ADULT VICTIMS OF CHILDHOOD SEXUAL ABUSE: TREATMENT OF POST-TRAUMATIC STRESS RESPONSES THROUGH RELAXATION IMAGERY

by

ALBERT HAJES

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CHAPTER ONE: INTRODUCTION

1. The Problem Issue

In recent years, clinical observations and research studies of adult clients of health and social service agencies have increasingly shown that many have been subjected to episodes of sexual abuse in their childhood (Finklehor and Browne, 1986; Herman and Russell, 1986; Wolfe, Gentile and Wolfe, 1989). Many of these adult clients are now disclosing these experiences that they have, for many years, kept secret. Through disclosure, and their descriptions, they are revealing that there has been a persisting negative impact from the abuse; and that this has subsequently resulted in years of psychological and social impairment, extending into adult life.

Researchers in the social and behavioural sciences have begun to focus a greater attention on the problem issue. These studies are indicating that the rates of prevalence for childhood sexual abuse are much higher than previously believed, both within the general population; but in particular,

within clinical samples studied. Further, these empirical studies are establishing that victims of childhood sexual abuse manifest an identifiable sequelae of psychological symptoms and patterns of social dysfunction (Lindberg and Distad, 1985; Patten, Gatz, Jones and Thomas, 1989).

Concurrently, clinical practitioners involved with these adult clients have also begun to identify and attend to this important clinical phenomenon. Increasingly, therapists are coming to view this issue as a critical etiological component in the comprehensive assessment, diagnosis and treatment of their clients (Vargo, Stravrakaki, Ellis and Williams, 1988; Sheldon, 1988). As such, direct questioning and the formulation of carefully structured interviews by clinicians is facilitating disclosure by clients; and showing significant rates of prevalence of victimization by childhood sexual abuse among adult clients.

2. Observations in Clinical Practise

The observations and trends being reported in the relevant literature are consistent with my own observations made in recent years at Brandon Mental Health Centre. In our work during the past few years, particularly through the Admission Unit, I and several other Social Work staff became aware of the growing frequency of reports of childhood sexual abuse among Inpatients admitted to the Mental Health Centre. We began to observe also that often, in spite of variable diagnoses, many patients displayed similar clusters of symptoms and patterns

of psychological and social functioning. With the recognition of these clinical similarities and on the basis of our growing experience with clients who had disclosed childhood sexual abuse, we began to suspect that, in spite of the variable diagnoses, many held in common that they had been sexually abused in childhood, but had not made such a disclosure.

With the index of suspicion thus raised, a definitive effort was then made to refine interviewing techniques so that, where abuse was indicated on the basis of clinical features, disclosure was made possible for the client. As with other clinicians and researchers, our direct questioning and structured interviewing began to reveal a significant rate of prevalence for childhood sexual abuse among adult clients at Brandon Mental Health Centre. The practicuum conducted, and described in this report, is then, a natural extension of the interest and clinical work begun on the Admission Unit at the Mental Health Centre several years ago.

3. Objectives of the Practicuum

The practicuum project described in this report was conducted at Brandon Mental Health Centre, and involved a sample of female adult clients who had disclosed victimization by childhood sexual abuse. Typically, these clients were in contact with the Outpatient Department at the Mental Health Centre and presented with a variety of symptoms and complaints. Each had previously disclosed exposure to childhood sexual abuse, and several regularly attended a community based support group operated under the auspices of another social agency.

All clients in the sample continued to complain of significant distress at the time of initial contact and generally expressed symptoms of anxiety, depression and interpersonal problems. These symptoms of distress were viewed through a theoretical framework of Post-traumatic Stress Disorder, a response pattern established as an outcome of the abuse (Wolfe, Gentile and Wolfe, 1989). This post-traumatic stress response had generalized for these clients to the extent that distress was easily evoked by many real or symbolic events and resulted in severe and debilitating symptoms that impaired adequate functioning.

Post-traumatic Stress Disorder is a relatively new diagnostic term, first introduced to the psychiatric nomenclature in 1987 with the publication of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) (APA, 1987). The disorder can present in acute or chronic form and is comprised of specific features of psychological distress in response to a recognizable stressor that is outside of the range of usual human experience. The clinical features of Post-traumatic Stress Disorder (P.T.S.D.) include a persistent re-experiencing of the traumatic event (intrusive phenomena) through distressing recollections, disturbing dreams and nightmares, and intense distress at exposure to similar or symbolic events or situations. As well, P.T.S.D. symptoms include a persistent avoidance of associated stimuli or a numbing of general responsiveness. This is manifested by avoidance of thoughts, feelings, activities

or situations associated with the event; psychogenic amnesia; and a restricted range of affect. Additionally, P.T.S.D. presents with symptoms of increased arousal as indicated by sleep disturbance, angry outbursts, concentration difficulties and an exaggerated startle response (APA, 1987; Patten et al, 1989).

Intervention involved training each of the clients in the use of relaxation imagery with the objective of moderating the severity of the post-traumatic stress response. Baseline (pre-test) data was acquired prior to the use of the intervention, and following a series of sessions training the client in the procedure, additional measures were used to evaluate outcome. Several instruments were used for outcome evaluation and were intended to measure changes in:

a.) global distress levels

b.) specific clinical features

c.) perceived locus of control

d.) perception of the impact of the abusive event

A more detailed description of the client sample; the intervention; the instruments, and the evaluation procedures appears in a later section of this report.

There were several objectives and anticipated benefits in the course of conducting the practicuum, and intervention procedure. In working with clients who have been victimized

by childhood sexual abuse, a primary objective for intervention is the reduction of the general distress that constitutes a significant part of the long-term sequelae. These symptoms are intrusive and often overwhelming to the client and tend to interfere significantly with other aspects of the counselling process. The objectives for the client were

1.) to teach a technique to enable moderation of post-traumatic stress and to reduce global distress levels

2.) to shift perception of locus of control to a greater internal orientation through the application of this technique and amelioration of symptoms

3.) to reduce the reported severity of the impact of the abusive event

For the student, it was expected that the practicuum experience would bring desired development to skill and knowledge in several areas. The practicuum provided an opportunity to review existing literature thoroughly in both the problem area and the choice of intervention; as well as develop the interventive procedure under supervision and with evaluation of outcome. The objectives for the student were:

1.) to develop knowledge of the issue of childhood sexual abuse, and its long term impact by reviewing the relevant literature

2.) to develop skill in the implementation of the specific interventive technique

3.) to develop knowledge and skill in the application of evaluation procedures to clinical practise

Generally, the design of the practicuum was such that aspects of clinical practice, theory and research would be brought together to provide a comprehensive framework for academic and clinical benefit to the student.

CHAPTER TWO: LITERATURE REVIEW

1. Prevalence and Definition of Childhood Sexual Abuse

Childhood sexual abuse, and its long-term effects has received a great deal of attention in recent years with numerous research studies being conducted and published (Briere, 1984; Finklehor, 1979; Herman and Russell, 1986; Lindberg and Distad, 1985; Patten, Gatz, Jones and Thomas, 1989). These studies, together with clinical observations, are identifying childhood sexual abuse as a serious concern as it pertains to the psychological functioning of many adults. The growing recognition and acceptance of long-term effects has created an identifiable sequelae observed by clinicians who work with adult clients; and current research continues to show the importance of childhood sexual abuse as a major contributing factor to impaired psychosocial functioning.

Childhood sexual abuse is generally recognized as consisting of two over-lapping types of interaction (Finklehor, 1986) as follows:

a.) forced, or coerced sexual behaviour imposed on a child

b.) sexual activity between a child and a much older person, whether or not obvious coercion has been involved

Current rates of prevalence in the non-clinical samples certainly seem to be widely varied. These figures are affected by such factors as sampling techniques, sample composition and inclusion criteria, as well as the demographic distribution

of the sample. However, current epidemiological studies are tending to show prevalence rates that range from approximately 3% to 50% of the general population reporting experiences of childhood sexual abuse (Sargent, 1987; Finklehor, 1979; Kilgore, 1988; Vargo, et al; 1988). A recent New Zealand study reported on a sample of 2000 randomly selected female respondants (Mullen et al, 1988). This study found that 13.1% of the subjects interviewed identified themselves as having had some form of sexual abuse as a child (defined as aged 12 years or younger).

The definitive Canadian study recently conducted by the Badgley Commission has shown that one out of two females, and one in three males report experiences of improper sexual contact. Of this sample, 80% reported these experiences to occur during childhood, and the offender was known to the child in 85% of the assaults (Badgley et al, 1984; Vargo et al, 1988). In studies conducted among clinical population samples, rates of prevalence are shown to be much higher. Among psychiatric patients in particular, recent studies have reported rates of 46% to 65% for female inpatients disclosing childhood sexual abuse. (Beck and Vander Kolk, 1987; Carman, Reiker and Mills, 1982; Jacobsen and Richardson, 1987; Sheldon, 1988). A very recent study of a sample of 31 psychiatric outpatients revealed a history of sexual or physical assault in 68% of the cases (Jacobsen, 1989).

Clearly, definitions of childhood sexual abuse can be quite varied and can include many types of specific sexual behaviours. Finklehor offers a five part definition that provides a comprehensive spectrum of sexual abuse, as follows:

1.) intercourse: simulated or attempted intercourse

2.) any instance of genital fondling

3.) any instance of exhibitionistic display of genitals by an older person

4.) any instance of kissing, hugging, or fondling in a sexual manner

5.) overt and frightening sexual overtures to young children

Most research studies have defined the child as being under the age of 18, and in those definitions where criteria include sexual contact with an older person, this is generally taken to mean that the adult is five years, or more, older than the child victimized by the sexual contact.

2. Long-Term Effects of Childhood Sexual Abuse

The prominent long-term effects of childhood sexual abuse are described by Browne and Finklehor in their 1986 review of the research. The most commonly reported feature described by adult survivors is depression. Non-clinical samples show rates ranging from 17% (Badgley and Ramsey, 1985) to 65% in a study conducted by Sedney and Brooks in 1984. Though the incidence of depression varies considerably, both studies report a higher incidence among sexual abuse victims, than with the control group.

Among clinical populations, the reported rate for clinical features of depression is much higher, but the difference between the victimized group and the control group is not as wide spread. Herman (1981) reported a 60% incidence for the victimized group of female inpatients, versus 55% of the control group. In addition, the victimized groups tended to experience more frequent depressive episodes, with more identified depressive features (Briere and Runtz, 1985).

Another commonly experienced long-term effect observed in adult victims of childhood sexual abuse is anxiety and tension. Briere (1984) reported that 54% of his clinical sample experienced anxiety attacks; 54% reported nightmares; and 72% experienced sleep disturbances.

Victims of childhood sexual abuse are also reported to experience disturbances in self-perception and cognition. Badgley and Ramsey (1985) found that 19% of victims scored "very poor" on self-esteem inventories, whereas only 9% demonstrated "very good" levels. Feelings of being branded and stigmatized are prominent among all victims (Patten et al, 1989), and the associated sense of interpersonal alienation was reported to be in the moderate to severe range by 73% of a sample (Courtois, 1979).

Briere (1985) has extensively studied, the presence of suicidal and self-destructive behaviours among victims of childhood sexual abuse, and reported that 51% had a history of suicide attempts. In addition, 31% of victims exhibited a desire to hurt themselves.

Of considerable concern is the tendency of women who have been sexually abused to be re-victimized later in life. Finklehor (1986) cites a study by D. E. Russell (unpublished) that found between 33% and 68% of sexual abuse victims were raped later on, compared with 17% of the control group. In addition to rape, victims of childhood sexual abuse also seem more likely to be abused later by husbands, or other adult partners (Briere, 1984).

An association betwen childhood sexual abuse and later substance abuse has received some empirical support. Peters (1984) found that 17% of victimized women in the sample had symptoms of alcohol abuse, and 27% abused at least one type of drug (Finklehor, 1986).

Victimization by childhood sexual abuse also produces prominent disturbances in interpersonal functioning. Feelings of hostility are often intense, and expressed both to the abuser, and very often to the mother. In many instances, feelings of hostility were generalized to all women, or to all men (Blume, 1986).

Trust in others is also reported to be a serious difficulty among victims. The development of trust is impaired by reactions of fear, suspiciousness, and a sensitivity to feeling betrayed. There is noted to be a higher incidence of difficulty in close relationships and a greater incidence of conflict in these relationships among victims of childhood sexual abuse (Briere, 1984; Finklehor, 1986; Patten et al, 1989).

Studies have also shown childhood sexual abuse to have possible profound effects on later sexual functioning. Promiscuity was noted to be one manifestation of premature sexualization of children who then continue to associate emotional closeness with sexual contact. Prostitution too, has been studied, and these studies have shown approximately 55% of the sample reported childhood sexual abuse (Finklehor, 1986). Another manifestation of the effect on sexuality is decreased sexual satisfaction in adulthood. In a study by Meiselman (1978) incest victims were more sexually anxious; experienced more sexual guilt; and reported greater overall dissatisfaction with sexual contact. A 1985 study by Jehu, Gazan and Klassen reported at least 50% of the victimized clients in their sample complained of some impairment in their sexual functioning.

In summary then, the prominent long-term effects of childhood sexual abuse reported in the relevant literature are:

- depressive features
- anxiety and tension
- poor self-esteem and stigmatization
- suicidal and self-destructive behaviour

- tendency to re-victimization
- substance abuse
- interpersonal hostility
- difficulty in developing trust in relationships
- sexual dysfunction

3. Contributory Factors and Severity of Outcome

Empirical evidence identified by Finklehor (1986) suggests that the greatest trauma occurs from sexual abuse that:

- continues for a longer duration of time and includes multiple events
- occurs with a more closely related person
- involves more explicit sexual contact
- is accompanied by aggression and force

These features are the most prominent of a number that have been identified as contributing to the severity of traumatic outcome for the victim of childhood sexual abuse.

Numerous studies that examine duration, frequency and multiplicity of the abuse overall, tend to show much greater association with negative effects. This is particularly so for those rating outcome as extremely or considerably traumatic (Badgley, 1984; Finklehor, 1986).

In terms of the child's relationship to the offender, empirical findings suggest that sexual abuse by a close relative is more traumatic than abuse by someone outside of the victim's family (Badgley, 1984; Finklehor, 1986).

Studies examining the type of sexual act are quite clear that the more explicit the sexual act, the greater the associated trauma for the victim. Of particular importance, genital penetration was found to be the single most powerful variable explaining severity of psychosocial impairment (Badgley, 1985; Tufts New England Medical Centre, 1984).

Regarding the severity of trauma and the use of force and aggression, most studies are quite clear that victims of sexual abuse that included aggression and force, rate themselves as considerably or extremely more traumatized (Finklehor, 1986; Herman and Russell, 1986).

Studies examining the relationship between age of onset and trauma show little clear relationship between these variables. The tendency is for abuse at a younger age to be most traumatic and severe in terms of outcome; although some authors suggest that middle childhood has shown to be the period with greatest vulnerability (Finklehor, 1986). The Tufts New England Medical Centre Study (1984) emphasized that the developmental stage of growth is likely of greater importance to outcome that the specific chronological age.

The Tufts study (1984) also examined the issue of disclosure and reported that the type of response to disclosure did have some bearing on the severity of trauma. The Tufts study states that when the response to disclosure was one of anger and punishment directed at the child, this resulted in more behavioural disturbances following the abuse. However, the same study failed to show that a positive response to disclosure resulted in better adjustment.

In summary then, the prominent features described (Finklehor and Brown, 1986) that contribute to the severity of the traumatic outcome of childhood sexual abuse are:

- duration, frequency and multiplicity of abuse
- relationship to the offender
- type of sexual act
- use of force and aggression
- age at onset of abuse
- age of perpetrator
- disclosure and response directed at the victim

4. The Psychiatric Context of Childhood Sexual Abuse

The long-term effects of childhood sexual abuse are illustrated most clearly in clinical studies that sample adult psychiatric patients. These studies indicate that childhood physical and sexual abuse is more common among adults who develop major mental illness, than was previously believed (Mullen et al, 1989).

In a recent study involving a sample of 105 female psychiatric hospital patients, 51% were found to have been sexually abused as children or adolescents. Additional findings indicated that in the majority of cases, hospital staff were unaware of their abuse histories; and only 20% of the study sample believed that they had been adequately treated for the effects of sexual abuse (Craine, Henson, Colliver, MacLean, 1988).

Another recent study sampled 66 psychiatric inpatients and reported that 72% of this sample disclosed a history of abuse at some point in their lives; and of these, 21% reported

exposure to sexual abuse only. An additional 33% reported both sexual and physical abuse. Among this latter group, 59% experienced the onset of the abuse prior to age sixteen (Bryer, Nelson, Miller, Krol; 1987).

In a similar study, Beck and Vander Kolk (1987) sampled a group of 26 chronically institutionalized and intractably psychotic patients, and found that 46% reported histories of childhood incest. Studies of psychiatric inpatients have also shown a relationship between childhood sexual abuse and the type and severity of psychiatric disorder. These results strongly suggest that victims of childhood sexual abuse continue to experience longstanding negative consequences from the abuse and the psychiatric manifestations are many (Bryer, et al, 1987; Herman and Russell, 1986; Jacobsen and Richardson, 1987; Sheldon, 1988).

Bryer, Miller, Nelson and Krol, (1987) used several standard psychometric instruments to evaluate the severity of symptoms among psychiatric inpatients. Using the Millon Clinical Multiaxial Inventory (MCMI) and the Symptom Checklist (SCL-90-R) they found that nearly three quarters of their sample reported abuse; and that these abuse victims also demonstrated higher levels of symptom severity than the control group.

Among research subjects who have disclosed sexual abuse in childhood, many have been found to be diagnosed with Borderline Personality Disorder.

This severe personality pattern is characterized by a variety of pervasive features (APA, 1987), that include:

1.) unstable and intense interpersonal relationships,

2.) impulsiveness,

3.) affective instability,

4.) inappropriate and poorly controlled anger,

5.) recurrent suicidal threats, gestures or self-mutilating behaviour,

6.) marked identity disturbance,

7.) chronic feelings of emptiness, and

8.) frantic efforts to avoid real or imagined abandonment.

Bryer, et al (1987) discovered that of fourteen patients with this diagnosis, in his sample, twelve had disclosed early sexual abuse other than incest. Wheeler and Walton (1987) also studied personality disturbances among victims and, similarly found that the Borderline Personality Disorder diagnosis was the most frequent in the sample. Among subjects with a diagnosis of Borderline Personality Disorder it is further reported that these subjects are over three times more likely to have been sexually abused in childhood than any other diagnostic group. (Carman, Reiker, Mill, 1984)

There is also growing evidence of the relationship between childhood sexual abuse and many other specific psychiatric and medical syndromes. Research studies examining Multiple

Personality Disorder (Ross, 1987); Chronic Pelvic Pain (Walker et al, 1988); Anorexia and Bulemia Nervosa (Sloan and Leichner, 1986); and Somatization Disorders (Morrison, 1989), all show increasing evidence of the occurrence of childhood sexual abuse in the childhood histories of these patients.

In terms of diagnosis for patients with evidence of childhood sexual abuse, Lindberg and Distad, (1985) have studied the similarities between the observable clinical features and Post-traumatic Stress Disorder. Their study concludes that Post-traumatic Stress Disorder (PTSD) is the most appropriate diagnosis for this group of patients. They report that the diagnostic criteria for PTSD outlined in the DSM-III-R (APA, 1987) incorporates the many varied clinical features identified as part of the long-term sequelae of childhood sexual abuse. These features include the intrusive phenomena such as distressing dreams, nightmares and recollections; avoidance of stimuli associated with the abusive event, or numbing of responsiveness; as well as a state of increased arousal with associated disturbances of sleep, concentration and physiologic reactivity (APA, 1987). They assert that the diagnosis of Post-traumatic Stress Disorder should be made concominantly with other diagnoses that refer to specific psychosocial features alone such as Major Depressive Episode, Adjustment Disorder, or a diagnosis of personality disorder. Doing so, introduces an etiological explanation

to the diagnosis and demonstrates that the patient has been subjected to a traumatic experience, and suggests that the clinical features are a part of the adjustment sequelae (Patten, et al, 1989; Wolfe, et al, 1989).

Within the psychiatric context of childhood sexual abuse, it is of interest to note that this issue has been previously identified as having etiological importance. Although it is in recent history that much attention has been focused on the issue, it was in 1896 that Freud first published his opinion that many of his patients had been subjected to sexual abuse as children (Freud, 1956). At that time the opinion was received as highly controversial and the subsequent debate ultimately led to rejection of the theory, and the eventual abandonment of the assertion by Freud (Masson, 1984).

Now some ninety years later, the issue is emerging again with growing evidence of the relationship between childhood sexual abuse and psychosocial disturbance, and in spite of some resistance, the issue appears to be increasingly incorporated into established psychiatric theory and practice.

In their review of the research on the impact of childhood sexual abuse, Browne and Finklehor (1986) conclude their discussion with several cautionary statements. They note that much of the research is still very much in its infancy and that most of the studies conducted would benefit from some basic methodological improvements. Concern has been expressed over biased sampling techniques that may distort the pathology most victims experience

as a result of the abuse. Samples have often been taken from those who have already disclosed sexual abuse and sought treatment. This may well over-represent the most serious of cases and the most seriously affected victims. Sampling procedures that attempt to use the general population, whole communities or other natural collectivities (such as school) would be favored.

Some studies have also been identified as failing to have used control groups, or comparison groups of any sort. Such a control is obviously important, even if it is only a group of other persons in treatment who were not sexually victimized. Some concern has also been raised regarding instrument use and the measurement of outcome variables. Many studies are reported by Browne and Finklehor (1986) to have used fairly subjective measures for the reporting of effects of abuse, and they emphasize the importance of using objective instruments to test for the specific and divuse sequelae that have been associated with childhood sexual abuse.

An additional source of concern is the readily accepted inference of a cause and effect relationship between childhood sexual abuse and traumatic outcome. Clearly, post-traumatic adjustment is a complicated matter and its course can be influenced by many diverse factors. Some of the effects of sexual abuse may be due to pre-morbid conditions such as family conflict or emotional neglect. It is also certainly not clear to what degree the characteristics of the individual contribute to

a vulnerability for the development of a traumatic outcome to sexual abuse. In addition to these contributory factors, the whole issue of buffering factors, such as social support, has yet to be significantly studied for its effect on moderating traumatic outcome. This leads then to the larger question of interaction effects between contributory and buffering variables and the degree to which the course of trauma recovery is shaped by their presence and interaction.

The studies reported in the literature tend to start with the assumption of a rather linear cause-effect relationship and have yet to explore the role of such important variables as characteristics of the individual (such as coping style), pre-morbid characteristics (such as genetic predisposition) and characteristics of the recovery environment (such as social support). Use of a conceptual framework that incorporates the interactional effects of these many variables will ultimately lead to a comprehensive understanding of the effects of childhood sexual abuse.

5. Locus of Control and Childhood Sexual Abuse

Locus of control, or Internal-External (IE) expectancies, first emerged from the social learning theories developed by Rotter (1954). This theory contends that locus of control represents the subjective perception that reinforcement is contingent on one's own behaviour; and the generalized expectancy that events are related to the individual's belief about locus of control (Lefcourt, 1976).

It infers that behaviour is a function of expectancy and reinforcement value (Strickland, 1989). Though early theorizing appears to have regarded IE expectancies as being a relatively neutral and value-free concept, its later clinical applications and findings began to ascribe some new meaning. Rotter hypothesized that people who view reinforcements as being contingent on their own behaviour (intervals) are better adjusted than those who see reinforcements as being determined by fate, chance or powerful others - externals (Levenson, 1973). Subsequent studies of IE expectancies in relation to health, tends to support this hypothesis (Strickland, 1989); and as a result a strong internal orientation has come to be associated with attributes of efficacy, empowerment, competance, and mastery over one's environment (Warehime and Foulds, 1971).

The issue of locus of control is of particular interest to this practicuum because of its relationship to the clients perception that events are, or are not, contingent on their own behaviour. Adults who have experienced childhood sexual abuse often display features of a "learned helplessness" that Seligman (1975) has described as a perception of non-contingency that leads an individual to believe that he or she has no means of escape or relief from an aversive situation.

Among victims of childhood sexual abuse, a significant aspect of the long-term sequelae is a pervasive sense of powerlessness

(Patten, et al, 1989). Successful treatment with adult victims, generally requires a cognitive shift in the perception of powerlessness that Carmen (1984) describes as the - "victim to patient process". Pinderhughes (1983) in describing the same perceptual shift, talks of the importance of the client in treatment developing a sense of empowerment.

Vargo (1989) associates this sense of powerlessness with the betrayal of trust inherent in the abuse. At a time when developmental issues such as efficacy, self-mastery, and control are particularly prominent, the abused child is overcome by the power of the adult perpetrator. Because of this dependency on powerful others, the child is particularly vulnerable to this exploitation and betrayal of trust; and particularly vulnerable to the development of a sense of powerlessness. Attributional theory holds that such negative life events are ascribed to an external source (Wolfe, 1989), and the victim thus, further develops the belief that power and control over the victimization and its impact is located outside of their own sphere of influence.

As such, locus of control is regarded as an important consideration in the treatment of these adults victimized by childhood sexual abuse. From observations in clinical practise, it is thought that many of these clients approach their symptoms of distress with the same external orientation and sense of powerlessness. Relief from the distress is seen

as being outside of themselves, and not contingent on their own behaviour. Such relief is usually sought externally, through counselling, or through medical contact. This process, again, reinforces the perception that, in relation to symptoms of distress, control is external. Adjustment to this chronic stress, and the perception of its severity depends very much on the belief about control, in the sense that, when the stress is perceived to be uncontrollable, its effect is much more deleterious than when there is a perception of control. (Briere, 1988)

The intervention applied in this practicuum has aimed to train clients in the use of a procedure that allowed them to assert power and control over their symptoms of distress. Though relief from the distressing symptoms was the primary objective, the secondary objective was that, in recognizing that the use of the procedure is able to ameliorate symptom distress, this will lead to a perceptual shift towards greater internal locus of control and subsequent greater control over their own lives.

6. Overview of Relaxation Imagery

The choice of intervention used in this practicuum project was determined to a greater extent by necessity than by preference. Having worked in counselling adults victimized by childhood sexual abuse for several years prior to the initiation of this project, gave some familiarity with the difficulties usually encountered in providing treatment for these clients.

Typically, clients are highly anxious in the interview setting and sometimes difficult to engage because of their stressed affective state; generalized mistrust, and periodic intrusive effects of abusive memories. Clearly, the act of counselling itself serves as a source of significant distress for the client in that the interview directs a focus of attention on the past abuses and all of its associated difficulties. This counselling process tends then to inhibit the clients use of avoidance as a strategy for coping with the distressing effects, and renders them more vulnerable to the distressing intrusive symptoms.

In the course of counselling these clients, it became necessary to develop a means by which some of these Post-traumatic hyperactivity symptoms could be brought under control, at least to the extent that these symptoms would not intrude on the clients ability to engage and respond to counselling efforts. This state of necessity then led to the use of a relaxation procedure whereby the client might learn to moderate distress; experience some symptomatic relief; and become more responsive to other aspects of the counselling process as well.

The practicuum project provided an opportunity to implement this interventive procedure with these clients. Though I had used the procedure, to some degree, in practise, previous to this project, it was done without suitable structure, review or evaluation.

The interventive procedure used with clients in this practicuum is a technique that has developed from several of the cognitive - behavioural variations of relaxation training. Clients were provided with training, over several sessions, in the method and application of a relaxation imagery technique with which they might learn to control and moderate many of the symptoms of distress associated with the abuse victimization.

Since relaxation training was first developed and popularized by Jacobson (1938) as a psychotherapeutic treatment, many modified versions of this procedure have evolved over the years; and have been applied to a broad range of clinical conditions (Hillenberg and Collins, 1982; Lehrer, 1982). Jacobson developed a procedure for training the client in a relaxation response by employing a muscle tense - release cycle and he applied this technique primarily to the treatment of psychosomatic conditions (Lehrer, 1982). The demonstrated effectiveness of this procedure served as a foundation for the development of other similar, or modified procedures; and was quickly adopted by practitioners with a behavioural orientation (Hillenburg and Collins, 1982). Among some such practitioners, relaxation training became such a consistent component of treatment, and so synonymous with behaviour therapy, as to be labeled the "behavioral aspirin" (Hillenburg, et al, 1982).

In his earlier work, Joseph Wolpe (1958) utilized the training of a relaxation response in the treatment of patients with phobias, and from this work developed a procedure known as systematic desensitization. In later years, Wolpe shifted his emphasis on the use of the muscle tense - release procedure, to one utilizing imagery instead (Wolpe, et al, 1964). In this procedure, clients were instructed in the use of imagined scenes that could evoke a relaxation response, or stimulate responses of fear and anxiety for which they had sought treatment. He used imagery in this fashion to inhibit what he regarded as conditioned responses of fear and anxiety. Wolpe based this procedure on the theoretical assumption that a fear response and a relaxation response could not co-exist in relation to the same stimulus; and he termed this procedure Reciprocol Inhibition.

Later work that utilized imagery to treat psychological and emotional distress has resulted in many modified forms, especially when blended with techniques of Transcendental and Zen meditation, Yoga, biofeedback and hypnosis (Jarvinson and Gold, 1981; Lazarus, 1982; Throll, 1982). Hillenburg and Collins (1982) surveyed twelve major publications on Relaxation Training Research and found 26 distinct approaches reported in the literature. In their analysis they found a relationship between the number of sessions used and the effectiveness of relaxation procedures. Studies have demonstrated effectiveness

in procedures employing four or more sessions. Most studies have demonstrated live sessions to be of greater effectiveness than taped instruction although many reports have shown methodological problems in relation to measurement of dependant variables. Successful training in relaxation procedures is clearly quite contingent on utilization of home practise and most authors agree that it is critical for the client to practise this skill, every day, twice a day, for periods of 15 - 20 minutes each time. (Bernstein and Borkovec, 1973).

Borrowing from the procedures employed by such notable therapists as Beck (1970), Horowitz (1970) and Lazarus (1984), the intervention used in this practicuum applies imagery and relaxation in a procedure intended to facilitate effective and efficient relief from distress for these adult clients victimized by childhood sexual abuse.

CHAPTER THREE: INTERVENTION

1. Overview

As has been described earlier in this report, the intervention used constitutes a series of training sessions in the use of relaxation imagery. Training in this technique is for a sample of female adult clients who have disclosed victimization by childhood sexual abuse. Its application is intended to provide a means by which the clients are able to moderate their significant levels of post-traumatic distress, typically associated with the long term impact of sexual abuse.

The primary objective of the series was to see a significant reduction in severity of both global and specifically measured levels of the distress. Additionally, by utilizing such a technique whereby the clients themselves would alleviate distress, it was expected that this would contribute to a shift in the perception of locus of control. In the acquisition of such a relaxation skill it was anticipated that clients would experience improvement in their sense of self-mastery and efficacy, leading to a change in perception of control of their symptoms. Finally, it was expected that as symptoms were successfully moderated and greater levels of control established, the perception of the long term impact of the abuse would be reduced.

2. Clients

The clients included in the practicuum project were recruited

from several sources. Several were already known and were attending counselling at the Outpatient Department at Brandon Mental Health Centre. They were regarded as potentially suitable participants because of their previous disclosure of childhood sexual abuse, and they were approached to be included in the project. None of these clients had received previous training in relaxation techniques and each had previously disclosed a history of childhood sexual abuse for which they had sought counselling.

Additional clients were recruited from a local support group operated in conjunction with another social service agency. The AMAC group (Adults Molested as Children) meets weekly and is intended to provide education, support and problem solving for its members, who are all victims of childhood sexual abuse. None of these clients were receiving counselling elsewhere, with the exception of one client who was also affilitated with the Outpatient Department at Brandon Mental Health Centre.

Initially, nine clients were contacted for possible participation in the project. Two from the AMAC group were unable to participate because of scheduling problems. One client from the AMAC group who initially expressed a strong interest, later became very ambivalent. After some discussion it was learned that she had received previous training in relaxation procedures that she had regarded as unsuccessful. As a result she was felt to be not suitable for the project and, by mutual agreement,

she was excluded from the sample. Each of the remaining six respondants was able to be included, and did participate in the project. Two of this sample, however, did not complete the training and evaluation, and withdrew at different stages.

One of these clients presented for an initial interview at which time demographic and baseline data was acquired. Plans for the subsequent session were discussed at that time, however she failed to attend that, and another rescheduled appointment, and no further contact was made. The second client who failed to complete the procedure, attended for several sessions before having to withdraw from the project. Pre-test and demographic data were obtained, and training in relaxation imagery was underway. However, following the first session in this training the client's alcoholic husband resumed drinking and became physically abusive. Progress data taken at that time showed her affective state to be extremely poor. Anxiety and depression became elevated to top percentiles and suicidal ideation had developed. She was then withdrawn from the project and managed with crisis intervention procedures. Of the remaining four clients, all were able to proceed with the training and complete evaluation data was obtained.

In order to participate in the project, each client was required to meet certain specific inclusion criteria that were reviewed at the time of initial contact, using a previously prepared referral form. Inclusion criteria restricted participation

to female adult clients who had previously disclosed a history of childhood sexual abuse. It was required that the client be an outpatient, and no hospitalized clients were considered for the project. Exclusion criteria included primarily features pertaining to the clients affective and mental state. If it was anticipated, on the basis of informed consent and initial assessment, that participation in the project would unnecessarily place the client at risk for decompensation of their mental state, or significant deterioration of affect then the client would be considered for exclusion. Similarly, if it was assessed that there was evidence of risk that participation might precipitate parasuicide gesture or alcohol and substance abuse the client would also be considered for exclusion.

3. Setting and Personnel

The practicuum project was carried out at the Outpatient Department of Brandon Mental Health Centre, and all sessions were conducted in those offices. This agency is a mental health clinic that provides aftercare service for discharged psychiatric patients, as well as general counselling services and community mental health program services to the city of Brandon.

All of the client contact, all sessions, all file recording, and all scoring of data, were completed by the student and no other personnel were directly involved in the project. A file was maintained for each client that contained all the

pertinent data; and these files were stored in a locked filing cabinet in the student's office. Any other written information not required for this report was shredded by the student at the Outpatient Department.

The practicuum project was supervised in Brandon, through weekly meetings, by Dr. Ron Richert, Associate Professor of Psychology affiliated with Brandon University, and a member of the practicuum committee.

4. Procedures

The design of the practicuum intervention and evaluation followed a single system design, changing intensity program, and it utilized an additive - progressive interventive format ($A - B^1 - A - B^2 - A$), also known as a changing program design. (Bloom and Fischer, 1982)

In terms of procedure, the initial requirements of the process were to screen the client for inclusion at the time of first contact. At this time as well, clients were given some information about the project and what they might expect. This initial contact was usually by telephone, and did provide an opportunity for the clients to withdraw easily, after hearing some initial remarks. Following this contact, a first session was arranged and the client was more thoroughly introduced to the project. At the time of the first interview the clients were given a detailed explanation of the procedures; purposes of the project; uses of the data; expectations, risks and

possible difficulties; and protection of confidentiality and anonymity. This informed consent was discussed and the clients were given a further opportunity to withdraw from participation. Consent forms (see Appendix A) were then signed by the client, and placed on the file.

As part of the opening stages of the session some consideration was also given to the client's presentation of mental status and affective state, in order to further evaluate risk factors. Clients were questioned specifically about aspects of their current psychosocial functioning to determine if any high risk factors, that might warrant exclusion, were indeed present.

When consideration of the referring information and informed consent was completed, a prepared data package was then administered in order to obtain demographic and pre-test (baseline) data. The data form for demographic information (see Appendix B) also included pertinent information regarding the exposure to sexual abuse. All information was obtained by the student in an initial interview with the client, and entered onto the data form by the student.

Instruments were then administered following brief instruction for each, and completed by the client during the session. The instruments and their application are described in more detail in a later section of this report.

The interventive procedure itself was divided into two stages and spread over several sessions depending on client

response to the procedure. The first phase utilized visualization and imagery as the primary means for teaching the client to induce a state of relaxation. The sessions were audio taped in order for clients to practise outside of the live sessions. Training and evaluation with each client was conducted over a minimum of four sessions, and each session was 1 1/2 to 2 hours in length. Some clients required additional sessions in order to satisfactorily complete the project. The sessions, and related activities, were planned to follow the schedule below:

1.) Session one:

- assessment
- informed consent
- baseline data

2.) Session two:

- training in relaxation response
- home practice

3.) Session three:

- progress data
- application of relaxation response
- home practice

4.) Session four:

- outcome data
- follow up and review

Overall, implementation of the interventive process with these clients was conducted over an approximate period of ten weeks.

Initially the clients were given a brief introduction to the technique with explanations as to purpose and intent.

It was then reinforced firmly that the client remains in control throughout the procedure and the client, not the therapist, would bring about a state of relaxation. An opportunity was given then for questions and clarification of concerns.

To begin the procedure, clients were asked to sit comfortably in the chair in such a way that no part of the body was strained to provide support or maintain body position. The client was given some instruction in deep breathing and asked to concentrate on the sense of relaxation as they exhaled. It was suggested that as the breathing exercise continued, the client close their eyes when comfortable to do so.

When the client was adequately settled, they were then asked to concentrate on a specific image and visualize a very thin layer of wax covering their body. Concentration was focused on the top of the head and the client was asked to visualize the wax melting as concentration was focused on specific areas. Further suggestion was made that as the wax melts and flows downward, a warming sensation results and produces muscular relaxation. The image was focused, beginning on the top of the head, and progressively moved over the body through all of the major muscle groups, until the entire body has been focused upon. This procedure generally follows the Jacobson progressive relaxation technique, but uses visualization and imagery to develop muscular relaxation rather than the muscle tense - release cycle.

When this portion was completed the state of relaxation was deepened by further use of imagery. The client was asked to imagine herself in a very pleasant setting. The scenario described was that of a small tropical island, and clients were asked to visualize themselves in the setting. Visual attention was directed to all aspects of the scene and an attempt was made to incorporate as many sensory experiences into the image as possible. These included the sensation of lying on a warm sandy beach, a description of colours, and the sound of waves rolling onto the shore line. When the client had constructed the full image, they were asked to attend to the resulting calming and quieting effect on their mental and emotional state.

In the next portion, clients were asked to remain in their relaxed state and then visualize a chalk board in front of them. They were asked to visually print the word "QUIET" on the board and as they did to concentrate on the sense of relaxation present. The word was then visually erased and printed again and this image repeated several times. The intention was to develop a strong association between the state of relaxation and the visual image of the word - "QUIET". This word would then serve as a cue that, after sufficient practise, would induce a relaxation response when visualized.

On completion of this portion, clients were asked to again visualize the island scene and again concentrate on

the relaxation briefly. They were then asked to return to a wakeful state following a count of five numbers.

On waking the procedure was reviewed with the client and an assessment of their orientation, mental state, and possible adverse effects, was carried out.

The client was then given the audio tape and a practise log sheet with instructions on home practise. Clients were asked to practise the procedure with the audio tape twice daily. On the log sheet they were asked to assign a numerical value on a scale (0 - 5) rating the degree of relaxation response, relative to the live session. They were also asked to record date and time of practise and to record any observations and comments. The log sheets were utilized primarily as a means of trying to enhance practise compliance, and a numerical weighting of response was necessary to report the subjective effectiveness of the relaxation response. Clients were required to practise the procedure until they had achieved, at least, as good a response as in the live session.

The second stage of the training involved the introduction of an additional image, and the actual application of the relaxation response to control symptoms of distress.

In the following session, after the client had achieved an acceptable level of relaxation response, a discussion was held regarding the client's distress response when specific stimuli occur. Each client was asked to note and describe

early sensations of distress and to identify where in the body these were first noticed. They were then asked to choose a scenario that was typically stress provoking to them, that would be visualized in the session.

The client was then asked to sketch a picture on paper of a simple thermometer and to mark and label gradients along the shaft. The bottom level was assigned a value of thirty, and a value of eighty was assigned near the top; and these served as reference points used later in the image formulation. Sketching the image prior to use was intended to help formulate the image during visualization.

The client was then asked to proceed with the relaxation technique as it had been learned, and to bring about a good state of relaxation. When this was established, the client was then asked to visualize the image of the thermometer as it was sketched previously. It was then suggested that the level of mercury visualized at the low end (thirty) corresponded to the internal state of relaxation. Clients were asked to concentrate on the deep relaxation and associate this state with the image of the thermometer with its level at the thirty gradient.

Following this the client was then asked to begin forming the distress provoking image (or sequence of images) and to note the onset of distressing sensations. This image or scenario was the one chosen by the client previously that was intended

to provoke distress; but was not an abuse memory. Usually the scenario chosen by clients was constructed around interpersonal conflict or another problem behaviour that was known to evoke strong responses.

When the client visualized the aversive image and distress began to develop, they were asked to note specific features such as muscular tension and increased respiration; and then to visualize a corresponding rise in the level of the thermometer image as the intensity of the distress increased. When distress reached a maximum level that was tolerable to the client they were asked to visualize the thermometer level at the top mark of eighty. This served as a cut off point, and the client was then requested to reduce the level in the thermometer, either visually or with the assistance of the relaxation cue (QUIET). As the level dropped and the distress diminished it was suggested to the client that signs of relaxation returned and they were asked to visualize the level returning to the thirty mark, at which time full relaxation was restored.

Following the application of this relaxation response the client was asked to return to the image of the island and to continue concentration on the relaxed state. The usual procedures for waking were then followed.

Discussion then followed and the client was instructed to continue practise outside of the sessions. They were also encouraged to apply the relaxation response to any other stress

provoking events and to continue strengthening the relaxation response. For additional details of the relaxation procedure, see Appendix G.

The use of this imagery and visualization process was intended not only to provide a means of achieving a relaxation response; but, by constructing the image and associating it with states of distress the client also came to attend, with greater sensitivity, to situational stressors and was able to guage the level of internal distress felt. When utilized regularly so that responses were conditioned and generalized the client was able to use the visualization and image formation quickly and effectively to prevent high levels of distress from developing.

Following completion of this procedure, post-test data was obtained by administering the same instruments as completed previously by the clients.

Again, with each client, following the second stage of the training, discussion was held with the client to review the procedure, and to emphasize the clients' ability to manage their own symptoms of distress.

When all of the post-test data was received and scored, clients were seen for a final session to conduct a review. They were given a verbal summary of the data and its interpretation, and shown a bar graph representation of the scores. Clients were asked for their observations of the procedures and asked to comment on changes or concerns.

5. Recording of Data and Instrument Use

At the time of the first interview with the client, a previously prepared file was opened to record and store all pertinent clinical and evaluation information. In order to protect confidentiality each file, as well as data packages, was assigned a specific code number to identify the client. As well, only the client's first name was used on any of the written material, with the exception of the Informed Consent form.

The following documentation was maintained in each client file:

1.) informed consent (see Appendix A)
2.) clinical case summary
3.) session notes
4.) demographic information (see Appendix B)
5.) evaluation instruments
6.) data summary sheet (see Appendix F)

Session notes were maintained on a regular basis, and completed following each contact with the client. The content of these notes was intended to reflect an overview of the client functioning and focused on client presentation in interview, response to session, and brief assessment on session completion. Use of these session notes maintained a record of observation about the client, and enabled ongoing assessment and monitoring of the client's psychosocial functioning. In accordance with usual recording practises, these session notes were maintained for clinical and legal purposes, and stored on the client's file.

Throughout the course of the intervention procedure, each client was also asked to keep a record of their practise sessions, using a prescribed form. The primary purpose in requiring a client log was as a means to try and improve practise compliance. It was felt that this log would add a measure of accountability from one live session to the next and might result in improved attention to the practise schedule. A second function of the practise log was for the client to assign a numerical rating to the degree of relaxation response following each practise. This subjective rating was necessary to evaluate if the client was responding to the procedure, and whether additional practise was required before proceeding to successive phases of the process. In addition clients were asked to record any observations or comments pertaining to each practise session for use in the overall evaluation.

The objective measurement of the intervention utilized several instruments. Each instrument was intended to specifically address one of the three stated outcome objectives. As identified in chapter one of this report, the practicuum intervention addressed the following objectives for each client:

1.) to reduce psychosocial distress
2.) to shift perception of locus of control
3.) to moderate the subjective severity of the impact of the abusive event

In order to measure changes in global distress, and along a variety of specific clinical dimensions, the Symptom Checklist - 90 - R (SCL-90-R) was used (Derogatis, 1977). This well

established psychometric test uses a 90 item symptom checklist with a five point Likert scale rating for each item. Validity and reliability have been described as excellent for this instrument and it is reported to be sensitive to change.

SCL-90-R results were initially computer scored using non-clinical norms, and conversion of scores to outpatient norms was done manually using tables provided in the scoring manual. Scoring of the SCL-90-R data provides for the conversion of raw data to T-scores on nine clinical subscales that make up the instrument. These clinical sub-scales include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism, to provide a comprehensive view of the client's psychosocial functioning. In addition, scoring provides three global measures that include the general severity index, the positive symptom total, and positive symptom distress index. Visual analysis of the scores is accomplished by plotting T-scores on a provided SCL-90-R graph. T-scores in excess of 50 are considered to be clinically significant, and plotting of the scores also provides percentile rankings in relation to normative data.

For each of the clients involved in the project, the SCL-90-R was completed on, at least, three occasions to obtain baseline (pre-test), progress and post-test data.

A second stated objective of the intervention was to shift the clients perception of locus of control to a greater internal orientation. To measure locus of control, clients completed the Multidimensional Locus of Control Scale (Levenson, 1973). This instrument measures perception of locus of control and empowerment using 24 items with a six point Likert scale. Scoring provides assessment of locus of control along dimensions of internal locus of control; control by powerful others; and chance control. Normative data is available for psychiatric patients and non-clinical populations. Scoring for the Multidimensional Locus of Control Scale is based on norms for psychiatric inpatients, and data is presented for the three sub-scales that make up the instrument. Normative measures for Internal Control (ILC) is 35.4; for Powerful Others Control (POC) is 23.8; and for Chance Control (CC) is 21.7. Higher scores on each of the sub-scales reflect greater levels of externality (Corcoran and Fischer, 1987). Clients were administered this instrument to obtain baseline and post-test data.

In accordance with a conceptual framework of post-traumatic stress disorder, another objective of the intervention was to moderate the subjective perception of the impact of the abusive events. To measure this perception, each client completed the Impact of Events Scale (Horowitz, 1979). This instrument uses a four point Likert scale for each item to measure the subjective severity of the traumatic events. The scale was developed out of the author's work (Horowitz, 1979) in the

area of post-traumatic stress disorder and reflects a two-dimensional model, measuring intrusive and avoidance clinical features common to this syndrome.

It is reported to be a reliable measure for acute and chronic post-traumatic responses to a wide range of traumatic life events. The Impact of Events Scale was scored using normative data for psychiatric outpatients. The normative score for the Intrusive sub-scale is 21.02 and for the Avoidance sub-scale, 20.8. Higher scores are suggestive of greater post-traumatic impact severity (Corcoran and Fischer, 1987). This instrument was administered to each client for pre-test and post-test data.

The three instruments used to measure intervention outcome were selected in order to correspond to the specific objectives identified for the client. Samples of these instruments are included in the appendix section of this report.

CHAPTER FOUR: EVALUATION

1. Evaluation Criteria

In terms of evaluation, it may be useful to begin by restating the objectives for the client. Primarily, the intervention implemented with this group of clients was intended to provide a means by which an improvement in psychosocial distress might be achieved. Further, the intervention was intended to result in a reduction in the perceived impact of the traumatic events, as well as to shift the clients locus of control in relation to the symptoms of distress.

In considering whether an intervention program achieves its objectives, evaluation addresses fundamental issues of effort, effectiveness, and efficiency. These three criteria constitute the foundation of outcome evaluation.

Evaluation of this practicuum intervention will be guided by visual inspection of the data. Multiple dependent variables were measured with several instruments and constitute an overall statement about the global distress of client and changes to the levels of reported severity. The significance and meaning of the intervention outcome is evaluated in terms of differences in the measurable levels of these dependent variables between the baseline and the interventive phases. The comparison of these baseline scores and post-intervention scores provides a measure of the statistical significance of the intervention (Bloom and Fischer, 1982). Practical

significance of the intervention refers to changes in the dependent variables in comparison to prevailing and acceptable normative data (Bloom and Fischer, 1982). In this practicuum project, each instrument used has well established normative data available, and comparison of client scores to this data provides an evaluation of the practical significance.

Scores obtained from all instruments were initially recorded on a data summary sheet and then transferred to tables and graphs for purposes of visual inspection. The charting of the data illustrates scores for the baseline and post-intervention phases. Plotting of the data in such a way allows for simple visual inspection of differences in the measured levels of the dependent variables, and easy comparisons between baseline and post-interventive measures. The degree of difference, or discontinuity, in these scores is then used to evaluate the effectiveness of the intervention for the client.

2. Intervention Results

A. Demographic Profile:

The client sample (N - 4) that completed the intervention program were recruited from an existing outpatient caseload and from a local support group for adult victims of childhood sexual abuse. All met the inclusion criteria described earlier in this report and expressed a strong interest in participating. All clients were female and the group had a mean age of 29.25 years. One client was married, two were single and one was

previously married and now separated for several years. Three of the clients had children, all in their own care and custody. All clients were Canadian born and had a mixed European ethnic background (English, German, French). In terms of education, all had completed high school and one had attended one year of university in a general arts program. Three were unemployed and one described herself as a student and homemaker. The three unemployed clients were supported financially by Provincial Welfare and the fourth was supported by her husband's employment income.

Two of the clients had received previous outpatient counselling and both of these had previous admissions to a mental health facility as well. The other two clients had no previous admissions or outpatient counselling other than their contact with the support group.

In terms of the background of childhood sexual abuse, the mean age of onset for the sample was 6.75 years of age; and the mean duration of the abusive period was 9.25 years. All reported multiple occurrences of sexual abuse and, with the exception of one client, all were abused by more than one offender during the period. Perpetrators of abuse were reported to be older brothers, brother's friends, step-father, family boarders, and a high school teacher. Three of the four clients were subjected to force and physical assault as part of the abuse and the fourth was coerced by threats of assault. All had experienced multiple forms of sexual abuse including sexual intercourse.

In all cases, the abuse was not disclosed during the abusive period and all eventually disclosed the occurrences after the abuse had ceased. Two of the clients did not disclose the abuse until adulthood (ages 28 and 29) and did so to a non-family member. They received supportive responses. Two of the clients made disclosure during adolescence (ages 15 and 19), both to family members, and received responses of disbelief and disinterest.

Clients reported several different means by which the abuse was terminated. One client relocated; one client was able to assert herself to stop the offender; one client's family broke up and relocated; and one client was unable to recall how the abuse stopped.

B. Client #1 profile:

This client is a 28 year old woman who had volunteered to participate in the project, from the local support group (AMAC). She is married, has two young children, and also attends university.

Initial assessment indicated that she was easily engaged on interview and responsive to questions. She complained of long-standing difficulties with anxiety and tension, provoked especially by interpersonal situations. She expressed feelings of hostility, mistrust and social isolation.

Her abuse history began at age 8 when she was sexually assaulted by her older brother. Later abuse included incestuous contact with her father for a period of 6 years; and repeated sexual assault by a High School teacher over the course of one school term during her adolescence.

Inspite of her reported problems in interpersonal situations she was able to respond quite well to the intervention sessions. She was compliant with practice instructions and reported a favorable response to the relaxation imagery training.

Evaluation of the data for the SCL-90-R (Table 1-A) indicate a reduction of reported symptom severity across all sub-scales with a range from 14.8% (Hostility) to 37.7% (Positive Symptom Distress Index). Data obtained from the Impact of Events Scale (Table 1-B) indicates a reduction of 15.8% on the Intrusive sub-scale and 11.1% on the Avoidance sub-scale. The findings of the Multidimensional Locus of Control Scale (Table 1-C) indicate an increase in internal control (ILC) of 17.6%; an increase in powerful others control (POC) of 40.7%; and a decrease in chance control of 10.7%.

The data for Client #1 is shown in the following group of tables and graphs.

TABLE 1 - A

Client #1

TABLE OF SCORES FOR SCL-90-R

	PRE-TEST	POST-TEST #1	POST-TEST #2	DIFFERENCE (%)
SOMATIZATION	61	41	41	-32.8
OBSESSIVE-COMPULSIVE	53	40	40	-32.5
INTERPERSONAL SENSITIVITY	65	49	50	-23.1
DEPRESSION	49	34	38	-22.4
ANXIETY	51	39	39	-23.5
HOSTILITY	54	39	47	-14.8
PHOBIC ANXIETY	47	35	35	-25.5
PARANOIA	51	48	42	-17.6
PSYCHOTICISM	57	41	48	-15.8
GSI	56	38	38	-32.1
PSDI	61	36	38	-37.7
PST	51	39	39	-23.5

COMPARISON OF SCL-90-R SCORES WITH
PERCENTAGE CHANGE BETWEEN
PRE-TEST AND POST-INTERVENTION SCORES

TABLE 1 - B

Client #1

TABLE OF IMPACT OF EVENTS SCORES

	Pre-test	Post-test	Differ.(%)
Intrusive	19	16	-15.8
Avoidance	18	16	-11.1
Total	37	32	-13.5

Comparison of Impact of Events Scores
(Intrusive and Avoidance Sub-scales)
with percentage difference between
pre-test and post-intervention scores

TABLE 1 - C

Client #1

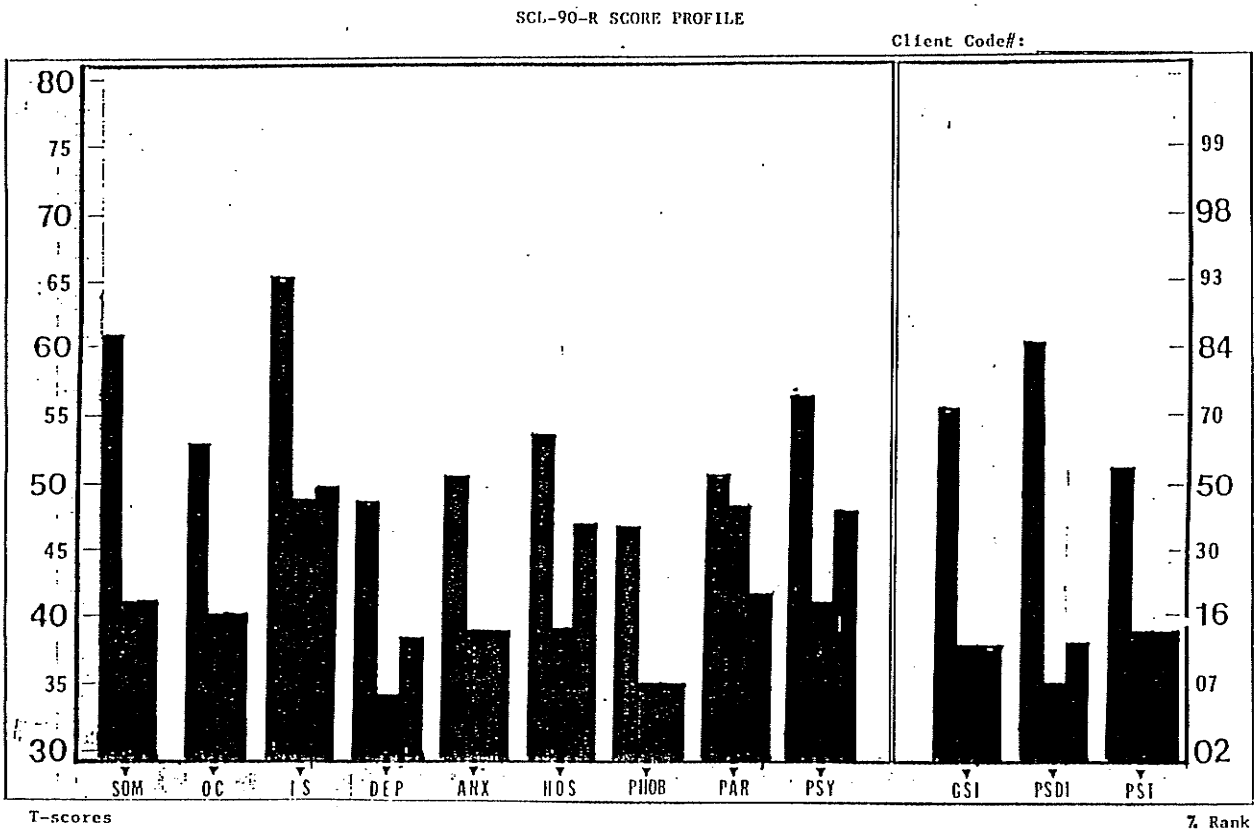
TABLE OF MULTIDIMENSIONAL LOCUS OF CONTROL SCORES

	Pre-test	Post-test	Differ.(%)
ILC	17	20	+17.6
POC	27	38	+40.7
CC	28	25	-10.7
Total	72	83	+15.3

Comparison of Locus of Control Scores
(Internal, Powerful Others, and)
(Chance Control Sub-scales)
with percentage difference between
pre-test and post-intervention scores

FIGURE 1 - A

Client #1

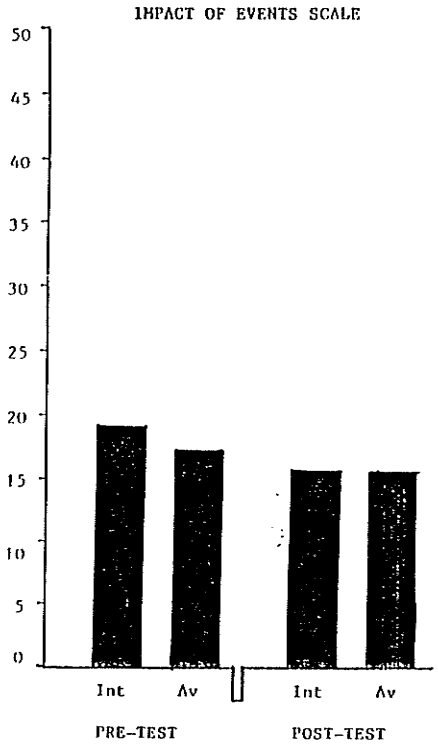


COMPARISON OF BASELINE AND
POST-INTERVENTION SCORES

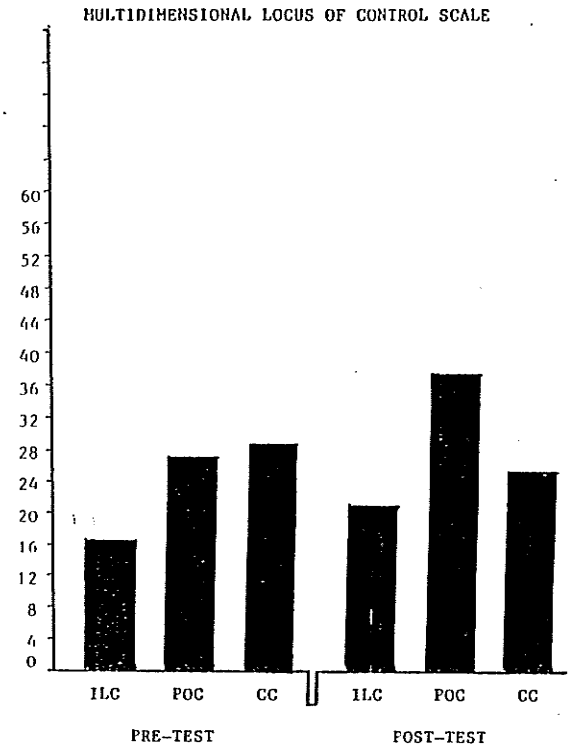
FIGURE 1 - B

FIGURE 1 - C

Client #1



Comparison of Impact of Event Scores
(Intrusive and Avoidance Sub-scales)



Comparison of Locus of Control Scores
(Internal, Powerful Others and)
(Chance Control Sub-scales)

C. Client #2 profile:

Client #2 is a 30 year old woman, self-referred to the project from the local support group. She is the mother of two children (ages 2 and 11), has never been married, and currently is living alone with her children. She was not employed but attended an adult work skills upgrading program.

Initial assessment indicated some difficulty with engagement as she presented with reservation and caution. She was initially quite tense and anxious but was able to settle without difficulty. She complained of ongoing problems with mood lability, anxiety and tension; and periodic depressive episodes.

The onset of her victimization by sexual abuse began at age 6 when she was first assaulted by her stepfather. The sexual assault occurred repeatedly over a lengthy duration, until age 17.

Though she exhibited periodic tension and nervousness in sessions, she was able to involve herself quite well in the sessions. She was compliant to practise instructions and she reported a good response to the relaxation imagery training.

Evaluation of the data for the SCL-90-R (Table 2-A) indicates a reduction of reported symptoms severity on all sub-scales with a range of 7.5% (Interpersonal Sensitivity) to 35.7% (Anxiety). Scoring on the Impact of Events Scales (Table 2-B) shows a reported decrease of 55.0% on the Intrusive sub-scale and 50.0% on the Avoidance sub-scale. Findings for the Multidimensional Locus of Control Scale (Table 2-C) indicate a decrease of 15.8% in internal control (ILC), an increase of 50.0% in powerful others control (POC) and a decrease of 46.7% in chance control (CC).

The data for Client #2 is shown in the following group of tables and graphs.

TABLE 2 - A

Client #2

TABLE OF SCORES FOR SCL-90-R

	PRE-TEST	POST-TEST #1	POST-TEST #2	DIFFERENCE (%)
SOMATIZATION	50	40	33	-34
OBSESSIVE-COMPULSIVE	53	48	40	-24.5
INTERPERSONAL SENSITIVITY	53	51	49	- 7.5
DEPRESSION	55	46	39	-29.1
ANXIETY	56	50	36	-35.7
HOSTILITY	52	47	39	-25
PHOBIC ANXIETY	55	57	48	-12.7
PARANOIA	54	53	42	-22.2
PSYCHOTICISM	53	53	43	-18.9
GSI	53	46	37	-30.2
PSDI	51	48	35	-31.3
PST	52	46	39	-25.0

COMPARISON OF SCL-90-R SCORES WITH
PERCENTAGE CHANGE BETWEEN
PRE-TEST AND POST-INTERVENTION SCORES

TABLE 2 - B

Client #2

TABLE OF IMPACT OF EVENTS SCORES

	Pre-test	Post-test	Differ.(%)
Intrusive	20	9	-55.0
Avoidance	34	17	-50.0
Total	54	26	-51.8

Comparison of Impact of Events Scores
(Intrusive and Avoidance Sub-scales)
with percentage difference between
pre-test and post-intervention scores

TABLE 2 - C

Client #2

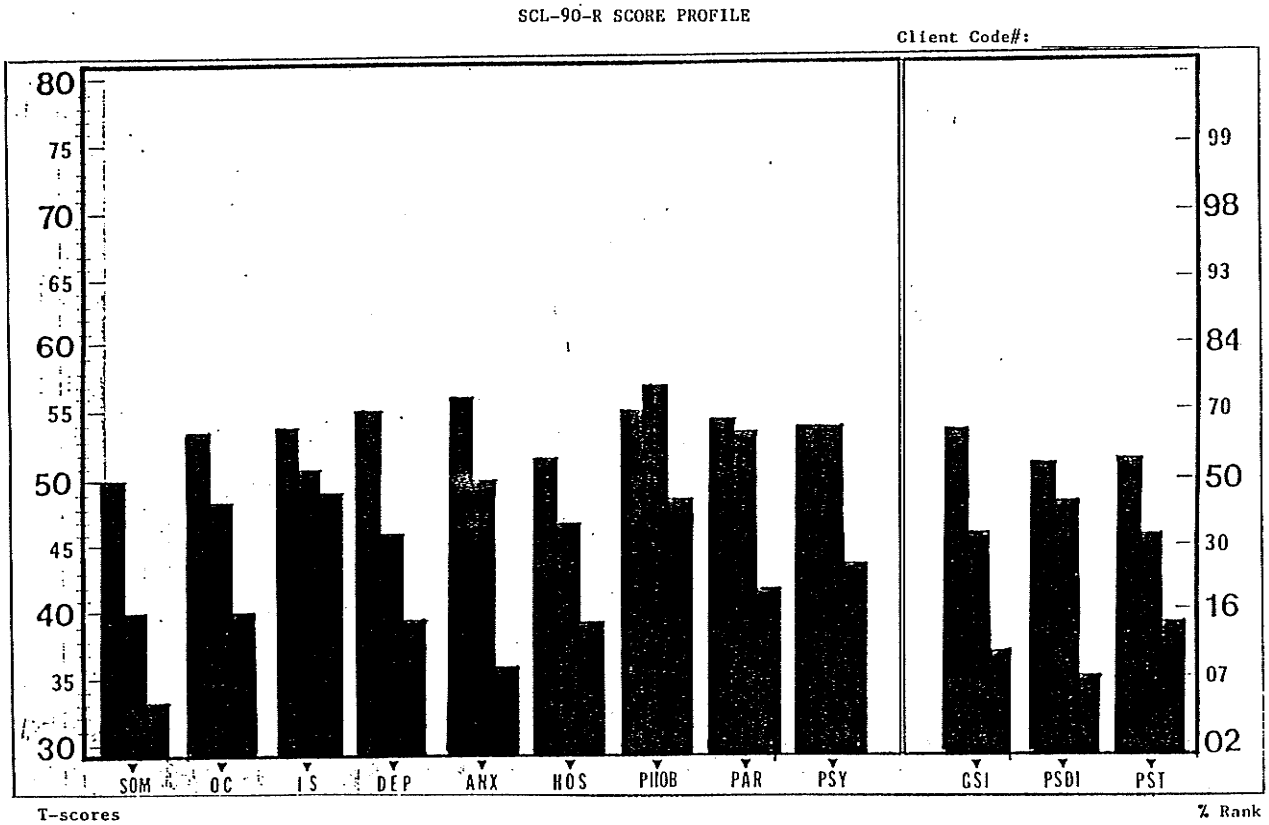
TABLE OF MULTIDIMENSIONAL LOCUS OF CONTROL SCORES

	Pre-test	Post-test	Differ.(%)
ILC	19	16	-15.8
POC	26	39	-50.0
CC	45	24	-46.7
Total	90	79	-12.2

Comparison of Locus of Control Scores
(Internal, Powerful Others, and)
(Chance Control Sub-scales)
with percentage difference between
pre-test and post-intervention scores

FIGURE 2 - A

Client #2

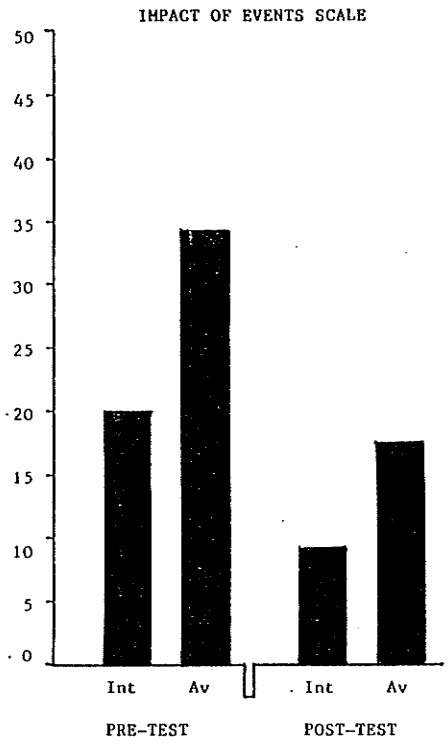


COMPARISON OF BASELINE AND
POST-INTERVENTION SCORES

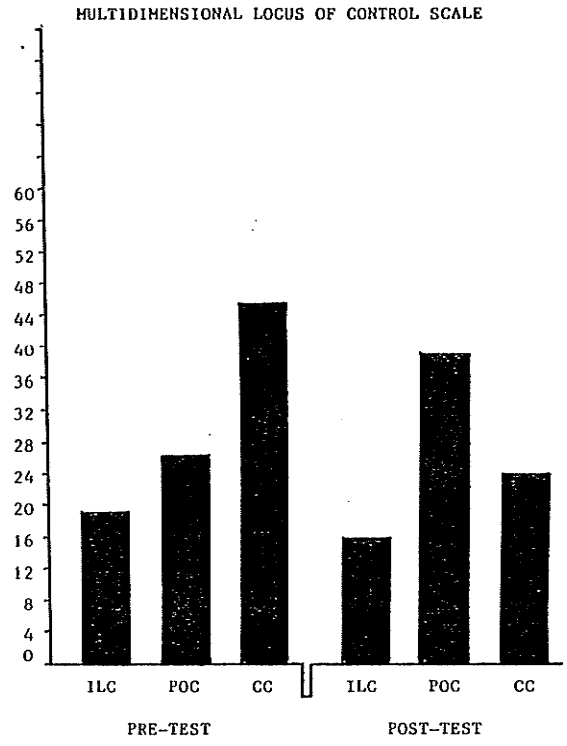
FIGURE 2 - B

FIGURE 2 - C

Client #2



Comparison of Impact of Event Scores
(Intrusive and Avoidance Sub-scales)



Comparison of Locus of Control Scores
(Internal, Powerful Others and)
(Chance Control Sub-scales)

D. Client #3 profile:

This client is a 30 year old woman recruited for the intervention project from an existing outpatient counselling caseload. She is single, has no children, and lives alone in her own suite. She had been seen in counselling for the previous year, and has had five prior admissions to the Mental Health facility for inpatient treatment. Previous diagnoses had included Major Affective Disorder, Adjustment Disorder with Depressed Mood, and Borderline Personality Disorder.

On initial interview for the project she presented reasonably well and was easily engaged. Her affective state had improved considerably but she still complained of periodic problems with anxiety, nightmares, interpersonal sensitivity and periodic depressive episodes.

Her abuse history began at age 6 when she was first assaulted by an older brother. The duration of the sexual abuse continued for a period of 6 years until age 12 and throughout that time included multiple assaults by her brother, as well as his friends.

She responded quite well to the intervention sessions and exhibited no significant difficulties throughout. She was quite compliant with practise instructions and reported the development of a good response to the training in relaxation imagery.

Outcome scores for the SCL-90-R (Table 3-A) show a reduction of reported severity with the exception of one sub-scale (Somatization) which increased by 5.9%. One sub-scale (Phobic Anxiety) remained unchanged and the remaining sub-scales showed a reduction with a range of 8.9% (Psychoticism) to 25.7% (Positive Symptom Distress Index). Scoring on the Impact of Events Scale (Table 3-B) showed a decrease of 46.2% on the Intrusive sub-scale and 6.25% on the Avoidance sub-scale. Findings for the Multidimensional Locus of Control Scale (Table 3-C) indicate a decrease in intenal control (ILC) of 12.0%; an increase in powerful others control (POC) of 14.3%; and an increase in chance control (CC) of 13.0%.

The data for client #3 is shown in the following group of tables and graphs.

TABLE 3 - A

Client #3

TABLE OF SCORES FOR SCL-90-R

	PRE-TEST	POST-TEST #1	POST-TEST #2	DIFFERENCE (%)
SOMATIZATION	34	33	36	+ 5.9
OBSESSIVE-COMPULSIVE	49	46	41	-16.3
INTERPERSONAL SENSITIVITY	44	35	35	-20.5
DEPRESSION	41	37	37	- 9.8
ANXIETY	43	39	36	-16.3
HOSTILITY	45	30	39	-13.3
PHOBIC ANXIETY	47	30	47	0.0
PARANOIA	39	30	30	-23.1
PSYCHOTICISM	45	43	41	- 8.9
GSI	40	37	35	-12.5
PSDI	35	33	25	-25.7
PST	45	40	39	-13.3

COMPARISON OF SCL-90-R SCORES WITH
PERCENTAGE CHANGE BETWEEN
PRE-TEST AND POST-INTERVENTION SCORES

TABLE 3 - B

Client #3

TABLE OF IMPACT OF EVENTS SCORES

	Pre-test	Post-test	Differ.(%)
Intrusive	13	7	-46.2
Avoidance	16	15	- 6.25
Total	29	22	-24.1

Comparison of Impact of Events Scores
(Intrusive and Avoidance Sub-scales)
with percentage difference between
pre-test and post-intervention scores

TABLE 3 - C

Client #3

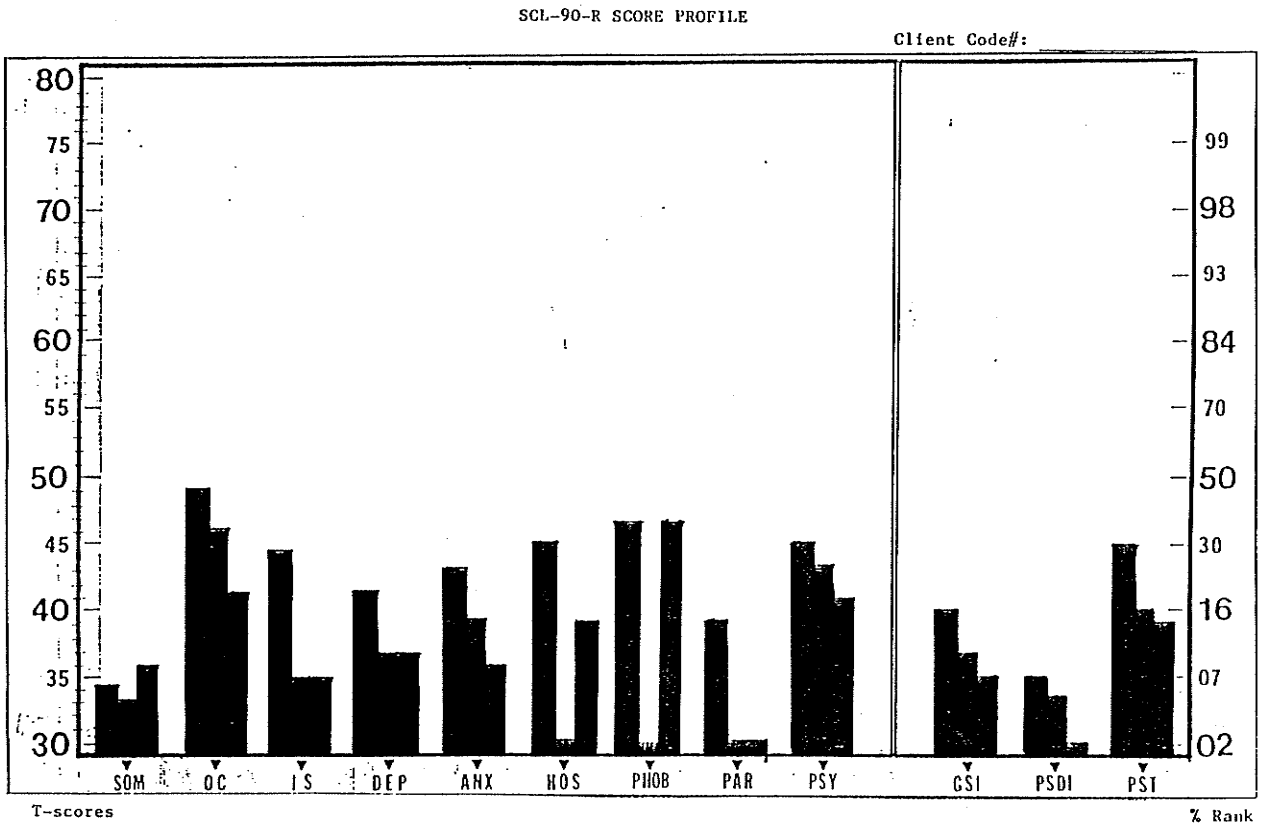
TABLE OF MULTIDIMENSIONAL LOCUS OF CONTROL SCORES

	Pre-test	Post-test	Differ.(%)
ILC	25	22	-12.0
POC	28	32	+14.3
CC	23	26	+13.0
Total	76	80	+ 5.3

Comparison of Locus of Control Scores
(Internal, Powerful Others, and)
(Chance Control Sub-scales)
with percentage difference between
pre-test and post-intervention scores

FIGURE 3 - A

Client #3

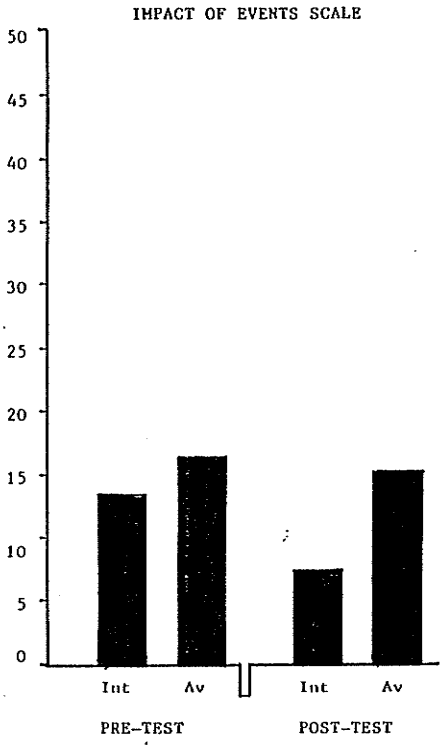


COMPARISON OF BASELINE AND
POST-INTERVENTION SCORES

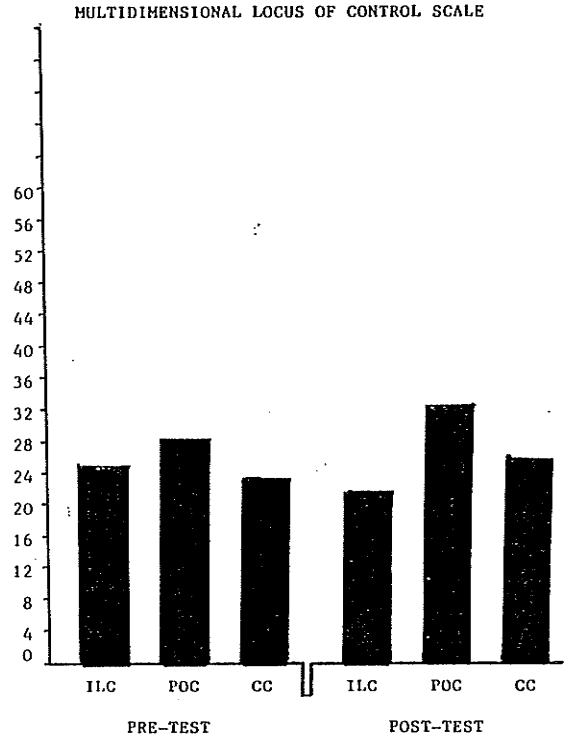
FIGURE 3 - B

FIGURE 3 - C

Client #3



Comparison of Impact of Event Scores
(Intrusive and Avoidance Sub-scales)



Comparison of Locus of Control Scores
(Internal, Powerful Others and)
(Chance Control Sub-scales)

E. Client #4 profile:

This 28 year old woman was recruited for the project from an existing outpatient counselling caseload. She has been married but has now been separated for several years. She resides with her three young children who were recently returned to her care by the local child welfare agency. She had been seen in counselling for the previous three months and had one previous admission to the Mental Health facility

for inpatient treatment of depressive features and suicidal ideation. Diagnoses included Major Affective Disorder and Borderline Personality Disorder.

Initial assessment indicated that she was quite easily engaged and responsive to interviews. She complained of frequent difficulties with anxiety, brief depressive episodes, mood lability and significant interpersonal sensitivity and frequent interpersonal conflict.

Her background of sexual abuse began at age 7 when she was first assaulted by her older brother. The duration of the abuse included multiple assaults and extended over a period of seven years until the death of her brother. In addition, she was repeatedly sexually assaulted by a family boarder in her early adolescence.

This client initially had to terminate involvement in the project after one session to take a short-term of employment. Following this term she returned to sessions and the intervention resumed with the acquisition of new baseline data.

Though she expressed significant interest in the sessions she had difficulty in complying with practise instructions and, as such, developed only a moderate response to the training. However her reported response to live sessions was significantly better.

Evaluation of the data for the SCL-90-R (Table 4-A) indicates an increase of reported symptom severity of 6.1% on the Hostility

sub-scale, and of 1.8% on the Paranoia sub-scale. All other SCL-90-R sub-scales indicated a decrease in reported symptom severity with a range from 1.6% (Phobic Anxiety) to 30.4% (Anxiety). Results obtained on the Impact of Events Scale (Table 4-B) show an increase in reported severity of 11.1% on the Intrusive sub-scale, and 93.3% increase on the Avoidance sub-scale. Findings for the Multidimensional Locus of Control Scale (Table 4-C) indicate no change in internal control; an increase of 47.6% in powerful others control (POC); and an 8.3% increase in chance control (CC).

The date for client #4 is shown in the following group of tables and graphs.

TABLE 4 - A

Client #4

TABLE OF SCORES FOR SCL-90-R

	PRE-TEST	POST-TEST #1	POST-TEST #2	DIFFERENCE (%)
SOMATIZATION	63	55	44	-30.2
OBSESSIVE-COMPULSIVE	63	54	50	-20.6
INTERPERSONAL SENSITIVITY	55	47	52	- 5.5
DEPRESSION	62	46	49	-20.9
ANXIETY	69	55	48	-30.4
HOSTILITY	49	47	52	+ 6.1
PHOBIC ANXIETY	61	59	60	- 1.6
PARANOIA	54	51	55	+ 1.8
PSYCHOTICISM	53	48	41	-22.6
GSI	62	51	48	-22.6
PSDI	55	43	43	-21.8
PST	66	60	54	-18.2

COMPARISON OF SCL-90-R SCORES WITH
PERCENTAGE CHANGE BETWEEN
PRE-TEST AND POST-INTERVENTION SCORES

TABLE 4 - B

Client #4

TABLE OF IMPACT OF EVENTS SCORES

	Pre-test	Post-test	Differ.(%)
Intrusive	9	10	+11.1
Avoidance	15	29	+93.3
Total	24	39	+62.5

Comparison of Impact of Events Scores
(Intrusive and Avoidance Sub-scales)
with percentage difference between
pre-test and post-intervention scores

TABLE 4 - C

Client #4

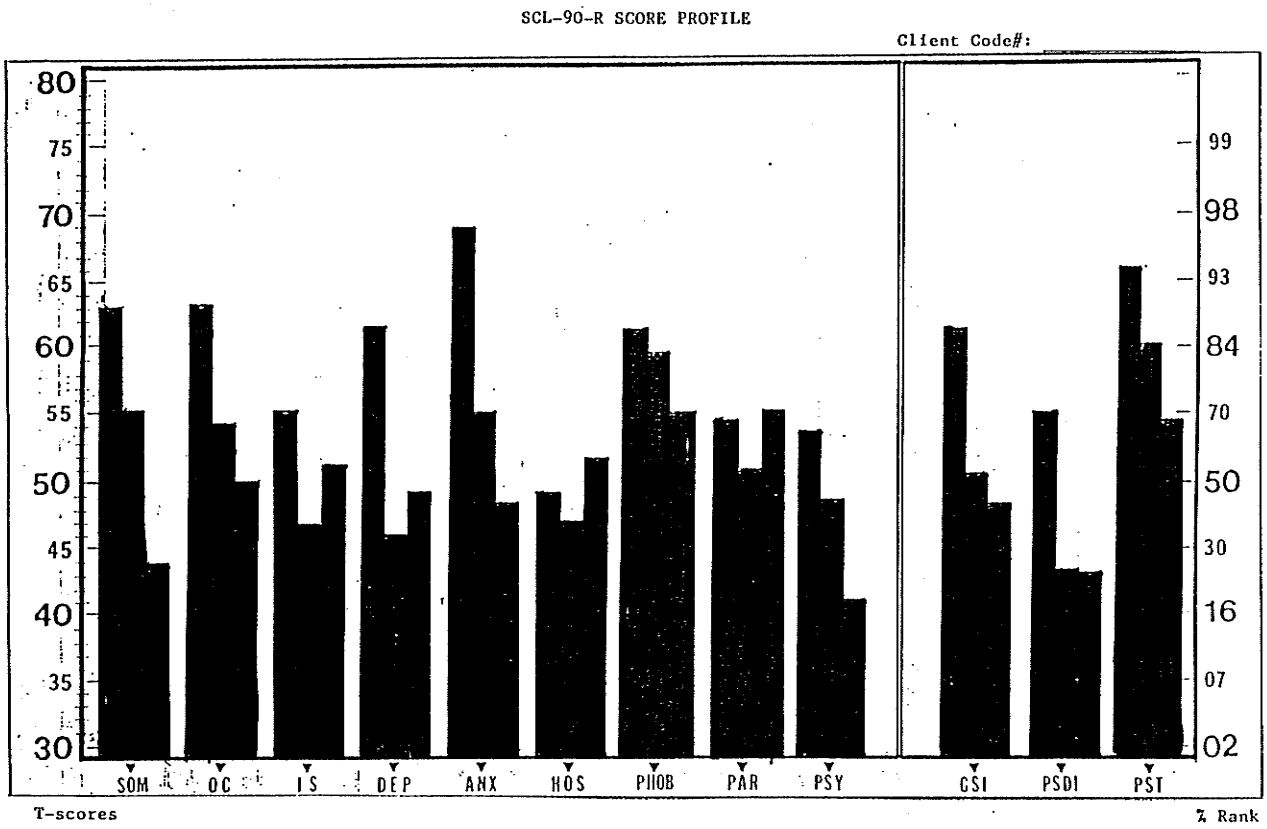
TABLE OF MULTIDIMENSIONAL LOCUS OF CONTROL SCORES

	Pre-test	Post-test	Differ.(%)
ILC	28	28	0.0
POC	21	31	+47.6
CC	24	26	+ 8.3
Total	73	85	+16.4

Comparison of Locus of Control Scores
(Internal, Powerful Others, and)
(Chance Control Sub-scales)
with percentage difference between
pre-test and post-intervention scores

FIGURE 4 - A

Client #4

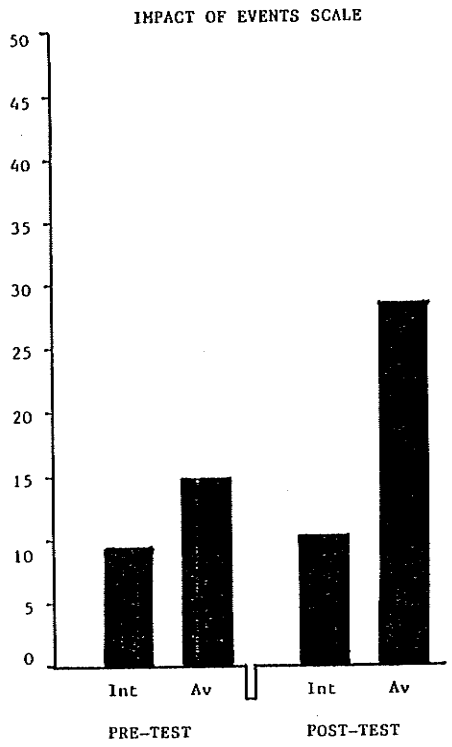


COMPARISON OF BASELINE AND
POST-INTERVENTION SCORES

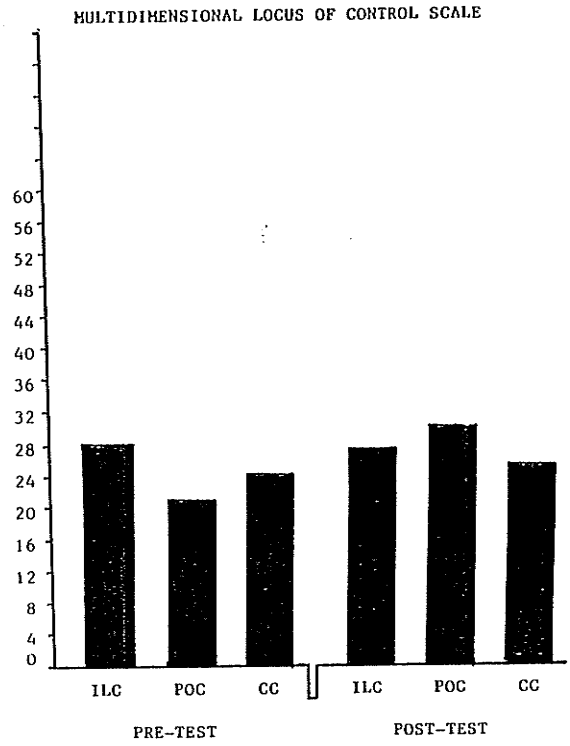
FIGURE 4 - B

FIGURE 4 - C

Client #4



Comparison of Impact of Event Scores
(Intrusive and Avoidance Sub-scales)



Comparison of Locus of Control Scores
(Internal, Powerful Others and)
(Chance Control Sub-scales)

F. Group Profile:

The mean scores for the sample obtained by the SCL-90-R are shown in Table 5-A. Findings indicate a reduction in reported symptom severity for all clinical sub-scales and global measures, with a range of 15.2% (Phobic Anxiety) to 33.2% (Global Severity Index). The trend across interventive phases is shown in Figure 5-A.

Mean scores obtained by the Impact of Events Scale are shown in Table 5-B. Results indicate a reduction of 31.1% on the Intrusive sub-scale, and a reduction of 7.2% on the Avoidance sub-scale.

The mean score results for the Multidimensional Locus of Control Scale are shown in Table 5-C. Findings indicate an overall reduction in internal control (ILC) of 3.4%; an increase in powerful others control (POC) of 37.3%, and an overall decrease in chance control (CC) of 15.8%. The trend across phases is illustrated in Figure 5-C.

The mean scores for the sample are shown in the following group of tables and graphs.

TABLE 5 - A

Group Profile

TABLE OF SCORES FOR SCL-90-R

	PRE-TEST	POST-TEST #1	POST-TEST #2	DIFFERENCE (%)
SOMATIZATION	52.0	42.25	38.5	-25.9
OBSESSIVE-COMPULSIVE	54.5	47.0	40.0	-26.6
INTERPERSONAL SENSITIVITY	54.25	45.5	40.25	-25.8
DEPRESSION	51.75	40.75	35.75	-30.9
ANXIETY	54.75	45.75	37.25	-31.9
HOSTILITY	50.0	40.75	40.75	-18.5
PHOBIC ANXIETY	52.5	45.25	44.5	-15.2
PARANOIA	49.5	45.5	38.5	-22.2
PSYCHOTICISM	52.0	46.25	39.0	-25.0
GSI	52.75	43.0	35.25	-33.2
PSDI	50.5	40.0	35.0	-30.7
PST	53.5	46.25	37.75	-29.4

COMPARISON OF SCL-90-R SCORES WITH
PERCENTAGE CHANGE BETWEEN
PRE-TEST AND POST-INTERVENTION SCORES
(mean scores)

TABLE 5 - B

Group Profile

TABLE OF IMPACT OF EVENTS SCORES

	Pre-test	Post-test	Differ.(%)
Intrusive	15.25	10.5	-31.1
Avoidance	20.75	19.25	- 7.2
Total	36.0	29.75	-17.4

Comparison of Impact of Events Scores
(Intrusive and Avoidance Sub-scales)
with percentage difference between
pre-test and post-intervention scores
(mean scores)

TABLE 5 - C

Group Profile

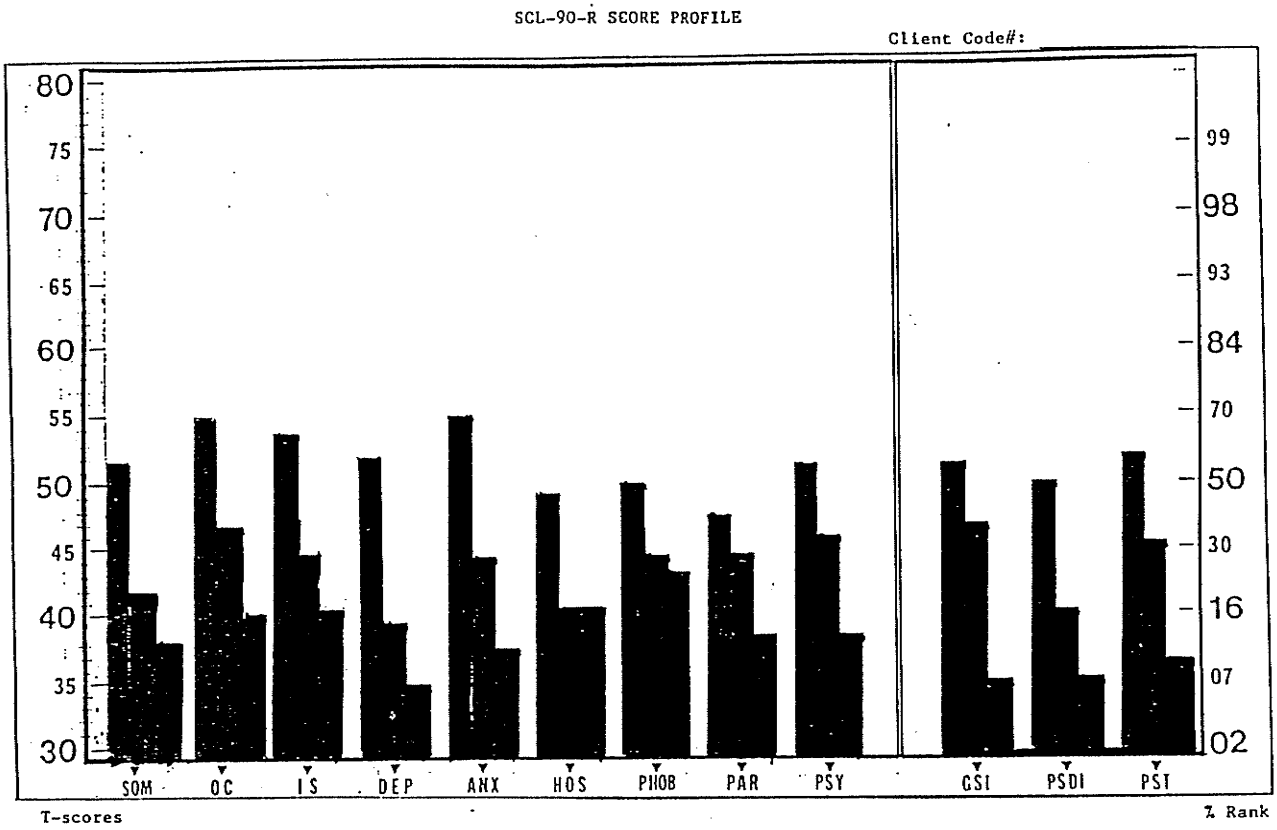
TABLE OF MULTIDIMENSIONAL LOCUS OF CONTROL SCORES

	Pre-test	Post-test	Differ.(%)
ILC	22.25	21.5	- 3.4
POC	25.5	35.0	-37.3
CC	30.0	25.25	-15.8
Total	77.75	81.75	+ 5.1

Comparison of Locus of Control Scores
(Internal, Powerful Others, and)
(Chance Control Sub-scales)
with percentage difference between
pre-test and post-intervention scores
(mean scores)

FIGURE 5 - A

Group Profile

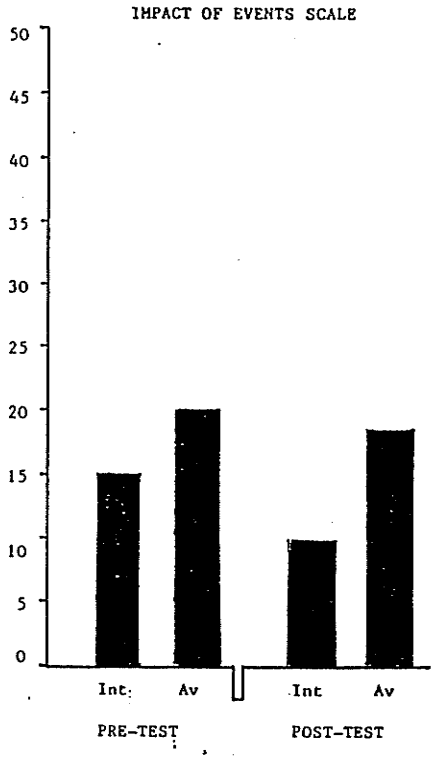


COMPARISON OF BASELINE AND
POST-INTERVENTION SCORES

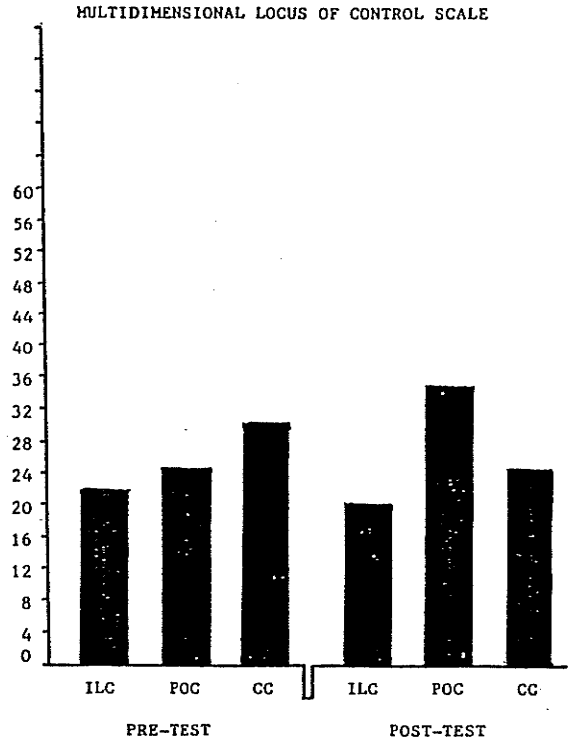
FIGURE 5 - B

FIGURE 5 - C

Group Profile



Comparison of Impact of Event Scores
(Intrusive and Avoidance Sub-scales)



Comparison of Locus of Control Scores
(Internal, Powerful Others and)
(Chance Control Sub-scales)

G. Summary of Results:

Throughout the intervention phase the clients in the sample remained well engaged and enthusiastic participants. With the exception of one client, participants were compliant with practise instructions and all developed and reported a favorable relaxation response, and the subjective impression that distress was diminishing. Although one client was less than consistent in her response to training in the procedure she too reported benefit from use of the technique.

These subjective impressions tend to be supported by the results obtained. The data obtained by the instruments used in the project is summarized in the following table:

TABLE 6 - A

SUMMARY OF RESULTS

INSTRUMENT	Baseline	Post - Intervention	Difference (%)	Normative Scores
SCL-90-R				
Global Measures				
1. GSI	52.75	35.25	- 33.2	T50
2. PSDI	50.5	40.0	- 30.7	T50
3. PST	53.5	46.25	- 29.4	T50
IMPACT OF EVENTS				
1. Intrusive	15.25	10.5	- 31.1	21.02
2. Avoidance	20.75	19.25	- 7.2	20.8
LOCUS OF CONTROL				
1. ILC	22.25	21.5	- 3.4	35.4
2. POC	25.5	35.0	+ 37.3	23.8
3. CC	30.0	25.25	- 15.8	21.7

Table 6-A summarizes the mean scores obtained by the sample, and records baseline and post-intervention data for all instruments. The discontinuity, or degree of difference (shown in percentages), is also recorded, as is the normative data for each sub-scale.

Using the global measures of the SCL-90-R to evaluate the level of change in the reporting of symptoms and their severity, scores indicate a favorable improvement. Comparison of pre-test and post-intervention scores indicate a decrease, or improvement, of 29.4% on the Positive Symptom Total; 30.7% on the Positive Symptom Distress Index; and a 33.2% reduction on the Global Severity Index. This comparison of pre-test and post-intervention data provides a measure of the statistical significance of the outcome.

In relation to normative data for the SCL-90-R, baseline scores indicate pre-test elevations in the clinically significant range (> 50); and place the mean scores in the 50 to 60 percentile ranking for female psychiatric outpatients. Post-intervention scores indicate a reduction of the ranking to the 7th (GSI) and 35th (PST) percentiles. This comparison of scores to normative data gives a measure of the practical significance of the findings and is suggestive of a favorable improvement for this client population.

Taken together, the global measures of the SCL-90-R indicate a mean reduction of 31.1% in symptom reporting and severity,

as well as a favorable reduction in the percentile ranking relative to a normative population.

Data obtained on the Impact of Events Scale, similarly indicates a reduction of the post-traumatic symptoms. The most significant finding by this instrument was on the Intrusive sub-scale, which showed a 31.1% decrease, or improvement across phases. The Avoidance sub-scale indicated an improvement, as well, reducing the reporting of these post-traumatic features by 7.2%.

In relation to normative data for the Intrusive sub-scale, baseline scoring at 15.25 was below the norm of 21.02; indicating that clients were not markedly disturbed by typical post-traumatic intrusive phenomena at the outset. However, the baseline scoring for the Avoidance sub-scale at 20.75, is virtually equal to the normative score of 20.8. This is suggestive that many avoidant coping strategies were active with these clients, and may well have successfully reduced the presence of intrusive phenomena, as reflected in that sub-scale score.

Overall, scoring on the Impact of Events Scale indicates a favorable improvement with clear reductions in severity, across phases; and resulting in post-interventive scores well below normative data for psychiatric outpatients.

The findings of the Multidimensional Locus of Control Scale are less clear and favorable than those obtained by the other instruments. The interpretation guidelines for

this instrument suggest that higher scores reflect higher levels of externality. The sub-scale measuring Internality (ILC) indicates only a small improvement at 3.4%. Measures taken across phases, in relation to Powerful Others control (POC) indicate a substantial shift to externality with an increase of 37.3%. This suggests an increase in the perception and expectancy that events and outcome are contingent on (external) powerful others. The sub-scale measuring the level of belief in Chance control (CC) indicates a shift away from this perception, with a reduction of 15.8% across phases.

Normative data for the Multidimensional Locus of Control Scale is based on psychiatric inpatient populations. Along the dimension of internality (ILC), clients in the practicuum sample scored 22.25 (baseline) and 21.5 (post-intervention). This compares to the normative score of 35.4 for psychiatric patients, and suggests that clients in this sample reported an orientation towards internal locus of control and that it did not change significantly throughout the course of the intervention.

Along the dimension of powerful others control (POC), clients scored 25.5 (baseline) and 35.0 (post-intervention). This compares to a normative score of 23.8 and suggests that these clients reported a subjective perception of significant external control by powerful others. Additionally, this perception appears to have increased significantly throughout the course of the intervention.

CHAPTER FIVE: DISCUSSION

The interpretation of the findings of the intervention do suggest some success in the achievement of the stated objectives for the clients. Indications are quite clear that there was a favorable reduction in the reporting of specific symptoms, and symptom severity. This was the primary objective of the interventive process and the SCL-90-R test results would tend to indicate that this was satisfied.

Another stated objective of the intervention was the intended change in perception of the impact of the abusive events, and the subsequent improvement in post-traumatic adjustment through a reduction of intrusive and avoidant features. As measured by the Impact of Events Scale, this objective too, appears to have been successfully satisfied with a favorable improvement reflected in the outcome data.

In terms of locus of control, an objective of the intervention process was to bring about a shift in the levels of internal, powerful others, and chance control. These perceptions do, indeed appear to have shifted somewhat, but they did not necessarily result in higher levels of internality as was intended. In fact, it appears that internality was not improved remarkably. Instead, it seems that externality, comprised of the two components of powerful others and chance control, was considerably reinforced and increased. Though there was a notable reduction in scoring for the Chance Control sub-scale, this may have remained external in orientation, and reflected in the substantial increase on the Powerful Others sub-scale.

Unfortunately, this may well infer that clients did not perceive the intervention and its subsequent clinical improvements as being contingent on their own activities. They may have, in fact, attributed these changes to the therapist and the intervention process as part of the therapist's activities. If this is so, it might have important implications for the durability of the outcome. It would have been most desirable if the improved clinical outcome could have developed in correspondence with a shift to greater internality. However, further clarification of this finding would only be highly speculative without further investigation and a longer term follow up of the clients.

The interpretation and meaning ascribed to the findings is subject to a variety of limitations. Although the findings are suggestive of a favorable outcome, it is not clear to what degree of significance the intervention has produced the outcome. This question might be clarified through more sophisticated statistical analysis procedures than visual inspection; however, the sample size is such that such procedures do not appear possible. Nor, is such data analysis intended for the scope of this practicuum project, so it is with that limitation in mind that these findings are viewed.

Additionally the design of the intervention is such that it does not control for other variables and possibilities that might have contributed to the favorable outcome. A series

of baseline scores was not taken over time, and the single baseline score does not rule out the possibility of an improving trend based on chance or other influential variables. Because the design is not experiemental, it does not control for these variables and it is not known, for example, to what extent simple supportive contact may have contributed to the outcome.

The composition of the sample is another factor that tended to skew the results in several directions. One of the clients in the sample entered the intervention with significantly higher pre-test scores, which tended to elevate the mean scores somewhat. Conversely, one of the clients began participation at a time when situational factors were quite stable and clinical distress was not significantly elevated. A larger sample size would have given a greater measure of reliability to the findings.

Thus, it is understood that there are a number of limitations to the interpretation of the findings, and the outcome must be framed with these reservations in mind.

However, from another perspective a number of optimistic observations can be made. Taken as a whole, the interventive process did seem to bring about significant favorable change. The relaxation training procedure when applied together with other basic elements of counselling such as proper engagement of the client, expressed support, and development of trust may well be an effective means of moderating clinical distress.

Adult victims of childhood sexual abuse, as a client population, are widely reputed to be time consuming and demanding of the therapist's attention. Largely this is due to the ease and frequency with which distress is precipitated. These clients come to rely heavily on their therapists to provide relief from the symptoms of distress. What is suggested by these findings is that this procedure in relaxation - imagery may well be an efficient means by which clients can become more self-reliant in ameliorating symptoms, and less dependent on the therapist to do so for them.

This procedure may be efficient in the sense that efficiency is an outcome of the ratio between effort and effectiveness. Its clinical effectiveness for the client has already been established by the outcome data. The procedure requires relatively brief periods of input for the therapist and the client, and appears to become effective over a short period of time. This rather small investment of effort, relative to its apparent effectiveness, suggests a good degree of efficiency for the interventive procedure.

It is not suggested either, that this procedure alone is the only means by which the therapist approaches the client. Certainly treatment with this clinical population often requires a full spectrum of counselling approaches, usually implemented over a lengthy duration of time. However, often the significant distress that is a part of the post-traumatic sequelae is

so severe so as to frequently place the client in crisis and interferes with the usual counselling process. If the distress can be managed through the contribution of this procedure, crises might become less frequent and usual counselling procedures more effective, and of shorter duration.

CHAPTER SIX: PRACTICUM SUMMARY

1. Participant Observations

Throughout the intervention process the participating clients involved themselves with determination in spite of fears and reservations that developed from time to time. They were generous contributors, surely in their participation, but also in their comments and their observations. The anecdotal information received from these cleints about themselves, the intervention, the implementation and its effect was actively solicited but also given spontaneously, and its value is not underestimated. As such, these comments and observations are recorded in this report as part of the overall outcome of the practicuum experience.

In describing themselves as victims of childhood sexual abuse all of the clients highlighted a core set of issues that were prominent areas of difficulty in their adult lives. Though some of them saw themselves as consistently having difficulties, they identified cyclical patterns of dysfunction that would be easily precipitated, usually by concrete or symbolic reminders of the traumatic abuse.

It was during these dysfunctional periods that symptoms developed rapidly and they all described the ease with which they were quickly overwhelmed.

Most prominent of these issues was a powerful anxiety that would quickly rise to the level of panic. These clients

saw themselves as having an easy startle response that could be triggered by numerous antecedants and give rise to the anxiety.

These clients were also aware of the level of hostility and anger that they felt to be rather frightening. Most felt themselves to be restraining this anger and were fearful of its expression, anticipating a sense of losing control.

These clients knew also that this resulted in problems in their interpersonal functioning and they tended to enter most relationships with suspicion and restraint, and would generally sustain a strong element of distrust.

In terms of self-perception, these clients tended to describe themselves as having a belief about themselves as being centrally bad and weak. However they also saw themselves as surviviors, and as such, having efficacy. But this tended to related to their ability to endure suffering and adversity rather than actively direct their lives productively.

Overall, they did not see themselves as suffering and dysfunctional individuals all of the time, but instead talked of fluctuation in the symptoms of distress that they often felt helpless to control.

In terms of participation in the interview process several of the clients remarked on the therapeutic value of simply participating. Though they were initially fearful, they framed this process as an opportunity to confront and overcome their

fears. Other comments reminded me, again, of the importance of attention to good fundamental interviewing skills. With this group of clients in particular, basic issues such as seating and positioning or body posture could easily create a sense of entrapment or intimidation. This was especially amplified because of the gender differences in the relationship and the clients sensitivities in relation to men.

Most of the clients quite quickly became comfortable with the relaxation imagery procedure, although all described an initial fear of submitting to the instructions. The feeling of submission reminded these clients somewhat of their past experiences of victimization.

They all commented on the effect of the procedure, and though they reported differing levels of relaxation they all described beginning to use the procedure spontaneously and apply it to various stressful situations. In addition to the intended quieting effect, they all described a sense of being able to control the stressful situation by use of the procedure and thereby manage it for a better outcome.

Each client expressed a sense of achievement in having completed the process and verbalized the subjective impression that by doing so they had been able to gain some control over their post-traumatic responses.

2. Assessment of the Practicuum Experience

In this portion of the practicuum report, I would like

to make some comments about what was gained from the practicuum experience. On one level there are the positive findings. Such objectives, as those identified at the outset of the report such as familiarization with the relevant literature to the problem issue, clearly have been of educational benefit. In completing the project there has been an evident gain in knowledge of research methods and design, and the implementation of such an undertaking. Though understood theoretically, without the experimental grounding it is not possible to have a full appreciation of what research truly entails. This refers not only to the planning of ideas and a conceptual framework, or the design and methods, or the measurement of outcome and analysis; but the host of practical and technical issues associated with the implementation and maintenance of a practicum project. Of course, any undertaking in which specific activities and goals are specified and evaluated, in working with clients, is likely to result in both knowledge and skill improvement. Though the interventive procedure used in this practicuum report was an approach used previously in clinical work, subjecting it to supervised scrutiny and evaluation resulted in ongoing appraisal and adjustment.

Apart from the self-evident objectives associated with a practicuum experience there are some subtle issues that emerged as important factors that were not as clear at the outset.

The importance of association with an academic community and network has been solidly underscored through this experience. Such a community frames the context within which the work is undertaken; knowledge and perceptions are exchanged; and the interaction with such a community stimulates broader learning.

In the practicuum experience, the importance of being in a position to assert full attention to the project is now realized. In order to do so one must maintain focus and concentration to maximize the benefits. Without full attention these benefits and standards are compromised.

In clinical functioning the practicuum experience has become influential in that there is an ongoing awareness of the balance and integration between theory, practise and research. The practicuum experience creates a discipline of thinking that proceeds around objective guidelines. The value of this in practise is that it brings a model of purposeful design to clinical work. Clinical activities are best formed within a conceptual framework. Practise activities need to be defined and identified for objective assessment. Outcome is not entirely valid without reliable measurement. The incorporation of these principles into clinical practise provides a means by which knowledge and skill are improved and adjusted for the benefit of both the practitioner and the client.

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APPENDICES:

Appendix A: Informed consent form

Appendix B: Demographic information sheet

Appendix C: SCL - 90 - R

Appendix D: Impact of Events Scale

Appendix E: Multidimensional Locus of Control Scale

Appendix F: Data summary sheet

Appendix G: Relaxation - Imagery Script

RE: _____

INFORMED CONSENT FOR RESEARCH PARTICIPATION

I hereby agree to participate in a research study conducted by ALBERT HAJES, and I authorize the use of information provided for research purposes.

I acknowledge that 1) guidelines for confidentiality and anonymity, 2) purpose of the study, and 3) uses of information have been explained and understood by me.

DATE: _____ SIGNED: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ALBERT HAJES to release the information provided, as follows:

REQUESTED BY: _____

AGENCY: _____

RELATIONSHIP: _____

The information has been requested and is released for the purpose of therapeutic treatment, and will be protected by the guidelines for confidentiality in accordance with the respective agency policy.

DATE: _____ SIGNED: _____

WITNESS: _____

DEMOGRAPHIC INFORMATION

PART A:

Client code: # 16 Male / Female

Current age: M S D Sep CL

Location: AU OPD FRC Oth

Children: Age: Custody:

Ethnic Background:

Education: Occupation:

Financial Support:

PART B:

Previous Counselling:

Age: Location:

Previous Psychiatric Treatment:

Age: Location:

Current Counselling: How Long:

Current Psychiatric Medication:

CAS Wardship: Age Location

PART C:

Age of Abuse Occurence: _____

Duration of Abusive Period: _____ to _____

Relationship of Offender(s): _____

_____

Events: sing / mult
Offend: sing / mult _____

_____

Use of Physical Violence: _____

Use of Threat of Violence: _____

Was Alcohol Abuse a Factor: _____

Was Abuse Disclosed: _____

Ages of disclosure: _____ To whom: _____

_____ _____

_____ _____

_____ _____

Reaction to disclosure: _____

_____

_____

How did abuse stop: _____

_____

_____

Research Code: E 16

Date: _____

IE Scale

Below is a list of comments made by people about stressful life events and the situation surrounding them. Please read each item and decide how often each was true for you during the past seven (7) days, for the event which you are dealing with. Indicate on the line at the left of each comment the number that best describes the item. Please complete each item.

1 = NOT AT ALL
2 = RARELY
3 = SOMETIMES
4 = OFTEN

_____ 1. I thought about it when I didn't mean to.

_____ 2. I avoided letting myself get upset when I thought about it or was reminded about it.

_____ 3. I tried to remove it from memory.

_____ 4. I had trouble falling asleep, or staying asleep, because of pictures or thoughts that came into my mind.

_____ 5. I had waves of strong feelings about it.

_____ 6. I had dreams about it.

_____ 7. I stayed away from reminders of it.

_____ 8. I felt as if it hadn't happened, or wasn't real.

_____ 9. I tried not to talk about it.

_____ 10. Pictures about it popped into my mind.

_____ 11. Other things kept making me think about it.

_____ 12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.

_____ 13. I tried not to think about it.

_____ 14. Any reminder brought back feelings about it.

_____ 15. My feelings about it were kind of numb.

Research Code: _____

Date: _____

MLOCP Scale

Indicate the extent to which you agree with each of the following satements, using the scale below:

1 = STRONGLY AGREE
2 = MODERATELY AGREE
3 = SLIGHTLY AGREE
4 = SLIGHTLY DISAGREE
5 = MODERATELY DISAGREE
6 = STRONGLY DISAGREE

_____ 1. Whether or not I get to be a leader depends mostly on my ability.

_____ 2. To a great extent my life is controlled by accidental happenings.

_____ 3. I feel like what happens in my life is controlled mostly by powerful people.

_____ 4. My behavior will determine when I am ready to stop counselling.

_____ 5. When I make plans, I am almost certain to make them work.

_____ 6. Often there is no chance of protecting my personal interests from bad luck happenings.

_____ 7. When I get what I want its usually because I'm lucky.

_____ 8. Even if I were a good leader, I would not be made a leader unless I play up to those in positions of power.

_____ 9. How many freinds I have depends on how nice a person I am.

_____ 10. I have often found that what is going to happen, will happen.

_____ 11. My life is mostly controlled by powerful others.

_____ 12. It is impossible for anyone to say how long I will continue to need counselling.

_____ 13. People like myself have very little chance of protecting our interests when they conflict with those of powerful others.

_____ 14. Its not always wise for me to plan to far ahead because many things turn out to be a matter of good or bad fortune.

_____ 15. Getting what I want means having to please those people above me.

_____ 16. Whether I get to be leader depends on whether I'm lucky enough to be in the right place at the right time.

---

please continue on following page

Research Code: 16

Date: _____

MLOCP Scale (2)

1 = STRONGLY AGREE
2 = MODERATELY AGREE
3 = SLIGHTLY AGREE
4 = SLIGHTLY DISAGREE
5 = MODERATELY DISAGREE
6 = STRONGLY DISAGREE

_____ 17. If important people were to decide they didn't like me, I probably wouldn't make many freinds.

_____ 18. I can pretty much determine what will happen in my life.

_____ 19. I am usually able to protect my personal interests.

_____ 20. How soon I finish counselling depends on other people who have power over me.

_____ 21. When I get what I want, its usually because I worked hard for it.

_____ 22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.

_____ 23. My life is determined by my own actions.

_____ 24. Its mostly a matter of fate whether or not I have a few freinds, or many freinds.

DATA SUMMARY SHEET

Client Research Number: _____

Impact of Events Scale:

	Client	OP Norms	Range
Intrusive Scores		21.02	7 - 28
Avoidance Scores		20.8	8 - 32
Total			

****

Locus of Control Scale:

	Client	IP Norms	Nonclin	Range
Internal LOC		35.4	35.5	8 - 48
Powerful Others LOC		23.8	16.7	8 - 48
Chance Control		21.7	13.9	8 - 48

****

Symptom Checklist (SCL - 90) T Scores :

Som _____ Host _____

Ob Com _____ Pho Anx _____

Int Sens _____ Par Ide _____

Dep _____ Psych _____

Anx _____ Addit _____

Grand Total: _____

GSI: _____ PST: _____ PSDI: _____

****

APPENDIX G

Relaxation - Imagery Procedure Script

Client Preparation:

Briefly provide an overview of the procedure to the client summarizing the content of the process. Emphasize that the client remains in control throughout the procedure and that they are simply being guided through a series of practices and images intended to achieve a deep state of relaxation.

In consultation with the client select an image scenario that is normally stress provoking for the client. Explain that this image will later be incorporated into the procedure to evoke distress and that this will be managed and resolved through use of the relaxation response.

Explain that the procedure will take only about 15 to 20 minutes to complete, and that on waking, the client will feel rested and alert. Emphasize that the procedure can be terminated by the client at any time.

Procedure:

Please begin by seating yourself comfortably in the chair, sitting so that your feet are flat on the floor and your arms are resting comfortably on the sides of the chair...sit so that no part of your body has to strain to support...now begin by taking several slow and deep breaths so that your chest expands fully without straining... exhale slowly letting the air release on its own...let your chest sink slowly as you exhale...concentrate on the sinking sensations as your chest muscles relax and you exhale...good...now take another deep breath...allow yourself to feel the release of muscle tension as you exhale...and your muscles begin to release...and when you are comfortable to do so...let your eyelids slowly close and continue taking deep

breaths...exhaling slowly...and releasing the tension as you breathe out...very good...and now I would like you to imagine that your body is covered with a thin layer of hard, crusty wax...just like candle wax...and I want you to concentrate your attention on the very top of your head...as you concentrate a warm glow is created...and the wax begins to melt and flow downward...it melts away from the very top of your head...flowing downward...melting as it passes...it flows down around you forehead...warming and soothing...down around the sides of your head...down across the back of your head towards your neck... sinking and sinking...slowly it melts and flows downward through all the muscles of the neck...releasing all the tension...down across the sides of your head...around your ears...down across your forehead... over your eyes...through the muscles of your cheeks...releasing all the tension...down to your chin and around your throat...relieving all the tension as it passes...warming and soothing...spreading and sinking now...down into your shoulders...through all the large muscles... warming and soothing...sinking down across your shoulders now...into your upper arms...down and down...across your elbows...into...your forearms...pushing ahead of it all the tension that has accumulated... sinking and sinking...down towards your wrists and across your wrists... into your hands...pushing ahead of it all the tension that has accumulated... your finger tips begin to tingle slightly as all the tension drains from your body...through your finger tips...down through your hands now... across your knuckles...through your fingers...to the tips of your fingers and out...and your arms are limp and relaxed now...and starting at the shoulders again...sinking down across the top part of your back...

through all the large muscles...sinking and sinking...releasing all the tension...warming and soothing...sinking down...through the middle of your back...down to your lower back...soothing all the muscles... around your sides now...sinking from your shoulders...down through your chest muscles...and down towards your abdomen...through the muscles of the stomach...warming and soothing...melting further and further down...sinking down through your hips now...warming and soothing...down through your hips and through the muscles of the buttocks...releasing all the tension...soothing the muscles...down into your thighs...sinking and sinking...warming and soothing...down towards your knees now...melting...soothing...sinking across your knees...into the muscles of your calves...sinking and sinking...leaving the muscles relaxed and limp...down towards your ankles now...pushing ahead of it all the tension that has built up...down towards your ankles...and you feel your toes begin to tingle slightly as all the tension drains from your body through your toes...down across your ankles and into your feet now...soothing and relaxing...through all the bones of your feet and all the muscles down towards your toes... through your toes and out...and now feeling relaxed...from the top of your head through all the muscles of your body...into your feet... breathing is quiet and regular...you feel relaxed and calm...and now I would like you to imagine an island scene...please see it from above... a small island...with a ring of warm white sand on the outside...lush green vegetation in the center of the island...and now see yourself standing on the edge of the beach...looking out across the beach...to the clean blue water...that stretches out to the horizon...take several

steps onto the sand...feel the softness under your feet...the warmth radiates up through the muscles of your feet...soothing and relaxing... you lay down on the sand...and feel the warmth through all the muscles of your body...soothing and relaxing...high overhead...a warm, yellow sun pours down around you...the warmth of the sand relaxing...comforting... a slight breeze blows across your face...the smell of salt water in the air...you look out across the blue ocean...to where it meets a clean, blue sky...you lay down and let yourself sink into the comfort and the relaxation...sinking and sinking...and the comfort and relaxation... very good...and now if you would turn your attention to another image... I would like you to imagine a blackboard in front of you...and see your hand holding a piece of chalk...and on the blackboard I would like you to print in capital letters...the word QUIET...beginning now...Q...U... I...E...T...QUIET...and erase the word...and begin again...Q...U...I... E...T...QUIET...QUIET...and as you look at the word...feel the calm and the quiet in your body...in your thinking and in your emotions...at this moment...say the word to yourself...QUIET...QUIET...and one more time erase the word...and again print the word...QUIET...Q...U...I...E...T... QUIET...QUIET...concentrate and let yourself sink into the calm and the quiet in your body...in your thinking...and in your emotions...as you look at the word...feel the quiet...QUIET...and now I would like you to visualize the sketch of the thermometer that you had done previously... I want you to see the bottom and the shaft and the top of the thermometer and see the gradient markings along the shaft...with 30 at the bottom and 80 at the top...and as you look at 30 on the bottom I want you to

feel the deep relaxation that you do at this particular time...feel the calm in your emotions and the quiet in your thinking...look at the number 30 at the bottom of the thermometer and feel the calm and the quiet...and now I want you to begin imagining the scene that we had discussed earlier that causes you distress...begin forming the picture... and see the problem taking shape...as you visualize this...you feel muscles begin to tighten...breathing begin to speed up and overall you become more tense and anxious...when you feel this develop... visualize the thermometer rising in correspondence with that feeling of distress...higher and higher it goes...up to 40...45...50...as you continue to visualize the distressing scene and symptoms of discomfort begin to develop please visualize the thermometer also rising...up to 55...60...65...as you become more anxious and uncomfortable...while you visualize the distressing scene...the thermometer also rises...70... 75...and now reaching the cut off point at 80...visualize the thermometer at 80...and this is the cut off point...and now I want you to concentrate on the image and as you feel all the discomfort that you do at this moment...I want you to visually bring the level of the thermometer down... and as you do this...all of the feelings of discomfort will also begin to reduce...dropping the level of the thermometer now to 75...70... slowly dropping and returning to a state of relaxation...65...60...55... the tension beginning to slip away and calm beginning to be restored... 60...55...50...45...beginning to feel calm and quiet again...returning to a state of relaxation...45...40...35...and visualize the thermometer back down to 30...at which point you feel the relaxation fully restored... concentrate now on the full feeling of relaxation...the calm in your

emotions...and the quiet in your thinking...the relaxation that is calm and quiet...calm and quiet...visualize the thermometer at the level of 30...and feel the calm and quiet...calm and quiet...and now I would like you to return to the image of the island and see yourself on the beach...relaxed and comfortable...feeling warm and calm and quiet...calm and quiet...and in a moment I am going to ask you to awaken and I will count from 5 to 1...at which time you will open your eyes...and feel refreshed, alert, calm and quiet. Beginning with 5... 4...3...beginning to awaken...2...1...and open your eyes please.

Client Evaluation:

Following completion of the relaxation-imagery procedure, discussion with the client should be undertaken to determine the client's mental and emotional status. Assess client for concentration and clarity of thought processes and to ensure that there is no residual affective distress from the procedure. Verbally review with the client the steps of the procedure and ask the client to comment on their experience at each step, evaluating relaxation response, clarity and ease of image formation and attention to the procedure.