with the employment counsellors, realizing that she was bright enough and worthy enough to attend some form of further education. She also had learned that she knew how to have fun, to laugh, and to do all kinds of crafts that she had assigned herself as some of her tasks to learn healthier coping mechanisms! Amanda allowed that she might seek counselling again to explore further sometime in the future, but for now she was content with the changes she had already made for herself.

For myself, work with Amanda was again different. Amanda showed less overt interest in direct solution focussed tasks, but she did accomplish much in the way of discovering some of her present and past identity and strengths. She did learn to value herself much more, and to treat herself with greater care. While I placed a good deal of emphasis on regular, prompt attendance at sessions as an indicator of readiness to work for herself... in actuality I might have labelled this attendance as overt cooperation. Instead, Amanda did

the best she could, it seemed , to accommodate my conventions and schedule, and worked instead more on the interactions with the important people in her life outside of sessions. About halfway into these session, when Amanda was sometimes ill, and sometimes late for sessions,or needing to reschedule, I was very concerned that counselling was of little value to Amanda . Amanda kept coming, and working in her own way, and I humbly admit that I had to adjust to her pace, her needs, and her path. While I still believe that it is important to maintain the contract between counsellor and client as best possible, I now understand that growth can occur in less than optimum conditions, and within many different timetables.

4.7 MARILEE

Marilee is a woman in her early thirties. She was referred to me from the sexual assault program at Klinic, where she had been involved in a couple of counselling sessions to heal from a sexual assault in the work place by her previous boss. (This incident she had reported to the Human Rights Commission, and it is still under investigation.) The counselling to deal with the effects of the sexual assault opened up memories of past sexual abuse by a brother when the was very young, and exposure to deviant sexual behavior by her father throughout her childhood. She also experienced a sexual assault by an uncle in her early teens. Marilee revealed that at fifteen she left her home where alcohol was abused by both parents , and physical violence on the part of her father was the mode for discipline. Marilee moved in with a man a few years older, found full time employment and supported the two of them. He was also physically, sexually , and emotionally abusive towards her. Marilee left this relationship and married at seventeen. The young man she married was emotionally and physically remote. The couple had two children and divorced two years prior to Marilee starting counselling. She had not been 'allowed ' to work during the marriage, so the

assault taking place on the work place, by her employer was doubly difficult to deal with- Marilee had just been discovering again her openness and her pride in being able to support her family.

When we met, Marilee was experiencing nightmares, difficulty keeping food down, anxiety attacks, low self esteem, and frequent suicidal ideation. She had one previous attempt in adolescence. Marilee was very angry that she was unemployed through no fault of her own. She was also in a relationship with a police officer who had at first seemed like a security figure, but now was becoming threatening and controlling.

Marilee's goals for counselling were to lessen the nightmares, raise her self esteem, lessen the anxiety attacks, learn about and be able to be involved in healthy relationships with males and females, be able to work again, or,if possible attend some type of education which would help her feel worth while and find a job. She also said that she needed to be able to deal with her very mixed feelings about her family, and try to find a way to relate to some of the members without feeling so drained and angry. Marilee said she needed to be able to trust her own judgement and to know that she was a 'good person'. She said she would know that she was feeling better about herself when the anxiety attacks lessened and when she began to wear colors again-especially purple. Marilee, at this point was dressing almost totally in black.

The first couple of sessions were spent with Marilee focussed on her present relationship. It became clear that she was not feeling safe. This safety decreased, and by November it was apparent that she might be in grave danger. Indeed, her partner had been apparently making covert and then overt threats abut what would happen to her if she ever left him. At one point, her apparently showed her his gun as a warning. We immediately began work on protection planning, and after the gun threat, contacted the police, Marilee making the first contact and myself following up at her request. Over a short period of time, the man was issued a

restraining order and warning by his superiors to stay away. Looking at this relationship and Marilee's feelings about it became the jumping off point to look at the other relationships in her life. After initially chastising herself for the mistake she had made trusting this man, she was able to look at the fact that she was able to end the relationship under very difficult circumstances, and after a relatively short period of time. We then worked on firming up her supports, rallying around friends and agencies she could trust, as well as reconnecting her with useful coping mechanisms such as writing, cleaning, and dancing, instead of self-destructive behaviors, in order to prepare her for the continuing work.

Marilee continued to have crying bouts, but lessened her attacks of diarrhea prior to sessions and began to be able to sleep and eat on a more regular basis. Marilee found the work at home on the Incest History (Appendix C) too threatening , so we worked on it in sessions. Marilee also began to speak openly about her fears that she would not or could not be a good parent to her children. She assigned herself the task of building in time for herself, and we looked at her parenting style and apparent results in session. She also brought her children in to meet me a couple of times. It appeared that Marilee we a very conscientious, loving parent, but was not able to give herself credit for the work that she was doing. instead, her tendency was to focus on any 'negative' feelings she might have. She began to work on better communication with her children as well as her friends. Marilee was also able to realize that she was protecting her children when she ended the relationship with her partner.

Marilee worked hard in sessions at expressing her feelings, and exploring ways to deal with the effects of the childhood abuse. As she spoke more about her childhood, she found positives about herself she did not know were there. She also increased in her desire to heal or end the relationship with her father. Marilee did a lot of journalling, and at one point, wrote her father a letter confronting on his behavior towards her and her siblings in earlier

years. Astonishing to her, he replied with a lengthy and apparently sincere apology and a statement to her that he wished to develop their relationship, but would understand if she did not wish to.He also wrote about his pride in her and her accomplishments as an adult who was facing her past, and as a mother to her children. This was a marker point for Marilee! She mourned the losses from her childhood,and the hurts she felt from her father. She continues to communicate with him, feeling that the father who wrote the letter is as real as the father who hurt her so much. Marilee also expressed that her father had never before told her he loved her-and she had always acted with some hope of gaining recognition from him. From here Marilee began to work on furthering relationships with one sibling in particular. It appears that they are good friends.

Marilee continued to explore feelings in sessions and between sessions on paper and with trusted friends. She assigned herself weekly tasks of pleasurable self-care or sometimes more difficult tasks such as going to an employment counselling service. One major goal for her for practical, monetary, control and self esteem reasons was to find some kind of employment. Through this work, Marilee was offered a position in a training program, with a job guaranteed at the end in a field in which she seems to excel.

She continued to have some ups and downs as she met and dated different men, and seemed to find herself doing all the giving. She looked more closely at what she needed for the moment and decided that she had enough friends, both male and female, and was being nurtured by them and herself, and decided that a physically intimate relationship could be put on the back burner while she worked on boundaries.

At the beginning of May, Marilee gave herself a belated birthday present by coming to her final counselling session. She was delighted that she had superseded her goals as set out in October. She was brightly dressed and took a break from class to attend. She had plans to spend part of the weekend with her children and part

out dancing with friends. She related that she felt very strongly that she is a very good person, bright, strong and sensitive, and that she can and does make good decisions for herself and her children. She allowed that she might,want a few more sessions some time in the future, especially if she is in a relationship, but she noted that this would not be a negative thing to her..just part of living and growing.

My work with Marilee was intense and exiting. She became very open very quickly, and this made the work 'up-front' at all times. It also meant that when she experienced anything initially,it seemed like a crisis. We worked hard therefore to ascertain that she was aware of and would use all of her safety nets, both internal and external. Marilee challenged herself constantly , and she moved along so quickly that I was uncertain at first that I could trust how quickly she had met and passed her goals. Marilee's pattern had been to burst into session with a burning item to look at. She never missed a session. Marilee made it clear that she had better things to do when she began to change appointments because of school or children's activities,near the end of April. We addressed this, and it seemed that, in fact, there were more important things to do!

5.0 The Basic Map of the Work.

This practicum provided an opportunity to review the relevant literature prior to beginning the work of counselling. As I worked with the women, I found myself looking for more and more information. My intermediate certificate in reality therapy had been earned in 1986, so refreshed information was needed. I was able to attend a two day workshop on Reality Therapy to brush up on my knowledge in this area. I also attended a five day workshop, put on by Evolve, in Winnipeg, on working with women affected by battering, the men who batter, and the children affected by the violence.

I spent many hours with my supervisor, and other counsellors at Klinic, talking about what they had learned doing the work and what tools they would recommend. I was also fortunate enough to be able to cofacilitate a group for adult women survivors of child sexual abuse and found that much of the work done in group could be adapted to individual work and vice versa. The work at Klinic was all done using a feminist analysis as a base.

As is evident from the previous section, there are many similarities, and differences in working with these women. The women are all individuals with their own individual experiences. They have different styles of communication and ways of learning. They have also shared much. They have had common experiences of painful breach of trust by a loved, trusted adult. They have experienced a sense of their own control in their world being confused or taken away and their self esteem has suffered. All of these women had learned to cope with these losses by developing other strengths, some of which no longer served them as well as they once had. Joanne, Laura, Marilee, Amanda, and Elise had all been abused as adults in relationships with male partners. Penny stated that she could trust no one to allow herself to be in a relationship.

All of these women included in their goals a desire to improve self esteem, a desire to learn about and feel more in control of their own emotions , and a desire to be able to trust themselves as well as others more. They also wanted to be able to feel something other than sadness or anger, and to believe that they deserved this 'positive' emotion.

How did client and counsellor, work together?

The previous chapter briefly described each woman's journey. In this chapter, I shall outline and summarize the framework used with all the women, identifying the source to the best of my knowledge. I shall begin will the feminist framework, followed by the basic tool, reality therapy/control theory. Following will be an analysis of how the two mesh. A brief recognition of other resources used will follow. Specific exercises used will be described in the next chapter.

4.1 A Feminist Framework in Action

5.1(a)The therapeutic relationship and attitude of the counsellor. Within a feminist framework, the relationship between client and therapist models as much as possible a power equal relationship.

As a feminist I believe that the client has a right to know about the therapist, her values and her methods, in order to feel comfortable enough to build any trust, and ,of course, to have enough information to be able to decide if this particular therapist is the 'right one'. Therefore, the first step in counselling was to fully reintroduce myself, talk a bit more about the contract that we had signed, and remind the client of the agency policy around file keeping, confidentiality, reporting, etc. (See Appendix..B..for contract.) At this point I also spoke a bit about the way I would be working, avoiding any jargon, and assuring the client that her goals were uppermost. I shared that my job, as I saw it was to be a resource or a guide along with her on her own journey. I made it

clear that I knew some of the work would be hard, but that the client had obviously worked hard before or she would not 'be here.' I then asked the client if she understood and was reasonably comfortable with this introduction. Note that the client would have been asked in intake what any previous experiences in counselling might have been like and what her expectations were.

I then advised that the way I work is to be aware of both the clients goals in a practical sense, and also to pay attention to how the client is feeling, both about the material with which we are dealing with and the process of counselling itself. I noted that we would most likely do some work to access and uncover some of the feelings that they might not have been able to look at before in reference to their pasts, and at the same time do some very practical tasks which they would assign themselves to change some of the situational things that they wanted to change for themselves in the present. In effect, we would be working 'from both ends'. I reminded the women that these were their sessions, and that if they ever felt that I was asking them to do any thing that they were not prepared to do , that it was their job to express their reservations and 'not do it'. They would always have the final say on an exercise or discussion topic. I made it clear that I considered that they were the experts in their own lives.

Included in this beginning piece of the work, a was the setting up of a support network for the client. For some of the women, this meant just reviewing the network they had already set in place. For others, this meant carefully constructing and going over contacts that they could use in case of emergency. Emergency contacts included friends, neighbours, and the crisis lines. This work is borrowed from crisis work (Curtois,1988; Dolan,1991)

5.1(b) Attendance to Practical Issues. Part of demystifying the healing process consititutes basic social work practice, and, in this case was an important jumping off place for many of the women. Attendance to child care issues was very important for Elise, Myrna,

and Marilee.. A feminist analysis helped address this very real barrier for the women. Reality therapy(discussed in later section in this chapter) provided a mechanism for practical solution, as much as was possible in our social setting.

Employment and education were important to all of the women with whom I worked. Again, a feminist analysis helped the clients to stop blaming themselves for some of the difficulties and attitudes they encountered in themselves, and their larger network. Reality therapy(discussed later) provided the tools to help the women access some of the resources available to them both internally and externally. A feminist analysis aided in the realization that it was not each woman alone who was affected by the issues of role expectation and of less education and lower employment that their partners. Attendance at referred agencies such as Women's Employment Counselling Services provided concrete examples that many women were in similar situations to themselves. This service in particular also did some important concrete work in the area of education an job referral.

It was also important to normalize feelings and fears the women might be having at the beginning of therapy, and as difficult issues arose, most of my clients had, at times, thought that they were a little 'crazy' in their feelings and reactions to the world around them.

5.1(c)Education. In a sense, this is an extension of the role of the feminist counsellor in a therapeutic relationship. In working with the seven women in this practicum, education in three particular areas stood out.

i. Post Traumatic Stress Disorder: The work of Figley(1985) provided a base to share with my clients in order to normalize their feelings and reactions after the experience of childhood sexual abuse. The Courage to Heal Workbook (Bass,E.,Davis,L.,1990) provided information and exercises for the women to work through identifying how the trauma had affected each one of them . The workbook, with

it's feminist focus, also was a powerful tool in helping each woman identify which coping mechanisms she had used, and which ones were either still working or not working for her. With some of the women , the written work was shared, surrounded by lots of discussion. Joanne and I worked through the exercises by talking through the exercises in a fairly concrete way in sessions.

ii. Victim/Survivor/Warrior.(Lorde,1980;Pinterics,1992) This exercise, shared with each of the women in a way that would most suit her style of learning, provides an analysis which identifies the context in which each woman had become a victim, was now, and had been working on being a survivor (since her first acknowledgement of the abuse, is only to herself), and was next battling ,as a warrior to be her own protector. The warrior theme suggests to the women the need to go beyond the accepted standard of 'ok' as set out by our society to a place where she can be truly fulfilled as a wholely empowered person. The term 'warrior', while not my personal favorite as an image, does describe to some extent the fact that the work beyond 'getting along' according to societal standards, involves the energy needed not only to stand one's ground but to do battle for change. The exercise is described in some detail in the next chapter.

5.2 Reality therapy/Control theory.

5.2(a) The counselling relationship. As in any feminist based therapy, the counselling relationship is of great importance. A basic tenet of reality therapy is the fact that the therapist becomes involved with the client and creates a warm, supportive and challenging relationship (Brierly,1986; Glasser,1968,1984; Gossen,1986). The therapist challenges the client to challenge herself, while providing tools with which to make some change, should the client chose. The therapist supports the client to make her own value judgement regarding what is and what is not working for her in her life., and helps her to figure out more effective ways of using the creative process that has kept her alive thus far.

Throughout therapy, the counsellor gently confronts the client with the reality and consequences of her actions. One of the catch phrases of reality therapy is 'never give up'.

5.2(b)Teaching of the Philosophy and Basic Assumptions of Reality Therapy.(Glasser,1965,1984;Gossen,1986).

After having the client outline her goals and having established the beginnings of a therapeutic relationship, the women were all introduced to the idea that all human behaviour is an attempt to get what we need. The women were taught the idea that all behaviour has four components, which are, thinking, feeling, doing and physiology. Within this philosophy, humans have varying amounts of control over feeling thinking and doing. Reality therapy teaches that the individual generally has the most control over her physical actions, thinking second, and feelings, last. Therefore, when change is needed, one is taught to begin with 'doing' behaviours. How the client picks the doing behaviours is based on her 'pictures' of what she wants and needs for herself. This concept was particularly helpful with goal clarification and description of how the women would know when they were where they wanted to be in the healing process.

i. Basic Needs. Reality therapy teaches that humans have four basic needs beyond the need for food clothing and shelter. My clients were taught that all people have the need for love and belonging, personal power and control, freedom and fun. In typical reality therapy sessions, the client is asked to chose which areas she needs fulfilled the most. I chose not to do that with my clients, as most of them identified that they felt losses and emptiness in all areas, as was readily identified when they shared their goals for therapy. However, the notion of defining these as needs for all humans, helped normalize my clients' feelings, and also helped the women realize that they did indeed deserve, and have a right as human beings, to live in a more satisfying way.

ii. 'Pictures' as tools. Reality therapy teaches that people all have ideal pictures of what they need and want in order to fulfill their basic needs. This was always done after some history had been shared by the client. The woman was asked to describe pictures she could conjure up if she could 'wave a magic wand'....that is if she had all the power in the world to make something happen, lifting her out of 'the now'.

Each woman was asked to identify 'pictures 'she had of 'love and belonging','personal power', "freedom' and 'fun". Using reality therapy terms, the women looked at the goals they had set for themselves, and assessed 'what they would have' if their pictured were fulfilled. In all cases, the pictures just served to flesh out the goals the women had set for themselves. I spent some time explaining the concepts of choices and using behaviors to 'get what we need', and related this in a positive way to the behaviors the women had used to date to keep themselves as safe as possible. A piece that seemed to be particularly important was the concept of personal control, and the fact that we have first control over physical actions, next control over thought and last, control over emotion. (Glasser, 1965,1984) We talked about acting towards oneself in a caring way, and the importance of positive self talk. We also talked about the importance of recognizing feelings, naming them, and then making choices about how to act or not act upon them ie. act to sustain the emotion, or to chose to do something different,but at all times learning to acknowledge and name what they were feeling!

iii. Self-assignment of tasks. After discussing these concepts on a basic level, often lending reading material(noted later), a small part of each session then involved the construction of some small task that the woman would do in order to explore an avenue , to obviously move her closer to her goals, or seemingly small, but very important, the construction of a plan for self-care and personal safety. The client would set up a task, look at possible benefits in carrying out the task, and also possible losses in completing the task. The client would look at what might come in the way of completing

the task. The following session, the client would report on the process of initiating and doing the task, and evaluate her results and how she felt about the whole process.

For example, Elise, who was a perfectionist housekeeper and never allowed herself to sit down during the day because it would mean that she was slothful, assigned herself the task of watching an hour long much loved television show each afternoon. Initially she reported that she felt guilty and would rush around doing work during the commercials. Then , with the help of some 'self-talk',telling herself she deserved a break, was able to watch and enjoy the show. The result in the end was that Elise learned that she could pace herself, still get the work she felt she needed done. She began to realize that she had a right to dictate and decide how she would spend her time, not her absent but disapproving mother or her abusive and perfectionist ex-husband. Elise judged that the task she had set was worthwhile and continued to assign herself tasks weekly.

Another example of tasks which became almost rote for Penny was the establishment of a list of things she could do to keep herself from cutting her arm when overwhelmed with pain. Penny continued to work on this throughout our time in counselling, and decided a couple of months before moving to send me her knife along with a letter describing the tasks she was using and the emotions she was feeling. When we met the following session, Penny was wearing short sleeves, something that she had not previously done.

It is important for me to mention that there were parts of the reality therapy philosophy which I softened or ignored because they did not fit my beliefs or values and I believed they might not only be not helpful to my clients, but possibly be quite damaging. Glasser(1968,1984) states that people are self determining and in charge of their lives. I must qualify this. I shared with my clients a belief that we act towards self-determination, but that our gender,

class, culture and age has some effect on the amount of power we have and the 'success rate' we achieve. Also, as I stated in section 3.4, I disagree strongly with the terms Glasser(1968,1984) uses to explain whether a person is 'in effective control of (her) life. Glasser states that people have either a 'failure' identity(not in effective control of their lives) of a 'success identity' (in effective control of their lives). These terms which Glasser uses are blaming and judgmental and I chose not to share these notions with my clients. This analysis is in direct contradiction to any acknowledgement of the client's past and present creative choice of coping mechanisms.

5.3 Meshing Reality Therapy within a Feminist Framework.

5.3(a)The relationship between counsellor and client.

Both reality therapy and feminist based work focus heavily on the important relationship between client and therapist. Indeed ,in both, this relationship provides the base for the work. For me, a feminist philosophy allowed me to ally with the client in her work, as a resource and co-traveller along her journey in our culture. Reality therapy gave me the task of gentle confronter, challenger. urging her to take another look at her world and see if she could figure out another way to get what she needed for herself. Feminist counsellors, like Nomme-Russell (1988) call this behavior feedback. As a feminist, this meant also teaching the client to challenge herself, and as reality therapist and feminist , to evaluate and accept when she had done what she was able to or could do for herself within the limits of our society. My job as feminist counselor and reality therapist was also to help my clients to learn to celebrate all that they had been able to do both in the past , and more recently...

5.3(b) Clarification of goals of therapy.

As a feminist and reality therapist , I was clear that the goals of therapy for the client were to be of her choosing, and that she would evaluate the proximity of accomplishment. As a feminist, I shared with the client some of my values as well and made it clear

what my philosophy was so that she would not receive mixed or confusing messages. Reality therapy provided the means for the women to construct tasks which would be meaningful to them in order to come in closer proximity to their goals. Many of the tasks that the clients assigned themselves had their sources, I believe in feminist works. For example, journalling is well known in the work of Butler (1978) and Lorde (1980). Affirmations and creative visualization described in the work of Engel (1989) and Gawain (1979).

Other tools were borrowed from other sources, some of which I will briefly describe in this chapter.

5.4 Other Important Pieces.

5.4(a) The Goal line. In the first few sessions , Clients went over the goals they had outlined in intake, and were given an opportunity to expand on them. The premise for this work was described earlier The client was asked to address her goals point by point. She was asked how she would know when she had reached each one,ie. what would she be doing differently. If this was sometimes hard to describe behaviorally, I would ask what someone else might notice would be different, along with the clients own observation of change. These goal descriptions were often aided by the client looking at the pictures she had in her head for meeting her basic needs, as described in the earlier section on reality therapy. These descriptions would also be written down.

Then a goal line would be constructed (Corcoran and Fischer,1987). The client or I would draw a straight line and mark numbers at equal intervals along the line. I suggested a line numbered zero to nine, but one of the women prefered to use zero to ten. The client would then look at the line and place a mark with the date reflecting where they felt they were on the goal line in the beginning few sessions. Initially, I had planned to look at the goal line every few weeks. However, because most of the women encountered very strong memories and painful emotions attached

quite early on in counselling, it seemed that looking too soon at the goal line would have given a sense of very slow movement, or no movement at all. (As it was, several of the women noted this themselves later in counselling-that 'feeling the feelings' was a very important part of their healing, but that the feelings were very frightening at some times, and not necessarily perceived as positive at the time.). Midway, and then again, closer to the end of our committed time in therapy, the client evaluated her goals and placed herself on her goal line, looking at what she wanted still to do prior to ending counselling.

5.4(b). Crisis Management and assessment of lethality. Paying attention to the work of Briere and Runtz (1986) and Bass and Davis (1988), I noted that dealing with some of the some of the issues in therapy might put my clients in crisis. For some, the idea of speaking family secrets, or placing responsibility for hurtful actions on loved ones, acknowledging buried hurts, could leave my clients very vulnerable...especially if they spoke of things before our relationship was well established. I evaluated with the women their level of crisis as they began the work, paying particular attention to suicidal thoughts or plans, even though this would have been checked out in intake. The next step was to ascertain what supports that each woman had and how she would access these supports. This involved concrete safety planning, noting to the women that sometimes doing this work brought up feelings that were hard to cope with on one's own. A helpful aide in setting out a safety plan are the chapters on creating a support network in the book The Courage to Heal Workbook (Bass and Davis,1990). For all of the women there was a familiarization with the crisis line services at Klinic and a contract to use the lines if all else failed and they were having trouble keeping themselves safe. This was done in a very matter of fact way, reminding the women that they had kept themselves safe thus far, but that it was not uncommon for people to feel unsafe once they spoke about things that they had not talked about before --especially to a relative stranger-and that it was important to have some safe ways to deal with the feelings. I also

often noted that it was not unusual for a person to feel particularly unsettled for the first hour or so after a session, wondering if they 'should have said that'. I suggested that this uneasy feeling usually dissipates once the client and counsellor get to know each other better. As an aside, I note that familiarizing the women with the crisis lines as well as other supports was a very important step in reminding them that there are already supports available to them, some of which they have already been using, and that counselling is only one small part of their lives, and the counsellor only one of a number of helpers available to them.

5.4(c) History. Reality therapy (Glasser,1965,1984) states that the past may be acknowledged, but is not to be dwelled upon. Feminist therapists (Brickman,1984; Butler,1978; Goodrich et al,1988) note the importance of acknowledging the woman's experience in therapy. Curtois (1988) and Dolan (1991) note that many survivors are afraid to tell their story because it is so horrific that the therapist might not be able to handle it, so, without help, it remains a deep secret to be sheltered, weighing the woman down. In this practicum, I chose to deal with history by offering my clients a written questionnaire, to be completed by them in writing, verbally, in session, at home, or not at all. The tool I chose was the Incest History (Appendix C) ,adapted from Curtois (1988). Some of the women were exited to begin and took the form home immediately, returning it completed in great detail the following week. Others expressed a reluctance to do the work on their own, afraid of the feelings they would experience, but wanting to go over the material in session. One woman preferred to write her responses, but to use some of the time on our sessions , with me out of the room, coming back to discuss a section before the woman left . She would then return the following session and begin where she had left off. Another woman did not do well with written material, and, indeed, found some of the language too difficult to understand, so I adapted the form further to suit her understanding, and we completed the form in discussion format in session. At any rate the questionnaire served as a vehicle to state any unstated secrets in a way that was

fairly straightforward and as normalizing as possible. Talking over the responses at whatever length benefitted the individual client was a way to access some of the emotions and to start to grieve some of the losses. (Loss theory, Benedek,1985: Curtois,1988).

From here we generally moved into talking more in depth about family history, and usually spent some time on loyalty and what the client had learned from her family (Karpel,M., Strauss,E.,1983). We also spent time looking at positive individuals in the woman's childhood. In every case except Amanda's the women had no trouble identifying at least one person who had in some way nurtured and cared for them. Amanda had to search ,but was able to identify times when her mother was healthy and had cared for her, and times when a school teacher had nurtured her.

4.4(d) Cognitive therapy. All of the women found work in the areal of cognitive therapy useful at times. (Beck,A.T., Shaw,B.F., Emery,G.1979). Cognitive therapy was particularly useful in working on the reduction of anxiety attacks, which all of the clients described themselves as having in varying degrees,when faced with stressful situations and remembering or flashing back to past abuse.All described times of disorientation, varying degrees of shortness of breath and heart palpitations, among other symptoms. Clients learned to look at their perceptions of the anxiety producing situations they were in , assess the reality base for their perceptions, and then learning ways to calm themselves, or leave the situations.

Clients also worked on 'grounding' themselves,or focussing on the present (Engel,B.,1989) with concrete statements about their surroundings, breathing exercises and positive self talk.

Each woman moved at her own speed, as you can see from their profiles in the previous chapter. With all of the women there were times when crises would occur, and it would feel to the woman that she was 'right back where [she] started'. These times of crisis

usually occurred at a time when the woman was made vulnerable by revictimization or the threat of revictimization. These crises served as times to test out newly acquired skills and ways of thinking. This was a time when I introduced to the women the concept of healing in stages. The exercise,"Victim,Survivor,Warrior" (Lorde, A.,1980; Pinterics,L.,1992) was most helpful and will be described in a following section.

As noted, at least three months prior to termination the goals were again looked at and a mark made as to progress. Termination was talked about along with what the woman wanted to accomplish before ending and all the feelings attached. The women were reminded that there were minimally referrals available if they felt that the work was not complete at the end of the contracted time. Each woman ended in her own way. All came to a final session to terminate. One constructed a ceremony for ending, while others just reviewed , summarized and said good-bye. Four of the women requested,and were referred to a group work waiting list.

All of these women invested an incredible amount of effort, time and trust in this work,and they achieved results which reflect this. Their evaluation of the process follows.in Chapter.6.

5.5 Helpful tasks and exercises.

This section briefly outlines some of the exercises and tasks that I found useful working with the women in this practicum. All of these are adapted from different sources. Where I know the sources, I will cite them. In other cases, the exercises have been handed down by word of mouth or adapted beyond recognition of any particular source. When this is the case, I shall cite the source which is closest to my knowledge. I would remind the reader that in each instance there was no hard and fast way in which to present the exercise. Rather, it seemed important to adapt to the particular client's learning style.

All of the tasks were presented to the women after first being taught the basic reality therapy/control theory principals as outlined in my initial proposal. This was done early on in the first few sessions in order to clarify my values and beliefs and create a common language for the client and myself. It was also a useful way to challenge early learned destructive beliefs and clarify a few basic principles. These were an affirmation that the abuse that the women had suffered was under no circumstances their fault or responsibility, and that the abuse was far out of their control as children. However, healing could come about only with the acknowledgement of feelings, and then taking personal responsibility and control for actions following these feelings. It was made clear that choice of actions towards goals would be the easiest to control. Thoughts or self talk could also be controlled, and feelings would and could change, but that they were often last to change. Tasks might be suggested by myself as counsellor, but more often they would finessed by the client, as she would probably have a better sense of what might be valuable to her in particular.

5.5(a) Rainy Day Letters and Letters from the Future

The purpose of these letters is to provide comfort and hope in times of stress. These letters have been used in group work with adult survivors of sexual abuse (Bolton, M.J.,1992) .Similar exercises are found in Dolan (1991, p.131).

One version of the rainy day letter is to have the client reflect on paper in a letter to herself celebrating and affirming her goals and the work that she has done to date. This type of letter is particularly helpful for those times when the client feels less control or has an experience of revictimization, a not uncommon experience for any woman in our society. When the woman rereads the letter,she is reminded of her goals and of her accomplishments. She is reminded that she has had hope and has been able to work to affect change for herself.

A rainy day tape can also be used. One of my clients, Joanne, decided to audiotape her stated goals and her response to how she had come to achieving them, along with some affirmations. This she did on her last day of counselling,to take with her as a reminder and celebration of what she had accomplished, being cognizant that there would be days when she would not feel so strong.

The 'letter from the future' is a letter the client writes herself when she is feeling strong and hopeful. It may be addressed one year or five years from the present . In the letter, the client writes about how much she has accomplished, and what she will be doing five years from the time of writing, as if it has already occurred. She then tucks the letter away to be read when she is feeling less strong.

5.5(b) The Talisman, or Medicine Bundle

Many women found it helpful to put together for themselves a small package or even one special article to carry with them, particularly when they anticipated being under duress, for example when attending court, confronting a person or challenging situation. This bundle or article would be something that represented a safe place or time for the woman, and carrying the article on her person, would be a reminder of strength , safety , and comfort and self-nurturance. Dolan (1991) writes of a similar concept.

5.5(c) Creative Self-expression

Every woman I worked with had her own very creative way of expressing her feelings through writing, song, craft work, dance,etc. Some of the women had put aside these tools years prior, thinking that they were 'silly' or childish. The women were encouraged to rediscover their own unique ways of self-expression, and as they did they were able to touch and release some feelings long hidden as well as find and celebrate more of themselves. In a couple of

instances, the artistic work done by the women has become part of their work for employment. In all cases, this work has been noted as very affirming and very positive in self care.

For me, and for my clients, this focus on the creative was a very important step at acknowledging the value of work which has been traditionally women's work that has gone unnoticed or taken for granted. Within a feminist framework, the women were asked to look again at work which was generally unpaid, but was very important, once reframed, when looking at the aspect of 'richness' in their lives. Once this creative work was valued by the women, their sense of valuation, or 'love' of self was also increased along with their sense of personal power.

5.4(d) Self-Nurturing

All of the women noted that they were very 'other focussed' and spent very little tome in activities or situations that were just for them. Laidlaw, Malmo et al (1991) join feminist writers such as Brickman (1984) French (1985) and Goodrich et al (1988) in acknowledging the fact that women in general are focussed in care for others and often experience feelings of guilt when they engage in activities stictly for their own care and enjoyment.

Other focussed for survival reasons, my clients had often adopted self destructive activities, such as cutting their bodies or not eating or sleeping. Using reality therapy within a feminist framework, the women began to look at self-nurturing as part of what they needed to do to fulfill some of their need for love and belonging and working towards a more healthy sense of power and control. Fun, another basic need was also considered. Thus, many of the assignments the women gave themselves focussed on self-care. These activities included learning to cook, taking an exercise class, taking daily walks, reading a novel for half an hour a day, meditating, singing, meeting friends for coffee on a regular basis, even buying foods that they liked. For one woman, the creation of a

nurturing nighttime routine, including a bedtime story and a warm cup of cocoa helped in nurturing and in dispelling nightmares.

5.5(e) Letters of Confrontation

Dolan (1991) writes about letters of confrontation, and her method has proved very helpful . Most of the women, at some point in counselling, decided that they would like to confront their abusers. This can be a very difficult and potentially dangerous thing to do, so it must be approached carefully and with great self care by the client, and only when she is certain she is ready. One way of building in some safety is to do the confrontation by letter, at least as a first step. The client writes three letters. One letter is a letter of confrontation to her perpetrator. The second letter is a response that she imagines would be most likely from him, and the third letter is the response that she would like to have from him. None of the letters is mailed or sent, until they are discussed in counselling. The letter to the perpetrator is sent by the client only when and if she feels entirely prepared. Sometimes it is enough for the client to write the letter, and she may decide to have a ceremonial burning of the letters rather than send them, especially, if her perpetrator is dead.

5.5(f) Nondominant Handwriting

This exercise was used when clients spoke of feeling stuck.feeling that the child part of them needed something and they did not' know what it was. This seems to stem from the self-development theory (Vander Kolk,1987). In this exercise, the client draws a line vertically down the middle of a large piece of paper. Then, with a crayon or marker in the nondominant hand and a pen or marker in the other, the client writes with her dominant hand asking what is needed from her. The nondominant hand responds as the child within. A dialogue then continues down the page. This exercise was usually explained, and then the client left for fifteen or twenty minutes alone to write, with me returning later to debrief the exercise. This exercise was reported by client s to be most helpful in

identifying feelings, and what needed to be done to acknowledge and go on with living. Cappacione (1988) and Dolan (1991)refer to variations of this exercise.

5.5(g)Victim/Survivor/Warrior

This exercise was constructed by Lyn Pinterics and Pam Jackson (Pinterics,L.,1992) as a way of framing and normalizing the healing experiences of many of her clients, who are survivors of wife abuse. The exercise was based on work by Audre Lorde (1980) in her Cancer Journals. All of my clients said they had an"ah ha!" experience once they became familiar with this material. The exercise comes from a feminist philosophy which acknowledges the importance of challenging the roles we find ourselves in society in order to become truly self-actualized.

In this exercise there are three steps. First, the counsellor speaks with the client about her experience of Victim, writing down the thoughts , feelings and environmental situation that she experienced as a victim of abuse. Usually, the client notes that a major factor keeping her in that position was lack of power and having 'a big secret' and not having a voice-being silenced. There is also noting of the various methods the client used to cope as a child victim, and affirmations that these coping mechanisms were very creative and helped to keep the client as safe as she knew how.

Next, the counsellor asks the client to look at what changed to make her a survivor. The client speaks of telling the secret, of how she may have changed her environment, of the difficulties she still encounters, but how she acts still to keep herself safe. The emphasis here is on speaking and acting for her own protection. The counsellor asks the client to note specific coping mechanisms she uses now, and how some have changed from the old coping. This may include things such as getting enough sleep, talking about the abuse, going for counselling. The counsellor then asks what happens if a crisis happens. How does the client react? Most often, the client will state that she will usually return to old coping mechanisms like

overeating, or alcohol abuse or some other mechanism as a first reaction, and then, within a short period of time, chose methods that will be more helpful to her in the long run. The counsellor normalizes this, often using some example from her own experience, so that the client realizes that this is 'normal' behavior. (A little humour here is often helpful.)

The third step is for the counsellor and the client to look at what the client thinks are proactive things for a person to do, things she might want to do or might already be doing to keep herself and others safe from abuse. The focus here is on action, or 'outgoing' things the client is doing, such as helping with a parenting course, being active in a parent teachers association, writing letters to city counsel members, joining a civil action group, being part of a support group, etc. The counsellor affirms with the client any proactive work she has done or is doing. Then, the counsellor asks again,how the client might react if some crisis took place, usually giving a specific example. The counsellor than normalizes the response, which usually incorporates some of the previous 'victim' coping behaviors. The counsellor then talks with the client about how she them chooses other healthier behaviors to bring herself back to the position of survivor and then warrior. The counsellor also talks about this being a very natural pattern for all of us to follow.

The above exercises are only a few of the tools that clients may use to assist in their healing process. Each woman will adapt and create her own specific tasks with the aide of her counsellor.

I am swinging branch to branch
skipping across the surf
scaling cliff shelves
wiggling through velvet grass
The sun burns me satisfyingly to exhaustion
A splash of ice pearls, drip-dropping
on my head
reawaken and fuel me in my arms breadth
They are the lovers of my heart.

"Penny"
February,1992

6.0. Evaluation of the work.

This chapter will be divided into two main sections. First, the clients' evaluation of the work, taken from client evaluation forms, as contracted with the women at the beginning of therapy. This will be followed by my own evaluation, using the goals for the practicum as the base for evaluation.

6.1 Evaluation From the Clients' Point of View

As planned, the evaluations were done at the end of counselling, with a couple of weeks between the evaluation and final session for several of the women, and immediately on ending for others. One client, Elise, completed the evaluation two weeks after one sessions, and two weeks prior to continuing as a regular counselling client at Klinic, as described earlier. Penny was the only client who chose to write her own responses rather than meeting

with a third party. Unfortunately, Laura's comments are unavailable, as she left the province too suddenly to be able complete an evaluation.

To best reflect the feedback on the counselling process and it's effects as noted by these women, I shall provide a condensed form of the Evaluation Form along with condensed responses of the women. The form as it was presented to the women can be found in Appendix D.

6.1(a).Satisfaction with the number of sessions:

Four of the women stated that they were satisfied , while two would have liked more time in counselling. Of these two, one had to leave for work outside the area, and the other was continued as a client of the same counsellor, as I was later hired to continue working at Klinic.

6.1(b) Comfort with the counselling space:

Initially, counselling was done in a small private room in Klinic. This room did not have windows, but did house a two-way mirror and equipment for audio and videotaping. While the equipment was shown to the women, and it was clear that it would not be used without their prior consent, in all cases the women noted that they were quite uncomfortable with the space. They all noted that they felt much more comfortable when we moved into another office which I was later assigned. This office was smaller, but it had a window, and because I was the only person using the space, I was able to personalize it a bit with artwork and poetry, much to the delight of all the women.

The women also commented favorably that the building of Klinic itself offered services other than counselling, and they were not labelled as counselling clients by walking in the door. Several

also chose to use the medical program services as well, and this was a welcomed convenience.

6.1(c).How helpful clients found counselling:

All of the women noted that they found counselling "very helpful". Comments included the following:

"I found a new perspective."

"I was allowed to acknowledge what I can do, both the positive and the negative."

"If I hadn't come for counselling, I would have committed suicide."

"It gave me a place to talk about not only the abuse, but the other things happening in my life."

"I got to set my own goals and then had help in achieving them."

6.1(d). How close did the client come to realizing her goals?

Two of the women stated that they reached 'some' of their goals in the time period allotted. These were Elise, who contracted for further counselling at Klinic with me--she had had a break of a couple of months because of employment. The other woman was Amanda, who stated that she was not really prepared at this time to do any more work in the area. Amanda reached a seven and a half on a scale of nine she had set for her goals. Penny stated that she was 'unsure ' in that she felt that she had reached some goals different from those initially set out. Penny had court to deal with! Penny reached three out of nine. At the beginning of sessions she had placed herself below zero.

Three of the women stated that they felt that they had reached or surpassed their goals as set out. Joanne reached a ten on ten. Marilee reached nine out of nine and Myrna reached seven and a half out of nine, where she had stated at onset that seven would be

acceptable. Interestingly, all seven of the women had stated that they would be happy reaching about seven on their scales. All of them stated that 'perfection' would include daily ups and downs. That is, none of these women expected to 'feel happy' all of the time. They saw 'normal' as having some texture to life. Some comments from the women were:

"I feel much better about myself."

"I reached all of my goals. By setting and reaching my own goals, I gained courage, self-esteem, and confidence in myself."

".....I realized that I developed further goals when into counselling and I realized that I could affect change in areas I'd never thought I had any control."(Myrna)

6.1(e). What did the clients like most about their time in counselling?

"...being able to voice feelings...."

"...knowing there was someone there- -didn't have to do it all by myself."

"I was relaxed and comfortable with [therapist] . [Therapist] helped me look for positives/strengths in myself and in my learning/growing process."

"...was free to let my emotions out."

"...comfortable with the therapist."

"...liked not being told what to do....having to do my own thinking about what I want to do."

"...being able to talk without being judged...being understood..."

"...never being rushed, and always time for fun..."

6.1(f) What the clients liked least about therapy/counselling:

One woman stated that there was nothing that she didn't like. Others commented as follows:

"I found that it wasn't the right time for me to deal with some of the things that I think I'll eventually want to work on."

"The preparation involved in getting to sessions, the childcare arrangements were difficult."

"I got comfortable enough to let feelings out. My anger at first scared me. And I cried. I don't like to cry."

"...one hour was sometimes too short for the feelings being felt..."

6.1(g) What was most helpful about counselling?

"....talking, realizing that sometimes I can make pretty good sense...Also, the reading material..."(Amanda)

"...[therapist] understood what I was going through."

"...being able to express myself."

"...[therapist] had faith in me. She encouraged me and was supportive of me no matter what I decided I had to do."

"...[therapist] made me think on my own. [She] encouraged me to use my mind."

"...not being judged...encouraged to think on my own...being understood and having someone who actually seemed to appreciate and understand...someone I could trust to show my writings, my drawings, my poetry...'

6.1(h) What was least helpful about counselling?

To this question, four of the six women replied "nothing". One woman stated that she felt the time (one hour) was sometimes too short. The sixth woman noted that it was initially difficult to connect up with the therapist to set an appointment time. This may reflect

the fact that this woman was first seen by another counsellor through the intake process at Klinic. Others of the women were seen by me at intake and throughout.

6.1(h) Was there any thing that would have been better done differently in specific sessions or in general?

Five of the women replied "no", while the sixth woman stated that, given better weather, it would have been nice to have had a session or two out of the building, in the nearby park, for instance.

6.1(i) How easy was the counsellor to understand and to talk with?

All of the women stated that [the counsellor] was 'very easy to talk with'. Their comments were:

"...She would listen first before commenting, and she could understand what I was saying."

"...[therapist] had a gentle, quiet nature --a quiet nurturance, which allowed me to trust her. I felt I had her unconditional acceptance."

"...[therapist] listens to me without judging. She is able to point things out that I didn't see before. She made me realize that what happened to me is not my fault and that I'm not to blame..."

" I was so amazed and relieved, because [therapist] always seemed to know about what I was saying...comforting to know that I'm not an alien, or at least that there is another one here in Winnipeg."

The sixth woman noted that my "small stature" helped in making her feel comfortable because she is a small person physically. She also noted that she felt that [my] 'strong person' could relate to her strength. She noted a feeling of sisterhood.

6.1(j) How safe did you feel with your counsellor?

All six of the women reported that they felt 'very safe'. Their comments included as follows:

"For me to remain in counselling, it was very important to me to feel safe with my counsellor, and I felt safe to do anything, say anything, or feel anything with [therapist]."

"I understood the [confidentiality policy] and knew that what I told her wouldn't leave the room. Also , she wouldn't criticize me or put me down."

"[therapist] is totally nonthreatening...and has twinkle in her eye..."

" I felt fairly safe with [therapist] in the beginning, and as time went on I felt safer. Now I feel very safe with her."

6.1(k) How comfortable were clients with the amount of direction offered in therapy?

Two of the women stated they felt "very comfortable" with the amount of direction offered. Two said they felt "fairly comfortable", while one woman indicated feeling between fairly comfortable and very comfortable with the amount of direction offered. One woman indicated that she did not know because she was not particularly aware of being directed. Comments were as follows:

" Overall, I felt comfortable with the amount of direction being offered,and very comfortable with [therapist], but had an underlying feeling of putting my life into someone else's hands by just asking for therapy."

" I trust [therapist].'

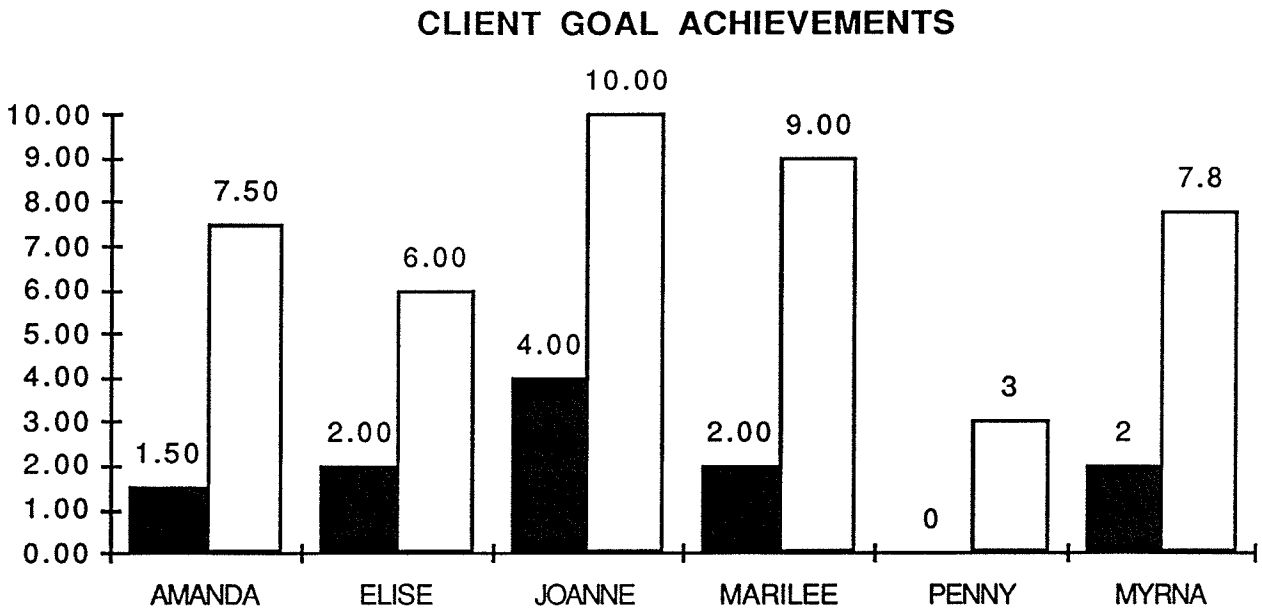
" I was scared at first by the choices and options being opened to me, but I trusted that [therapist] wouldn't suggest anything that would not be safe. The amount of direction was just right for me. I think [therapist] is a good judge of character."

" ..[therapist] let me make decisions. She let me talk,she was like a guide. I decided what it was that I wanted to talk about in sessions. [Therapist] gave me the freedom to express myself. If I came in with something negative, she would help me find some positives in it."

6.1(l) How satisfied is the client with the counselling experience overall?

Four women noted that they were "very satisfied", while the other two women stated that they were "fairly satisfied"with their counselling experience. Of the later two women, Penny, had some of her counselling time 'stolen' by court focussed work, and the other woman, Elise, continues as a counselling client of Klinic, with the same therapist. (As noted earlier, she had taken a two month hiatus from counselling due to work complications. A further three months has been contracted to work on issues as Elise has also had illness of herself and her children interfering with attendance at a few sessions.)

It should be noted that, while two of the women stated that they were 'very' satisfied with their experience in counselling, they said they would have preferred an open ended rather than the time limited contract . Both of these women reached their goals, but one noted that she may decide to do further work in later years, as her life situation and developmental needs change. This would be certainly in accordance with what has appeared in the literature regarding time in therapy. (Butler,1978; Dolan,1991).



The above is a graph depiction of the goal lines the women constructed for themselves. The first bar for each woman represents the number she attached to her goal achievement at the time of commencement of therapy. The second bar stands for the numerical value she attached to her personal goal attainment at the end of our counselling contract.

6.2 Evaluation From the Therapist's Point of View.

6.2(a)Interventive goals reviewed.

The interventive goals of this practicum were outlined in detail on page three of this document. In evaluating the success of reaching these goals, is taken into account the experience my clients expressed in their evaluations, the information from their goal lines and my own subjective experience.

As planned, I was able to meet with seven clients on average, once weekly for eight months. One of the women left the province in the fifth month of counselling. A second interrupted counselling for approximately six weeks because of work and other reasons.I was pleased to be able to meet with several of the women more than once weekly when they were in crisis.

Six of the women were available for final evaluations. All of them noted that the rapport with the counsellor was one of the most important aides to their healing process. All of the women noted the importance of feeling heard by the counsellor and connected to her in some way. Phrases like "unconditional acceptance", "very safe", "without judging", "feeling of sisterhood" were used to describe the therapeutic relationship. Both reality therapy and feminist based work insist on a joining with and not judging the client. Feminist work, however, notes the importance of equality and 'sisterhood' with the client.

All of the women commented positively on the process of setting their own goals and the effect this had on aiding them towards acknowledging and taking responsibility for their own lives. All moved towards self empowerment and a sense of control in their lives in very concrete ways. The client evaluations noted that the women themselves valued being able to 'enjoy' the process of counselling, learning to like themselves, feel their feelings, whether 'positive' or more painful (and their right to have their feelings), and

then learning concrete ways to acknowledge themselves and move towards their goals.

As a therapist, I note that four of my clients had time before and during therapy when they were actively contemplating suicide. My training about Post Traumatic Stress (Figley,1985; Curtois,1988) and the shared information from co-workers at Klinic helped to be able to normalize this for the women, thus lessening the feelings of panic and anxiety. Reality therapy tasks the women then were able to chose for themselves then helped focus the women on self-care, a concept described earlier as important within a feminist framework.

The evaluation of the women speaks quite clearly to me that the interventive goals of this practicum were met. All of the women moved toward their goals, and most of the women reached their goals. All of the women had named as two very important goals, the raising of their self-esteem, and the improvement of their sense of personal power and control. Their actions as outlined in their profiles in Chapter 4 state clearly that these women gained much in empowerment.

I would have liked to have been able to continue to work with Laura and Penny, to be able to celebrate with them as they come closer to their goals. I am confident that the same energy and insight and courage that brought them to counselling in Winnipeg, will carry them through to continue doing the healing they have begun. As it is we were able to celebrate many flashes of insight. The fact that they were able to go to safer (Laura) and more challenging places of work (Penny) shows their courage and ability to nurture themselves.

6.2(b)Evaluation goals reviewed.

Each woman constructed and developed her own goal scale. One woman preferred to use a scale of zero to ten,and the others zero to nine, and this was allowed since the comparison with the scale was of her own movement,not in comparison with others. As it is, she rated herself as having reached ten on her scale, so results are easy

to rate. In all cases, the women were proud of what they had accomplished, and this tool seemed to be an almost tangible, certainly visible way of looking at the progress.

The unstructured interview was completed with some variation. Two of the women chose to write their responses rather than meet an interviewer. In one case, Amanda's, this was partially due to difficulties in scheduling. The interviewer noted that the women she interviewed were quite free in their comments and the interviews which were scheduled to take forty five minutes usually took an hour or more.

6.2(c) Education goals reviewed.

I found that the tools of reality therapy could very easily be incorporated within a feminist perspective with some adaptation, as discussed in Chapter 3. The tools of reality therapy themselves were very useful, but some of the language, which tends to sound judgmental or blaming had to be changed or simply not used.

I also found that it seemed to matter less to the client than to myself what the actual tools were, as long as there was first of all a high regard for the client and that this was communicated to the client. The clients did not notice the tools themselves so much as the relationship with the client. I found that I used reality therapy as an underlying base tool to go back to as a reminder to clients that they had the choices as to what they would do towards self-empowerment and a sense of control. I also noticed that the time spent "doing" reality therapy seemed to be a small amount of the time in each session, once the basic concepts had been shared with the clients. Much of the balance of the time was spent on the acknowledgement of past and present feelings and their effects, and then working through grieving and celebrating survival. Then it would be back to reality therapy, using a feminist analysis for the client to decide and work upon tasks which would help her move beyond the role of 'survivor', as mentioned earlier.

I do believe that reality therapy/control theory was a vital piece in moving from the feeling state to an action state while still honoring the feelings, and helping the women take back control in their lives.

I also feel that the women's' response made it very clear that the feminist approach 'made the difference' for them in helping them commit to themselves and their healing, and in decreasing their sense of isolation, again, moving them beyond survivors.

6.3 Counsellor Self Care.

There were important things that I learned about counselling that I had not openly sought to learn. One very important part for me was the necessity of having a safe place to debrief after particularly difficult sessions. This work can be very taxing emotionally, and I found that the best way to deal with this was to debrief with my supervisor. In other work situations, a team approach where people can share their reactions to their work has also been helpful. Sometimes I just needed to vent the anger and pain I felt (yes, counsellors have feelings, too) in response to the pain and unfairness the clients have survived and the tremendous effort they put into reconstructing their lives. Some of this can be expressed through empathy with the client, but emotions other than empathy can be destructive to the client, perhaps hinting to them that there situation was too horrible to allow healing. I dealt with my anger by, again, debriefing with my supervisor, talking(in more general terms) with other counsellors at Klinic, writing, or running, dancing, jumping, walking, ...any physical activity which helped diffuse some of the energy.

I also learned that there are certain clients that 'push my buttons'. That is ,there are certain clients whose manner or presentation or 'soul' just pushes against whatever unresolved issues I may have lurking in my development. A key for me was that I felt very angry, or almost overwhelmingly sad after a couple of sessions. Rescuing impulses sometimes lurked. I shared this with my

supervisor, and did some writing, and after some work, discovered what of my own issues were being jarred. Once I realized the issue, I was able to work at distancing enough to put back into place the necessary emotional boundaries to continue the work more effectively and with much less personal stress. I know that there will be other times when my 'buttons will be pushed' and that I will have to be open to looking at myself to continue to improve in my abilities as a counsellor. I also know that frightening though this experience was for me, I believe that it was an indication that I am allowing myself to be vulnerable to some extent, and I think that some vulnerability is important to acknowledge,to self at least, in order to truly ally with a client.

I learned the importance of going at my clients pace. I had understood that intellectually before, and had even practiced it on occasion, but having seven women working on similar issues at the same time drove home to me that indeed, it is their work, and it must be done on their timetable or the whole ethic of the work is invalid. Not only that, it 'just doesn't happen'!

6.4 Conclusion

The work described in this report is a fingernail sketch of the tremendous effort of seven women in therapy to heal from childhood sexual abuse. With the help of my teachers , both official and otherwise, a therapy was developed incorporating reality therapy/control theory within a feminist framework. The purpose was to not only aide the women in healing, but to do this in a way that would demystify the process and give them the tools they would need to recognize, access and develop their own strengths. I believe that this was accomplished.

In addition to discovering that this combination could work, I made several discoveries,from doing the work and looking at my own process as I adapted to meet the women's needs. I discovered

that to be most helpful, I could not be rigid or narrow in my approach. The tools I used were important, but no 'one way' suited two women. Different combinations fit at different times for different clients.There was no magic formula.

One piece that did seem to be much valued was the fact that each client was asked to set her own goals, and evaluate them. This is an integral part of reality therapy, and it is a given within a feminist approach.

Another piece, perhaps the most powerful for me, was the feedback on the women's evaluation forms stating unequivocally that there was no tool or method that stood out as most helpful. What was most helpful, all the women stated, was the sense that they could trust their therapist and feel that the therapist truly empathized with them and 'seemed to understand', validating their experience.

Cautionary Note;

Those interested in doing similar work are urged to carefully examine their own values and method of self-presentation. I believe that there is danger in being too 'heavy handed' in using a feminist perspective. Attention to the client's comfort level is a must in building the trust necessary to work with a client. The therapist's agenda must facilitate rather than overshadow that of the client.

There are also serious concerns about using reality therapy to the letter' as discussed in Sections 3.3 and 3.4 of this text. A 'hard nosed' reality therapy approach could be deemed quite judgmental and blaming. Again, a strict, untempered reality therapy would most likely give the client the message that she had 'failed' in her coping to date.

I believe that the combination of reality therapy within a feminist frame worked here because the 'success' of the therapy

relied on the open sharing of the tenets of this perspective and the tenets of reality therapy, not on a conversion of the clients to these ways of thinking. The goals of the clients were uppermost. Respect and clear valuation of the client and her efforts were and are far more important in the healing process than any method or approach.

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APPENDIX A- Letter of Introduction

Welcome to Klinic. My name is Maureen Flaherty. I have worked as a counsellor since the mid seventies, and have recently completed the course work towards a masters degree in social work. The final piece towards the completion of the degree is the choice, on my part , to spend a period of time working with women who have survived the trauma of incest and want to work towards dealing with the effects that the trauma has left in their lives. I have worked in this area before but never at a time when I was able to have the supervision and support to be as focussed as I will be in this time of my work and learning.

During the period that I am working with you , I will be supervised by a staff counsellor from Klinic as well as a professor from the University of Manitoba, Faculty of Social Work who will consult with and supervise me. The supervision received away from Klinic will relate to issues in counselling but will keep your identity confidential.

As with any other counselling client at Klinic, a file will be kept under your name within the building. This information is kept confidential within Klinic, and would only be released with your permission or if legally required. Should you wish to review your file, you may request to do so. This is in keeping with general policy for all clients at Klinic.

I will also be keeping my own set of notes which will not bear your name, or any identifying information, but which will allow me to examine and write about the process in counselling. At the end of the counselling period, I will then write a report about this process . Again, there will be no identifying information about yourself in this report, and it will be available for your perusal. I will be asking you to meet with a third party approximately one month after the conclusion of our sessions, so that you will have a chance to evaluate the usefulness of the counselling with someone other than myself. This information will be summarized and also included in my final report.

Before beginning sessions with me , you will be asked to sign a consent form, indicating that you understand and agree to this process. Please feel free to ask any questions that you may have.

APPENDIX B - Consent Form

In undergoing counselling with Ms. Flaherty, I will also be participating in an educational study of a student of the Faculty of Social Work of the University of Manitoba. As a client, I understand:

1) That the intended time frame if these counselling sessions is to meet once weekly for approximately one hour for a period of between one and eight months.(This exact time will be negotiated as we proceed.) At the end of this time period, I will meet once with a different counsellor to better evaluate the effectiveness on the counselling.

2) That, as any other counselling client at Klinic Community Health Centre, a confidential file regarding my sessions at Klinic will be kept on the premises. This information, generated in my sessions at Klinic is available for my review upon request. All information, both verbal and written will be kept under strict conditions of professional confidentiality.

3) That information from this file will not be released outside the agency except : a) with signed consent by myself; b) if there is concern that I may be a danger to myself or others; c) as necessary if subpoenaed for court; d) if a child may be at risk and a report to Child and Family Services is deemed necessary.

4) That information may be shared within the agency only as such information is required by individuals who have an identified need to know the information for the purpose of helping me, the client.

5) That in addition to my file kept on Klinic premises, I understand additional non-identifying notes will be kept by Ms. Flaherty regarding the process of counselling/therapy. These notes shall in part make up a practicum report to be compiled at a later date. These notes will also be the basis for off site supervision by a member University of Manitoba Faculty of Social Work.

6) That observation and/or audiotaping or videotaping of a therapy session may be required but shall not be done without my immediate prior consent.

Read and agreed to:

Name of client:

Signature of client: Date:

Signature of counsellor, or other witness: Date:

APPENDIX C

Incest History Questionnaire

Instructions

This 52 question form is designed to help you to describe your incest experience. It has five sections: (1) Family Description; (2) Pre-Incest Self Description; (3) Description of the Incest; (4) Initial Aftereffects Rating Scale; and, (5) Long-Term Aftereffects Rating Scale;.

This Questionnaire asks detailed questions. Respond according to your ability to answer and your degree of comfort. Do not rush yourself or put yourself under intense pressure. Respond in as much detail as you can remember and you are comfortable with. Another version of this questionnaire has been used in research. The survivors who completed it found that it was a helpful tool in disclosure and discussion. This revised version is designed to help with information- gathering for the therapy process. It should help you to look at your family and its functioning, the incest and its aftermath, including direct and indirect aftereffects. This questionnaire will be used only for therapeutic reasons. You may decide whether to fill it out on your own or to work on it solely in sessions, or a combination of the two.

I. Your Family Description

1. Briefly describe what you know of your grandparents on both your mother's and your father's side. What were they like? How were your parents raised? Can you remember anything about what their relationship was like? Did they have any outstanding personal or family problems that you know about or have heard about?

a. mother's parents:

b. father's parent's:

c. their relationship, parenting, family deficits or assets, etc.:

2. How many children were there in your parents' respective families?

a. mother:
number of siblings.....
mother's birth order.....

b. father:
number of siblings.....
father's birth order.....

3. Are you aware of any physical or sexual abuse in either of your parents' families? How about serious emotional problems or illness, alcoholism or drug abuse?

a. mother:

b. father:

4. Describe your parents as individuals. Note any particular personal strengths, weaknesses, and/or problems or assets they have.

a. mother:

b. father:

5. Describe your parents' relationship/marital history.

a. If married, how old were they when they married?

b. did they get together or marry under any special circumstances of strains (e.g., extreme economic hardship, "had to get married")?

c. Have they ever separated , or divorced and/or remarried? Please describe the circumstances .

d. describe your parents' relationship as best you can.

e. Do you recall any major changes (good or bad) occurring in their relationship? When and of what type?

f. Describe how your parents interacted with the extended family.

g. Briefly describe as best you can the educational, occupational and work history of each of your parents.

mother:

father:

h. Briefly describe how your parents and your family functioned in the community at large(e.g., Were they isolated? Did they have friends?).

i. What was/is your parents' religion? How did religious traditions, beliefs influence family functioning?

j. What was your family's ethnic or cultural background? How did traditions, beliefs influence family functioning?

6. How many children are in your family (include self and any half brothers /sisters and stepbrothers/sisters. List all according to birth and note their order, sex, and the number of years between them. Also note children who died and their birth order.

	Sex	Age Difference
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

7. Now describe as best you can the roles in your family , including any roles you think you held (e.g., older sister acted like a mother, brother was the family clown or scapegoat, mother was the "softy". father was the authoritarian).

father:

mother:

siblings:

self:

8. Describe as best you can what your household was like, how it worked internally (for example: mother was boss,father was quiet; father was domineering but mother was the power behind the throne; parents always did what the children wanted/ always gave in).

a. Do you recall any major changes in functioning in your family? Describe them and when they occurred.

9. Describe any family problems ,trauma or upheavals you can think of that occurred before, during or after the incest (please note when). (e..g. , death in the family, divorce, alcoholism, severe illness or injury, desertion, child running away.)

10. Describe your relationship with your family and its members as you were growing up (e.g., warm, distant, conflicted).

mother;

father:

siblings:

11. Describe you present relationship with family members and the ways you relate to and interact with each other (e.g., warm, distant, conflicted).

mother:

father:

siblings:

II. PRE-INCEST SELF-DESCRIPTION

12. If you can, describe what you can remember about yourself before the incest occurred.

13. Answer the next four questions on a scale of 1 to 5.
a.How did you feel about yourself?
...../1...../2...../3...../4...../5.....
good neutral bad
don't know

don't remember

b. How did you feel compared to your friends?

...../1...../2...../3...../4...../5.....
felt better about myself — felt about the same — felt worse

c. What was you degree of comfort with others?

...../1...../2...../3...../4...../5.....
comfortable — neutral — uncomfortable
don't know/
don't remember

d. How well did you relate to others?

...../1...../2...../3/...../4/...../5/.....
good — neutral/ don't know don't remember — bad

14 Did you experience any type of major disruption, crisis or trauma when you were young before the incest situation? Please describe (e.g. , a family death, a separation from the family).

III. DESCRIPTION OF THE INCEST

A. The Incest

15. Describe the incest situation which you were involved in as a child/adolescent.

a. Please describe the type of sexual activity which took place. Describe if there was a progression of activity over time.

16 Onset of the incest.

a. When did it begin?

b. How did it begin?

c. Do you have any idea what was happening in the home when it took place?

17. Termination of the incest.

a. When did it stop? How old were you at the time?

b. How did it stop? How old were you at the time?

c. Did you or anyone else do anything to stop it?

18 Duration . How long did the incest go on?

19 Frequency.

a. How often did the incest occur?

b. Were there any patterns or particular circumstances surrounding the occurrence (e.g., Drunkenness, violence, loneliness)?

20 Location. Where did the incest take place?

21. The Perpetrator.

a. Who was the perpetrator (or perpetrators)?

b. What was his/her (their) age when the incest began? When it ended?

c. Can you remember anything about this person(or persons) that would have caused him/her(them) to engage in incest (e.g., loneliness, temper,drinking)?

d. Please describe this individual(or individuals) as best you can.

22. Describe your relationship with the perpetrator (or perpetrators)

a. prior to the incest:

b: during the incest:

c. after the incest:

23 Involvement.

a. Were you ever offered any favors or enticements for your participation?

b. Did you ever refuse to participate? What happened when you did?

c. Did you ever choose to participate? Please describe.

d. Were you ever threatened if you did not comply?

e. Did you ever struggle? What happened when you did?

f. Did you ever engage in any other type of behavior to get out of the situation (e.g. ,running away, getting married)?

24 Reactions at the time of the incest.

a. What were your reactions to the incest?

b. How do you think you coped with the incest? What did you do?

c. What were your reactions to the perpetrator?

d.What were your reactions to yourself/within yourself?

e. What were your reactions to other family members?

25 Describe what you were like while the incest was ongoing.

26 How did you function at the time of the incest? Do you believe any aspects of your life suffered or improved at the time due to the incest (e.g., school, relations with others)?

28. Are you aware of any other incest in your family (nuclear or extended) (e.g., sister with father, brother and sister).

28 Were you ever sexually approached by or involved with any other family member?

.....Yes .....No

a. If yes, was there any connection between this situation and the first incest?

B. The Issue of Disclosure

29. In your opinion, did anyone else besides you and the perpetrator know of the incest without direct disclosure?

.....No .....Yes

If yes, describe why you believe so.

30. Do you know if you had noticeable symptoms or signs that would have clued someone to the incest?

31. Did the incest result in a pregnancy? If yes , what was the outcome?

32. If the situation became known, did the people who knew ever intervene?

.....Yes .....No

a, What actions did they take?

b. What reaction did you have?

33. Did you ever disclose the incest to anyone and /or seek help in any way?

.....Yes .....No

If no skip the rest of this section and continue at section IV.

a. To whom did you disclose?

b. When did you disclose the incest ? How old were you then.

c. Describe you reasons for disclosure and any expectations and fears that you had.

d. What was your reaction after disclosure to this individual and to any action that was taken?

e. Did the perpetrator know of your disclosing to this person? What was his/her reaction?

C . Involvement of Social Agencies and Personnel

34. Was the incest ever reported outside the family to a social agency.?

.....Yes .....No

If no, go on to section IV.

Which of the following agencies or personnel become involved?

a..... police

b. medical services and personnel

..... hospital

..... clinic

..... physician

..... nurse

..... other:

c. social service/mental health agency and personnel

..... child protective agency

..... community mental health center/family services

..... psychiatrist

..... psychologist

..... counsellor

..... social worker

..... other:

d. minister,priest or church member

e. legal agency and personnel

35 Go back and describe your involvement with and response from the agencies and personnel that you checked above.

36. Describe your reaction to these some involved agencies and personnel.

37. Describe your reaction to the perpetrator at this time.

38. Were you or the perpetrator ever removed from your home after reporting?

.....Yes .....No

If no, go on to Section IV.

a. For what reason were you or the perpetrator removed?

b. By whom?

c. Where were you removed to?

d. What were your reactions?

e. What was the experience like for you?

39. Have you ever received counselling?

.....Yes .....No

If no , go on to Section IV.

a. If yes, , reasons for seeking treatment.

b. Did you disclose the incest experience experience on the counselling?

.....Yes .....No

c. If yes, how and why did you make the disclosure? How did the counsellor deal with your disclosure?

d. If no, why did you choose not to disclose it in counseling?

IV. THE INITIAL AFTEREFFECTS

40. Describe any aftereffects you experienced in the following eight areas. These aftereffects are what you think were the immediate (rather than long term) effects of the incest.

a. social (e.g., feeling isolated, different from others , unable to interact, mistrustful of others).

b. psychological/emotional (e.g.,not being able to feel anything or having too many emotions). Please discuss specific emotions.

c.physical (e.g., feeling sick at the mention of certain activities, pain, soreness. headaches).

d. sexual (e.g., sexual confusion, sexual fears, wanting sex all the time or avoiding it, sexual preferences).

e. familial (within or with your family) (e.g., family members were estranged, got closer, parents got divorced).

f, sense of self (e.g., powerful, ashamed, improved, or lowered self-concept)

g. relation to men(e.g., close, trusting, mistrusting, hostile)

41. Please describe any other aftereffects and symptoms.

V. THE LONG-TERM AFTEREFFECTS

42. Describe any aftereffects in the following eight areas that you experienced in the long term aftermath of the incest.

a. social (e.g., feeling isolated , different from others, unable to interact, mistrustful of others).

b. psychological/emotional (e.g., not being able to feel anything or having too many emotions). Please discuss specific emotions.

c. Physical (e.g., feeling sick at the mention of certain activities, pain , soreness, headaches).

d. sexual (e.g., sexual confusion, sexual fears,wanting sex all the time or avoiding it, sexual preference)

e. familial (within or with your family)(for example: family members were estranged, got closer, parents got divorced)..

f. sense of self(e.g., powerful,ashamed, improved or lowered self-concept).

g. relation to men (e.g., close,trusting,mistrusting,hostile)

h. relation to women(e.g., close, trusting, mistrusting, hostile).

43 Please describe any other aftereffects and symptoms.

44 Using the scale provided , indicate what type of effect the incest had on your life.

1	2	3	4	5	6	7
very positive	positive	somewhat positive	neutral no effect	somewhat negative	negative	very negative

a. Please discuss why you think this.

45 Describe you current feelings about the perpetrator.

46. Describe your current feelings about any other significant person(s) in your life.

47 Describe your current feelings about the incest. How do you understand your incest experience? Does it have any meaning to you?

48 Describe your current feelings about yourself.

49. Describe any difficulties or complaints you have concerning your present functioning or lifestyle(e.g., headaches, inability to concentrate, poor social skills).

50. Is there any other information you would like to add?

51 Do you have any immediate reactions to having discussed your incest experience in this way?

APPENDIX D - EVALUATION FORM

Name (optional):
Date Completed:
Interviewer (optional):

As discussed early on in sessions, the purpose of this form is largely for you , as client , to provide feedback on the usefulness of the counselling that you received, both what worked or was helpful to you and what could use some improvement. Please respond in each section as honestly as possible. Your opinions are valued .

1. Were you satisfied with the number of sessions that you had with your counsellor?
a) would have liked many more sessions
b) would have liked a few more sessions
c) satisfied
d) would have liked a few less sessions
e) would have liked many more sessions

Comments:

2.How comfortable were you with the physical setup of the counselling space?
a) very comfortable
b) fairly comfortable
c) comfortable
d) a little uncomfortable
e) very uncomfortable

Comments:

3.How helpful did you find counselling?
a)useless or harmful
b) not very helpful
c) not sure
d) somewhat helpful
e) very helpful

Comments:

4. How close did you come to reaching your goals as you had set them out at initial sessions?
a) showed no improvement
b) showed little improvement
c) unsure
d) reached some of my goals
e) reached many of my goals

Comments:

6. What did you like the most about your time in counselling?

7.What did you like the least about your time in counselling?

8.What did you find the most helpful in your time in counselling?

9.What did you find the least helpful?

10. Is there anything that you would have like to have been done differently either in particular sessions or in your experience in general?

11. How easy did you find your counsellor to understand and to talk with?
a) couldn't relate to her
b) difficult to talk with
c) unsure
d) reasonably easy to talk with
e) very easy to talk with

Comments:

12. How safe did you feel with your counsellor?
a) very unsafe
b) somewhat unsafe
c) neutral
d) fairly safe
e) very safe

Comments:

13:How comfortable were you with the amount of direction offered by your counsellor?
a)very uncomfortable
b) somewhat uncomfortable
c) don't know
d) fairly comfortable
e) very comfortable

Comments:

14. How satisfied are you with your counselling experience overall?
a) very dissatisfied
b) somewhat dissatisfied
c) don't know
d) fairly satisfied
e) very satisfied

Comments:

Is there anything else that you would like to add or comment upon?

APPENDIX E - HELPFUL READING MATERIAL FOR CLIENTS

Bass,E.,Davis,L..(1988).The Courage to Heal:A guide for women survivors of child sexual abuse. New York:Harper and Row.

Bass,E., Davis,L. (1990). The Courage to Heal Workbook. New York:Harper and Row.

Bass,E.,Davis,L. (1991). Allies in Healing.When the person you love was sexually abused as a child. New York:Harper Perennial.

Dreikurs,R.,Soltz,V. (1964). Children: The Challenge. New York.Hawthorne.

Daugherty,L.B. (1984). Why Me?: Help for victims of child sexual abuse (even if they are adults now).Racine:Mother Courage Press.

Engel,B. (1989). The Right to Innocence: Healing the trauma of childhood sexual abuse. Los Angeles:Jeremy Tarcher Press.

Faber,A.,Mazlish,E. (1982). How to Talk to Kids so Kids Will Listen and Listen So Kids Will Talk. New York:Avon Books.

Gawain,S. (1979). Creative Visualization. Bantam:Toronto

Gawain,S. (1981). Living in the Light.San Rafael,Cal.:New world Library.

Gil,E. (1983). Outgrowing the Pain:A book for and about adults abused as children. New York:Dell.

Goldhor-Lerner,H. (1985). The Dance of Anger. New York:Harper and Row.

Goldhor-Lerner,H. (1989). The Dance of Intimacy. New York:Harper and Row.

Kushner,H. (1981). When bad things happen to good people. New York: Schockton Books.

Mariechild,D. (1987). The Inner Dance. Freedom,Cal.:Crossing Press.