TIME-LIMITED THERAPY

WITH ADULT SURVIVORS OF CHILD SEXUAL ABUSE:

MATCHING CLIENT NEEDS WITH EFFECTIVE TREATMENT

by

Darlene L. Archer

A Practicum report

submitted in partial fulfillment

of the requirements for

the degree of Master of Social Work

to the Faculty of Graduate Studies

University of Manitoba

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ISBN 0-612-12958-6

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TIME-LIMITED THERAPY WITH ADULT SURVIVORS OF CHILD SEXUAL ABUSE: MATCHING CLIENT NEEDS WITH EFFECTIVE TREATMENT

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A Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

This Practicum explores short-term treatment for adult survivors of child sexual abuse, with recognition of the fact that survivors have varying degrees of impact and symptomatology. The participants involved in the study effectively demonstrated a wide range of impact and different stages of disclosure and recovery.

Therapists working with sexual abuse survivors need to respond to the individual need of each client, depending on where each person is in his or her journey toward healing. This project demonstrates an attempt to match individual client needs with effective intervention. This task includes the integration of memory-based abreactive models of therapy and solution-focused therapy techniques.

Evaluation instruments used in this Practicum include the Brief Symptom Inventory, the Hudson Index of Self Esteem and the clients' thoughts and expressions concerning their experiences in therapy and signs or indications of change.

ACKNOWLEDGEMENTS

This Practicum provided me with an extraordinary learning experience, not only in the area of treatment for survivors of sexual abuse, but also in the realization of professional and personal goals and dreams. The support and encouragement of many people played a significant role in its completion.

I am very grateful to special friends, such as, Phillip Hay, Alexandra Wright and Michelle Hudson. Your unconditional acceptance and encouragement helped me through many difficult struggles that arose during this process.

Thank you to my children, Ray, Steve and Leah Archer who always believed in me and demonstrated profound love and support, even while sacrificing their own needs and goals, Each of you had a special part in keeping your mother motivated and determined to see this task through to completion.

I would like to express my gratitude to my committee members, who readily shared their wealth of expertise, patience and many types of support during each stage of my Practicum process. Shirley Grosser, Sara Axelrod, and Diane Heibert-Murphy enhanced and enriched my growth as a student, a therapist and a person.

Special acknowledgement and gratitude is owed to Shirley Grosser, who made numerous personal contributions of time and support during my periods

of crises. Additional thanks to you, Shirley, for your invaluable editorial comments and suggestions.

Lastly, but certainly not in the least, I thank each of the seven clients who participated in this Practicum. Without your wisdom and determination, this project would have been devoid of meaning and purpose. I have learned something about life and the human spirit from each of you and your powerful testimonies. Thank you for accepting me as a companion on your journey toward healing.

DEDICATED

TO THE MEMORY OF

BETTY ASSAILLY,

MY LATE MOTHER,

IN HONOUR OF

HER

STRENGTH,

COURAGE,

AND

DETERMINATION

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CHAPTER 1

INTRODUCTION

In the past decade and a half the issue of childhood sexual abuse has received broad recognition as a major social problem, by both social service and mental health organizations. Unfortunately, both large and small communities across Canada cope with limited professional resources in dealing with both short-term and long-term effects of abuse on survivors.

Most clinicians find that the process of recovery for adult survivors requires lengthy periods of time to work through troubling issues and problematic symptoms or behaviours. Much of the long-term therapy process is challenging and painful work for both client and therapist. Some Clients, for example, experience a regression in wellness and daily functioning along the way, which is often discouraging for both parties involved.

Theorists and clinicians have sought to refine their interventions with survivors, in hope of increasing the effectiveness and efficiency of treatment models, and of reducing some of the needless retraumatization that often follows a common strategy, within the work, - that of memory retrieval. In this past decade, theorists have added to the repertoire of techniques and strategies for reworking the past within treatment for survivors, especially in the midst of

a growing popularity of solution focused and brief therapy models. As new ideas surfaced, therapists demonstrated growing enthusiasm for the use of different techniques, particularly since these ideas employed a more positive and hopeful frame of reference and therapist belief systems.

Other therapists, who were perhaps more resistant to change, have viewed the concept of solution focused therapy with scepticism and suspicion. Consequently, therapists who at one time seemed united by their concern for survivors and their willingness to commit to a long process in their clients' recovery, now seemed to develop an adversarial stance toward each other. I have witnessed numerous debates in staff lounges and classrooms, where therapists and students argued for or against the different styles of treatment. It was at this time that I began to identify the strength from each opposing argument, and became interested in integrating ideas from each form of treatment. With this in mind, I selected to explore this challenge in my graduate study, through a practicum experience.

Purpose of the Study

The primary purpose of the practicum was to offer individual counselling for adult survivors of sexual abuse. My objective was to assist

clients to improve the quality of and the satisfaction in their lives, and to encourage and facilitate the personal empowerment of individual participants. My secondary purpose, was to learn more about popular treatment strategies through study and practice, and to discover a path for an efficient integration of theoretical principles.

EDUCATIONAL GOALS OF THE STUDENT

My personal goals for this project were to offer clients a positive experience in building and nurturing a healthy therapeutic alliance. This goal involved the use of interpersonal skills when engaging clients, and assisting them to discern and develop trust in others.

My second goal was to provide clients with a profound experience of empowerment through disclosure. I hoped to unravel inappropriate messages survivors heard in the past, especially in terms of keeping their abuse silent and hidden. I also hoped to assist clients to dismantle myths and untruths, that kept them from success and happiness.

Thirdly, I hoped to assist clients by helping them identify and manage troubling symptoms. I hoped to help clients understand the connections that often link problematic behavioral patterns with childhood trauma and abuse.

Lastly, it was my goal throughout this project to develop and enhance my professional knowledge, skills and abilities in providing treatment for survivors of sexual abuse. I hoped that by increasing and developing my

awareness and instincts, I might more effectively integrate contrasting or divergent theoretical principles and discover useful timing for their application.

This Practicum report is divided into a number of chapters. The literature review consists of two sections. The first will review the list of long-term effects commonly associated with a history of childhood sexual abuse. The second section of the literature review will review the theoretical premises and therapeutic techniques used by the abreactive models of therapy and the solution focused model for work with survivors.

Subsequent chapters of this report will present the Practicum methods, a presentation of case examples, and an examination of the outcomes or results. The report will conclude with a discussion of practical principles learned from this project concerning the impact of sexual abuse on adult survivors, as well as the usefulness and practicality of integrating two predominant models. In conclusion, I provide a brief statement of how my project design could be improved.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

We have reached a stage in our society's social development where we can engage in a meaningful discussion of issues related to child sexual abuse. This is an important shift from a historical precedent of discounting and minimizing disclosures, as was so frequently done prior to the mid 1980's.

Until recently, when women disclosed sexual abuse, they were discredited according to Freud's popular belief that females have a propensity for, or are affected by, hysterical states of delusion and emotional instability (Saunders, 1988). Similarly, when children told stories of abuse, they were thought to be either confused by the highly suggestive nature of a mother's "panicky questions" (Olafson, Corwin & Summit, 1993), or victims of their own childhood fantasies (Saunders, 1988).

However, something has changed in the past ten years, so that we now think and speak about these matters differently. We see this change developing as a result of both the women's movement and the child protection movement, and their ongoing effort to raise social consciousness of ways in which women and children are victimized today, and throughout history (Finkelhor, 1984). Consequently, with an alarming new trend of unmasking abuse gaining momentum, our modern world, suddenly dislodged from its former state of denial and complacency regarding the issue, has been thrust into the crest of the wave . . . confronting child sexual abuse. Frequent media campaigns inundate the average home with numerous sensational and horrifying tales. They may arouse social outrage, and force professionals to acknowledge sexual abuse as a major social problem. Consequently, members of the public may discuss the issue in casual conversation which, while aiding public awareness on the one hand, contributes to some serious myths on the other. For example, many people influenced by talk shows and tabloids, have come to believe that adults molested as children are destined to struggle with lifelong psychological hangups. However, Finkelhor et al. (1989) refute this myth with a reminder that "a history of sexual abuse is only a risk factor for developing an impairment, and the development of such a problem for any individual is far from inevitable" (p.395).

It is interesting to note that even though the existence and prevalence of sexual abuse is now well documented and substantiated, attitudes reminiscent of old Freudian theories still manage to resurface. In both courtroom and family therapy sessions, survivors' testimonies are often dismissed or discounted, sometimes through influence from the False Memory Syndrome Foundation, referred to herein as FMSF (Fredrickson, in Winnipeg, 1993; Wylie, 1993). Many survivors continue to be accused of falsifying testimony, shamefully seeking attention and notoriety, wrongfully seeking revenge against innocent others, and of using sexual abuse as a rationalization for any number of problematic symptoms and behaviours (Wylie, 1993). I believe that the media bear some responsibility for this most recent development since in many ways, it has either glamourized persons with a sexually abusive past, or to the other extreme, it has reinforced society's inherent tendency to stigmatize and blame victims.

It should be noted however, that the movement of the FMSF has provided some benefit to the cause of victims and their families by challenging and motivating therapists to sharpen their clinical skills. Clinicians today, perhaps work harder than before to prevent their own use of poorly framed or suggestive questions, so as to avoid "contamination" of client's memories

(Yapko, 1993). Even so, I believe that the FMSF has done more to blur the reality of this recent problem, and cast shadow and doubt over research findings, than it has aided the cause of discerning truth. Fredrickson (in Winnipeg, 1993) explains that there is no doubt in her mind that "false" memories exist, "however, more often than not, they belong to perpetrators and non-supportive family members, than to victims in therapy."

Within this overview of past and present grappling with issues related to sexual abuse, it appears as though we have gone full circle. Yet, even during the revival of old scepticism and doubt regarding the issue, public interest and concern has not been withdrawn. In fact, numerous disclosures continue to be made, and a steady stream of victims continue forward, in search of therapy and support.

Unfortunately, we as a society, are not yet adequately prepared for the tremendous backlash of bringing these issues to the fore. In the face of a longstanding shortage of affordable programs and services, vast numbers of victims and survivors are often held in an awkward and somewhat re-victimizing state of powerlessness, before they can be seen by a therapist. Meanwhile, mental health organizations, strangled by the lengths of their own

waiting lists, are now overwhelmed and overextended, which of course impacts on quality service provision. Therapists, once so eager to learn theories and treatment models for work with survivors, are now so drained and emotionally taxed by the experience, that all too often, frustration, despair and scepticism have moved in where enthusiasm, compassion and hope used to be.

In conclusion, therapists today require a well-developed understanding of the problem of sexual abuse and the range of effects associated with it, a unique ability to apply treatment principles with skill and compassion, and the profound ability to keep oneself grounded, and in good mental health, in spite of the unfortunate chaos and confusion surrounding the theme.

DEFINITION OF SEXUAL ABUSE

As soon as one begins a review of the literature on the subject of child sexual abuse, one quickly discovers a problem that has plagued research in this area for years. How does one define the concept when so much conflict and inconsistency exist among experts, in terms of the use of definitions, either too narrow or too broad, to describe or distinguish sexual abuse from inappropriate play between adults and children; curious exploration of body parts and

genitalia among young peers; or perhaps "failed attempts" of sexual assault, where no contact occurred.

Some researchers draw lines of distinction around indications of contact, some form of anal or oral penetration, and of course vaginal intercourse (Briere & Runtz, 1988; Finkelhor, 1984; Finkelhor et al., 1990; Russell, 1983). For others however, this definition is too conservative, and fails to address some of the subtle or suggestive acts of abuse, including verbal harassment and indecent gestures or nudity.

It is interesting to note, for example, that in Finkelhor's 1981 study of a sample of Boston families, he states that "what most parents consider sexual abuse in reference to their own children includes many things that professionals in the field would not consider such" (1984, p.74). Finkelhor explains that when acts of indecent exposure, verbal harassment and sexual gestures occur in the absence of physical contact, they ought not to be perceived as sexual abuse per se, but as "thwarted attempts of sexual abuse" (p.74). Years later, Finkelhor describes questions he used in another survey as problematic because they were designed to include experiences without

physical contact and were therefore, lacking in their ability to "exclude experiences that did not meet the researcher's criteria" (p. 20).

I feel perplexed when undue weight and priority are placed on the researcher as holding the position of the expert in discerning what ought or ought not be recognized as abuse. The implications of this pattern put children at risk since acts experienced by the victim as abusive, are then minimized or trivialized by social authorities. Perhaps researchers need to find more relevance for their work in the victim's perception of the experience and reflect these perceptions more clearly in their research designs and report writing. Perhaps this reminds us that research is never as objective as one would have it, and one's attempt to operationalize a concept, in this case sexual abuse, is inevitably flavoured by the researcher's own bias.

On the other hand, there are experts who stretch the limits of the previous definition, to include nonphysical contact. Sandra Butler (1978) says that "any sexual activity or experience imposed on a child which results in emotional, physical or sexual trauma (is abusive) . . . the acts are not always a physical one" (p.5). Courtois (1988) explains that broad definitions of incest have purpose and meaning therapeutically, but are not always recognized

legally or in the psychiatric community. She states however, that in her use of the definition, "incestuous abuse can include gestures, comments and observation as well as actual body contact" (p. 13).

For the purpose of this document, a definition of sexual abuse includes any act (physical or nonphysical) that is imposed on a child that serves no other purpose other than to provide for the curiosity or sexual gratification of the abuser. The child does not have the power, nor does he or she have the emotional or sexual development necessary to give consent to involvement. I deliberately exclude Butler's (1978) comments regarding physical, emotional and/or sexual trauma because, in some instances, sexual abuse occurs without any apparent traumatic effect. The absence of trauma however, does not eliminate or reduce the exploitative or violent nature of the deed.

PREVALENCE OF SEXUAL ABUSE

When one confronts so much difficulty defining the term, sexual abuse, one is sure to encounter more problems sifting through prevalency rates. For example, some survey questions restrict the inclusion of data without indications of physical contact, while others do not. Second, when sampling

methods vary from study to study, the resulting data are likely to show differing rates. Third, some researchers include data reported by subjects relating to sexual activity between peers whereas others do not.

Regardless of the differences in findings, most researchers agree that reported incidents of sexual abuse are underestimations of reality. Many acts of abuse occur without detection, without disclosure, and often without evidence. In fact, Finkelhor et al. (1986) estimated that anywhere from 6-62% of all adult females, and 3-31% of all adult males have been sexual abuse victims. Finkelhor et al. (1990) reports statistics from a survey of 2,626 adults in the U.S.A., stating that 27% of women and 16% of men have a history of sexual abuse. Some examples of research findings from other sources are as follows: Russell (1983) reported that 16% of her female sample had a least one experience of intra familial sexual abuse before reaching 18 years of age; twelve percent had been sexually abused by a relative prior to 14 years of age; and 31% reported at least one experience of sexual abuse before reaching 18 years of age. Briere's (1984) clinical study reveals that a little less than half (43.8%) of his female sample was sexually abused, but he notes that these prevalence rates need to be used with caution since the sample was taken from a clinical treatment population and cannot be generalized to a non-clinical

population. Wind and Silvern (1992) state that 28% of their female university sample reported a history of sexual abuse; which is similar to the findings of Parker and Parker (1991) who found that 27% of their female university sample were sexually abused.

Perhaps we need recognize that an opposing view from the FMSF claims that current statistics are skewed by therapists' implantation of false memories, and over-exaggerate the rate at which sexual abuse occurs (Wylie, 1993). We would all be more comforted if significantly fewer individuals were sexually victimized than statistics show. However, criticism of research studies based on the idea that many or most therapists are guilty of imparting false memories in the minds of clients, does nothing more than shift blame from survivors of sexual abuse to the therapists who treat them.

LONG-TERM EFFECTS ASSOCIATED WITH CHILD SEXUAL ABUSE CAN WE KNOW THE EFFECTS?

Ideas concerning the long-term effects of childhood sexual abuse vary from one clinician or study to the next. Perhaps this is explained by the relative infancy stage from which experts recognize the problem, and gather information from victims concerning the impact of their abuse experience. Sexual abuse has received

wide spread coverage only within this past decade; therefore, exploration of the long-term effect is thus limited by certain obstacles. For example, retrospective research is the most popular method used to study adult survivors, and this method is solely dependent upon the subjects' memories, many of which may be forgotten, repressed or distorted. Secondly, researchers also contend with the presence of hidden and sometimes extreme subjectivity from which each research subject views the severity of his or her abuse and its effects; and this perception, as Finkelhor (1990) noted, may not always fit the researcher's criteria. To say the least, gathering information from research subjects in ways that allow for the generalization of the findings, especially in reference to sexual abuse, is never easy.

Another problem that impedes our ability to assess the extent of long-term damage with any degree of certainty involves the fact that often several factors, including other forms of abuse, can contribute to existing problems and symptomatology. Briere and Runtz (1990) designed a research project to assess the extent of all forms of child abuse (i.e. physical, sexual and psychological), and examine their specific and overlapping associations with various types of psychological symptoms. Their purpose was to "address the issue of whether a given problem or symptom associated with one form of abuse may actually arise from other coexisting forms of abuse, thereby allowing the researcher to

disentangle the source of trauma that often comprise a negative childhood" (p. 358).

Although the process of "disentangling the source of trauma" provides one with interesting information, assuming it is in fact possible; I question if this information really tells us anything useful. After all, one cannot presume to claim that the existence of a statistically strong relationship between research variables removes or eradicates the need for concern over the "less significant" relationships. In other words, even though Briere and Runtz (1990) report that a "substantial" relationship exists between parental psychological abuse and a victim's low self esteem, they do not claim that one's self esteem is therefore unaffected by sexual abuse. Therefore, we still lack certainty in our ability to know the extent to which sexual abuse impacts upon a victim's self esteem . . . from this example, all we know is that when compared with psychological abuse, self esteem is not as strongly impacted as the sample's sexuality. So, what are the implications of this? Do we ignore self esteem issues in the treatment process surrounding sexual abuse? Obviously not.

Another important fact to consider is that there is no evidence that cannot be at least partially explained by the presence of other forms of abuse or trauma,

that can pinpoint or prove that sexual abuse causes emotional damage to victims. We can only say that sexual abuse increases one's risk of encountering psychological difficulties. Finkelhor, et al. (1989) states however, that even in the absence of conclusive empirical data producing evidence that sexual abuse is a causal factor of adult symptomatology, most researchers believe that it is, at least to some degree. Still, in spite of what appears painfully obvious, clinicians must continue to exercise caution in the way they formulate and communicate ideas regarding sexual abuse.

The fact is, we really do not know what the long-term effects of sexual abuse are. The reality of life is such that many sources of trauma, including those that are unrelated to abuse, may contribute to the complexities of problems experienced by people. (Briere & Runtz, 1988; Briere & Runtz, 1990; Jehu & Gazan, 1983; Wind & Silvern, 1992).

THE RANGE OF REACTIONS AND POSSIBLE EFFECTS

Literature describing the scope of long-term reactions and common effects frequently associated with child sexual abuse covers a significantly wide range. Some survivors demonstrate rather strong reactions to their abuse history, and

struggle with a myriad of effects ranging from chronic and acute depression, anxiety, eating and sleeping disorders, difficulties with trusting others, low self-esteem and many other distressing patterns or problems (Bass & Davis, 1988; Briere, 1984; Briere & Runtz, 1990; Browne & Finkelhor, 1986; Courtois, 1988; Finkelhor et al., 1989; Jehu & Gazan, 1983; Jehu, Klassen & Gazan, 1985). On the other hand, some survivors appear to have very little reaction to their abuse, or describe their experience as "neutral, mildly disturbing or positive" (Courtois, 1988, p. 91).

It is usually difficult for most clinicians to accept the idea that one would describe his or her abuse as "mildly discomforting," let alone "positive." Clinicians are familiar with the phenomenon that some survivors, consciously or otherwise, minimize the significance of their abuse history. Clinicians might thus attribute the "mildly discomforting" and "positive" responses to such minimization. One therapist wrote, "Minimization serves a protective function by allowing the survivor to remember the experience, but deny its impact and therefore, avoid experiencing the related feelings." (Drauker, 1993, p. 250).

At the same time however, clinicians must strive toward the development of a balanced perception, being mindful of minimization, but keeping one's mind

open to the possibility that for some, sexual abuse has little or perhaps no long-term effect. A balanced perception avoids the danger of assuming a level of damage, and thus projecting this assumption onto clients, perhaps creating harmful effects. I wonder if Drauker made the mistake of many therapists by suggesting to clients that abuse is damaging, thereby influencing or contaminating her clients' perceptions.

Drauker (1993) quotes a client:

> *She did make me recognize the fact that (sexual abuse) was a big deal, and just knowing it was a big deal made me concentrate more on it. I hadn't realized that---how big a deal it was. It was affecting every aspect of my life, not just my personal relationships, everything I did revolved around my problem with incest (p. 250).*

We do our clients and ourselves, as therapists, an injustice when we are not mindful of ways in which our use of language may contaminate our work (Dolan, in Winnipeg, 1994). All too often, people are trained by their therapists to believe that victims will inevitably encounter major disruptions and dysfunctions in their adult lives and relationships, as a result of their abuse. However, Finkelhor et al. (1989) explain that the discussion of the long-term effects of sexual abuse needs to be tempered with caution, since we often neglect the fact that many victims do

not suffer extreme disturbance and psychopathology. "Research showing that sexual abuse is associated with problems in adulthood, must not be misinterpreted by victims, their families or their therapists as a guarantee of dismal prognosis " (p.396).

So, what is it that makes a difference in the lives of survivors, so that they are able to avoid extreme symptomatology? After all, Browne and Finkelhor (1986) note that "most sexual abuse victims in the community, when evaluated in surveys, show up as slightly impaired or normal" (p. 164). According to some clinicians, indications of social support, particularly from one's family both prior to abuse, and subsequent to disclosure, promote ongoing progress in healthy development and positive coping (Parker & Parker, 1991; Yama, Tovey & Fogus, 1993). In addition to this, Feinhaur and Valentine (1993) learned from their study of stable survivors, that prevalent resiliency themes include:

> *the ability to find emotional support outside the family; self-regard, or the ability to think well of oneself; religion or spirituality; external attributions for blame and cognitive style; and an inner-directed locus of control which seemed to emanate from internal values rather than from expectations and directions of others (p. 218)*

Most of the literature written on the subject of long-term effects of sexual abuse includes a description of the following eleven areas of personal development that are often damaged or effected by sexual abuse and exploitation.

Low Self-Esteem

Low self-esteem is frequently mentioned in literature describing long-term effects of sexual abuse. Browne and Finkelhor (1986) claim that "women with very poor self esteem were nearly four times as likely to report a history of child sexual abuse as were other subjects . . . self esteem problems among clinical samples of incest victims tended to be much greater" (p. 70). Courtois (1988) notes that the low self esteem of incest survivors is substantiated by his or her inability to explain why a loved one would sexually abuse him or her. She explains that "in the absence of information to the contrary, (survivors) answer this question in their own disfavour, (assuming they caused the abuse or signalled their willingness)" (p.105).

Gelinas, (1983) states that "relational imbalances have taught (victims) that they literally have no rights, particularly to needs of their own: nothing is owed them, . . . With such fundamentally impaired self esteem, incest victims

tend to be extremely unassertive and passive, to the point of paralysis" (p.322). Extreme passivity increases one's risk of revictimization and may produce other problems in interpersonal relationships.

Jehu (1989) reported that when using the Belief Inventory to ascertain the prevalence of self denigratory beliefs among survivors, 78% reported that the statement "I am worthless and bad," was partly, mostly or absolutely true. Ninety percent of victims believed, to some degree, that they were inferior to others because they did not have normal experiences; 76% believed they would never lead a normal life because the damage was permanent; and 82% of victims believed that others would not want anything to do with them because of their sexual abuse.

Briere and Runtz (1986) explain that often survivors of sexual abuse become suicidal, partially, because of their low self esteem. They state that "a poor self concept mitigates against valuing oneself enough to want to live or avoid self destruction" (p.417). Extreme forms of self hatred and contempt can result from internalized social stigmatization and/or incorporated negative messages from one's abuser (Browne & Finkelhor, 1985). Therefore, survivors often perceive themselves as Courtois (1988) explains, as having deserved the abuse, while

claiming responsibility for it. Feeling both responsible for and deserving of the abuse can reinforce the guilt and shame that are frequently internalized by survivors and create problems in self esteem. These beliefs also lead some survivors to suicide or other forms of punishment (Briere, & Runtz, 1986).

Impaired Relationships

Researchers often report that adult survivors have problems with interpersonal relationships. (Briere, 1984; Courtois, 1988; Gelinas, 1983; Herman, 1981; Jehu & Gazan, 1983; Jehu, Gazan & Klassen, 1985). In marital relationships, for example, Finkelhor et al. (1989) state that for women, a history of sexual abuse is associated with "more marital disruption, more marital conflict, more fear of men, and more sexual problems" (p.393).

Herman, (1981) explains that:

> *Many of the women described themselves as "different" or stated that they could never be "normal" . . . The isolation that these women felt was compounded by their own difficulty in forming trusting relationships. The legacy of their childhood was a feeling of having been profoundly betrayed by both parents . . . they came to expect abuse and disappointment in all intimate relationships: to be abandoned, as they felt their mothers had abandoned them, or to be exploited, as their fathers had exploited them (pp. 96, 98-100).*

Similarly, Gelinas (1983) explains that most female survivors experience much confusion and doubt regarding their role, especially in terms of "obligations and entitlements in relationships" (p.323). She explains:

> *one implication of this exploitative family system is that the patient will tend to allow or even induce future relationships to follow the same patterns. Having internalized the roles, identity and relational patterns of the family, she is at risk to recapitulate these patterns, with herself as the exploited, over-responsible caretaker, with no rights to reciprocity and no self separate from her caretaking functions. She may eventually become chronically depressed, apologetic but vaguely resentful, with poor self esteem (p. 325).*

Herman (1981) and Courtois (1988) refer to the fact that some female survivors tend to idealize men and overvalue their relationships with them. This pattern reinforces negative risks since the unrealistic perception of an abusive partner, in addition to a high propensity for self blame and self criticism, leads easily to ongoing abuse and all the classic, erroneous beliefs of deserving it as well. Briere (1984) reports that 48.9% of female subjects from his clinical sample were battered in adult relationships; Russell (1986) found that from 38-48% of her sample experienced violence in their marriages; and 40-62% of these same women were sexually assaulted by their husbands.

So far, the impact of sexual abuse on interpersonal relationships has been described in this paper in reference to adult female victims. Information regarding male victims of child sexual abuse is much more difficult to obtain. Finkelhor et al. (1989) make note of the fact that male survivors experience similar difficulties in sexuality and marital functioning as previously found in women. They claim however, that 28% of male victims versus 17% of nonvictims said that the recent attention to sexual abuse has made them more fearful of interactions with children. They are "less likely to want to be alone with other people's children, to offer to baby-sit, to hug (or) . . . to hold children, to help a lost child, or to smile at children they didn't know" (Finkelhor et al., 1989, p.395).

Depression

Depression is the most commonly reported effect of sexual abuse among adults molested as children (Browne & Finkelhor, 1986). Jehu, Gazan and Klassen (1985) report that fifteen out of twenty-one subjects involved in their study, experienced symptoms of clinical depression at borderline, moderate or extreme levels. Browne and Finkelhor (1986) report that "subjects with a history of child sexual abuse scored more depressed on the Centre for Environment Studies Depression Scale, than did non-abused women (17% vs. 9% with clinical

symptoms in the last week), as well as on the Middlesex Hospital Questionnaire's measure of depression (15% vs. 7%)" (p.69).

In a study involving a non-clinical sample, Briere and Runtz, (1988) support the previous findings even though their scores are less dramatic. They report that the abused group scored higher (22.8% vs. 20.6%) than the non-abused group in chronic depression; and slightly higher (19.6% vs. 18.1%) for acute depression.

It is important to note that not all researchers report these findings. For example, Wind and Silvern, (1992) did not find any significant differences between depression scores taken from the abused and non-abused groups. On the other hand, when the nature of abuse involved both physical and sexual abuse, scores between abused and non-abused groups showed significant difference.

Similarly, Yama, Tovey and Fogus (1993) report that family environment tends to influence the degree of impact of sexual abuse. In reference to depression, Yama et al. (1993) explain that:

> *sexual abuse was related to higher levels of depression when families were perceived as high in conflict, and it was related to lower levels of depression when*

> *families were perceived as high in control. (Sexual) abuse also appeared to be associated with more depression when the family of origin was perceived as more cohesive (p.139).*

Self-destructive Behaviours

Adult survivors act out the long-term effects of sexual abuse in a variety of ways. Often an individual will be so conditioned to the role of victim, and her self concept so depleted, that she continues the destructive process even though the original abuse has ended:

> *The goals and motivations of different types of self-damaging behaviours vary quite markedly and differ by degree of seriousness; however, all involve some measure of self-directed hatred and rage often operating at an unconscious level. These behaviours can be conceptualized along a continuum from less too more severe with overlap between them. They may be solitary or may involve getting others to be hurtful or destructive (Courtois, 1988, p.302).*

In most cases, harmful behaviours are reduced or discontinued as survivors experience positive support and develop healthier coping skills. However, some individuals continue and even increase the severity of self injurious conduct during periods of crisis or as more past memories and pain surface. Some of the

most common destructive patterns utilized by survivors are described in some detail in this next segment.

Substance Abuse

Child sexual abuse has a direct effect on both alcohol and drug use (Browne & Finkelhor, 1986; Watts & Ellis, 1993;). The proportion of substance abusing clients who were sexually victimized earlier in their lives, ranges from one-third to 70% for women, and from 6.6% to 24% for men (Watts & Ellis, 1993). Briere (1984) found that 27% of sexual abuse victims had a history of alcoholism compared with eleven of non-victims; and 21% had a history of drug addiction versus 2% of the non-victims. For this reason, " . . . researchers conclude that the problem of sexual abuse for chemically dependent women is so great that substance abuse treatment programs must include a substantial component of sexual abuse counselling" (Watts & Ellis, 1993, p.184).

Perhaps people question what purpose survivors find for the use of depressants such as alcohol and other chemicals to cope with problems. Some survivors use chemicals to find relief from stressors, both related and unrelated to their abuse. For example, Gelinas (1983) refers to mothers sexually victimized as children, who turn to alcohol when feeling "preyed upon by their children" and

overwhelmed by their needs. Here, alcohol is used to "muffle the effect" of stressful demands.

Others will use alcohol as a method of numbing (Bass & Davis, 1988) or self medicating (Courtois, 1988). Numbing one's mind and body is the only way some victims can engage in sexual activity and see various sexual acts through to completion.

On the other hand, Courtois (1988) notes that while some individuals use substances to self medicate and escape, others will use them to get in touch with their feelings. In some instances, chemicals are used to express and act out rage:

> *I also got more physically destructive when I was drinking. I could tolerate more physical pain when I was drunk: I had been drinking when I burned my arms and during several suicide attempts. I could express my anger under the influence of alcohol, and I purposely started fights so my boyfriend would beat me up . . . I felt I deserved it . . . (Courtois, 1988, p.312).*

It is also important to note that the abuse of chemicals among male victims will increase the preexisting risk of perpetrating sexual abuse against others. "Several researchers contend that males sexually abused as children are at risk for

becoming abusers of children as adults" (Vander Mey, 1988, p.68). Since chemicals such as alcohol are known to reduce or numb the inhibitive forces that usually prevent abusive behaviours, it becomes clear that while under their influence, victims, predisposed to such offences (whether they be male or female), may be exposed to higher risks of sexual perpetration.

Eating Disorders

A lack of information exists in reference to the relationship between child sexual abuse and eating disorders. I found no studies within sexual abuse literature showing the prevalence of this symptom among survivors, even though several authors refer to the problem as a symptom frequently associated with sexual abuse (Bass & Davis, 1988; Courtois, 1988; Dolan, 1992; Rew, 1989; Young, 1992).

Courtois (1988) states that "a history of sexual abuse has been most frequently associated with bulimia, but it seems to have a relationship with compulsive overeating and anorexia as well" (p.314). The explanation for this involves the idea that eating disorders provide individuals with a means of restoring power and control over their bodies (Bass & Davis, 1988; Courtois, 1988; Young, 1992). For example, some individuals believe that by either emaciating their bodies or gaining excessive weight, they reduce their sex appeal,

and discourage sexual advances. Young (1992) provides an example of this idea in an excerpt from a client's journal:

> *Someone came up to me the other day and said that I looked gaunt and it made me feel happy and safe. I have a friend who was sexually abused as a child and for a while she shaved her head and starved and everybody said she looked like a concentration camp victim and she was thrilled. I completely understand that. If you don't have a body, you can't be hurt (p.96).*

For others, eating disorders are a way of punishing the body and inflicting self abuse (Courtois, 1988; Young, 1992). Young (1992) explains that the body can be perceived by victims as a "foreign container" holding all of the bad memories and feelings associated with abuse. Starving oneself is one way to be rid of the "foreign container" and all of the "intolerable feelings and painful memories" (Young, 1992, p.96).

Lastly, eating disorders can also be used by survivors as "a means of physically representing the non-nourishing atmosphere of the family" (Courtois, 1988, p.314). Once again, Young (1992) provides as example of an anorexic client's powerful use of metaphor:

Her body was a precariously maintained shaft in an abandoned mine, its treasures long ago ripped out and taken away. Periodically the mine was turned inside and out by thieves and miners searching for something of value, who, in their rage at finding nothing, smashed up the remaining shafts and left (p.96.).

Post-Traumatic Stress Disorder

The American Psychiatric Association (1987) states that in order to diagnose post-traumatic stress disorder (herein after referred to as PTSD), the following criteria must be evident in the client's history and current experience:

The individual experienced a "psychologically distressing event" of a magnitude that would evoke disturbance in almost anyone.

The individual re-experiences the trauma through recurrent and intrusive dreams, nightmares or "flashbacks" of the original traumatic event.

The individual experiences a "numbing of general responsiveness" in an effort to avoid the external world. This includes dissociation, withdrawal and a loss of interest in other life experiences and relationships.

The individual may exhibit other reactions or symptoms such as sleep disturbance, difficulty concentrating, memory problems, irrational guilt and hyper-vigilance to danger or situations that resemble the original trauma.

Kaplan and Sadock (1991) state that "the psychoanalytic view of post-traumatic stress disorder is that the trauma reactivates unresolved conflicts from early childhood: including irrational traumas of childhood that had been unconscious. The revival of the childhood trauma results in regression and the use of defence mechanisms of repression, denial and undoing. There is a repetition by the ego to relive and thereby master and reduce anxiety." (p. 410).

Briere (1984) demonstrated that conditions of PTSD, when grouped with a host of other symptoms such as alcoholism and/or drug addiction, problems with anger, decreased sex drive and several other difficulties comprise "post-sexual abuse syndrome." PTSD and other symptoms of post-sexual abuse syndrome involve patterns of behaviour "which were originally coping mechanisms or conditioned reactions to a childhood characterized by victimization," (Briere, 1984, p. 12).

Dolan (1991) states that "a PTSD diagnosis is helpful for survivors of sexual abuse because the definition not only has a normalizing effect for clients, but also is clinically accurate. When symptoms of childhood sexual abuse are explained as initially reasonable, and in many cases valuable, efforts to survive extreme psychological stress, they become less stigmatizing in clients' eyes . . . Seeing themselves in the same group as victims of natural disasters, aeroplane and car accidents, and random criminal assaults can be helpful in overcoming a tendency to blame themselves rather than the perpetrator" (p. 5).

Kaplan and Sadock (1991) explained that the development of PTSD is positively correlated with the severity of the stressor, in other words, not all survivors of trauma develop PTSD, but the risks of this are higher when severe trauma is involved. Survivors whose childhood sexual trauma involves excessive force, violence and incest are more likely to develop symptoms of PTSD than survivors with more subtle or suggestive sexual experiences that may occur without physical contact.

Dissociation

Silon (1992) states that "dissociation is a self-hypnotic state which leads to the alteration of awareness" (p. 154). Stafford (1993) adds that "the term dissociative implies a separation such as the separation of feelings from thoughts or memories that ordinarily accompany those feelings. Another way of phrasing this process would be splitting off of some group of memories from the rest of the individual's identity, a classic example being that of amnesia." (p. 15).

Since all of us dissociate from time to time, the level or degree of separating the mind from the body varies from one individual to the next. Therefore, dissociation is usually described on a continuum since there is an observable range of dissociate states, some rather common and useful while others are more complex and problematic. (Chu, 1991; Stafford, 1993).

Some dissociative states enhance periods of restfulness, relaxation and creativity. Others increase the individual's ability to manage stress, pressure and pain while accomplishing difficult tasks that might otherwise seem impossible.

Further along the continuum of dissociative states "splitting off" becomes problematic. Stafford (1993) states that dissociation can alter individual

consciousness so that "thoughts, feelings and actions are supposedly not integrated in the usual way" (p. 17). She adds that "two characteristics are found in the most extreme types of dissociative experiences: disturbance in the individual's sense of identity and a disturbance of memory," (Stafford, 1993, p. 17).

Courtois (1988) states:

> *Dissociative symptoms are manifest by recurrent nightmares and night terrors, amnesia, especially for large segments of childhood, trance states, perceptual distortions, feelings of depersonalization or of seeing the self from afar, feelings of derealization, fainting spells, migraines . . . seizures and "sliding" or multiple personalities, (p. 99).*

Separating or splitting of the mind away from the body during sexual victimization is used by the victim as a defence against the stress and trauma of abuse (Strick & Wilcoxon, 1991). When the abuse is ongoing, the dissociative tendencies become regularized into the victim's day to day experience. This can pose a threat to the identity development of the victim, which may interfere with his or her ability to integrate memories into consciousness (Stafford, 1993).

Silon (1992) states:

> *The "wall" or dissociated state was the place some retreated to wall-in their emotions and early woundedness. Behind the wall they were safe to hide or block out early memories, to remain numb, insulated and detached from the pain . . . as the child, and later adult, spends more time in a dissociative state, building thicker walls to protect one's narcissistic wounds, more alienation and emptiness is experienced. (p. 161).*

According to Briere's (1984) clinical study, 41.8% of sexually abused subjects reported dissociative experiences compared with 22.1% of his non-abused sample; 32.8% vs. 10.5% experienced feelings of derealization; and 20.9% vs. 8.1% reported having out of body experiences.

Multiple Personality Disorder

Multiple Personality Disorder (referred to herein as MPD) is the most severe form of dissociation (Courtois, 1988; Dolan, 1991). "In the past, a lack of awareness of dissociative phenomenon lead to MPD being under-diagnosed" (Chu, 1991, p. 200). Chu adds that an increasing recognition and acceptance of the clinical profession for MPD has since lead to other dissociative disorders being misdiagnosed as MPD.

Stafford (1993) states that MPD can be effectively diagnosed and understood following three key points:

Multiple personality disorder (MPD) is a dissociative disorder in which two or more distinct personality states exist within an individual. At least two of these personalities recurrently take full control of the person's behaviour.

Most MPD clients report histories of severe childhood trauma, particularly physical, sexual, and ritual cult abuse. MPD most likely originates in childhood, but is not usually diagnosed until adulthood. In most reported cases the first dissociative episode is thought to have occurred at a very young age.

Signs and symptoms that suggest MPD include a history of medical and psychiatric diagnoses; inconsistencies in accounts of elapsed time and physical behaviours: psychophysiological complaints; experiencing voices inside the head; and an individual referring to herself as "we" instead of "I."

Rivera explains that individuals with MPD usually exhibit a wide array of symptomatology that permeates their past and present life:

> *Suicidal depression, severe somatic complaints, amnesia, self-mutilation, passive-influence phenomenon, fugue episodes, unstable personal relationships, sleep disturbances, nightmares, flashbacks, sexual difficulties, intense dysphoria, and dramatic swings in affect and behaviour are among the many symptoms of this post-traumatic condition (Rivera, 1991, p. 79).*

Courtois (1988), explains that:

> *The personalities, whatever their total, have varying degrees of distinctness and complexity, many with very different habits, values, and ways of expressing themselves. The individual may change dress, speech, mannerisms, body posture and movement according to the identity of the dominant personality at the time . . . The functions of the secondary personalities vary. They usually developed after the occurrence of trauma as protection against emotional pain. Later, they enable the individual to act on aggressive and sexual impulses unacceptable to the original personality. Common alternates include a fearful, dependent, childlike personality; a reckless, promiscuous personality who acts out forbidden aggressive and sexual impulses; and a calming, rational, soothing protector or advisor. At least one personality, usually that of a child, contains the memory of the abuse and the terrifying experiences. (p. 156).*

Courtois (1988) elaborates further, stating that:

> *The personality that seeks treatment in adulthood commonly presents as depressed, anxious, and suffering from psychosomatic symptoms. Presenting problems include substance abuse, homicidal, suicidal or self-mutilating behaviour, auditory hallucinations (usually from within rather than outside of the self), psychotic episodes, amnesia, criminal behaviour, hysterical conversion symptoms, phobias and sexual problems. (p. 157).*

Rivera (1991) concluded from her research based on 185 cases involving clients with MPD that 92% were female; 98% experienced physical abuse in childhood; 98% sexual abuse; and most experienced both physical and sexual abuse.

Self-Mutilation/Suicidality

Self mutilation and suicidality are also associated with a history of child sexual abuse. Briere and Runtz (1986) claim that "clients who are sexually victimized as children were over two times more likely to have made at least one suicide attempt in the past than were non-abused clients, and were more likely to be suicidal at the time of their intake" (p. 417). Similarly, Sedney and Brooks

(1984) found that 39% of their college sample of sexual abuse survivors thought about harming themselves physically, 16% of these had made at least one attempt.

Young (1992) explains that self mutilation often represents the survivor's wish to cut his/herself loose from the body, to be rid of it once and for all. She also explains that some survivors desire to punish and torture their own body as a result of their hatred of it for having been small, weak and vulnerable. "They seem to treat the body with the same callused disregard and cruelty, the same indifference to the value and sanctity of the human body, as the aggressor (his or her abuser)" (Young, 1992, p. 99).

Briere and Runtz (1986) offer explanations for survivor suicide ideation as:

- reflecting the intensity of the survivors self blame;
- the extreme sense of powerlessness over their situation;
- a cry for help;
- their sense of isolation, alienation and abandonment from others, in other words a lack of either social support and/or trustworthy relationships.

Sex and Sexuality

Bass and Davis (1988) explain that many survivors encounter repeated patterns of previous victimization from current relationships with abusive partners. For some, this pattern involves dangerous and/or humiliating sexual activities. Dolan (1991) states that the symptom of dissociation continues to place many survivors, especially women, in risk of danger and damaging sexual experiences. The separation of the mind from real danger for the body allows the individual to remain in situations that hold potential for ongoing damage to self esteem. For example, many women internalize a message that sex is all they are good for. Dolan (1991) explains that since survivors often discount or disbelieve that they are loveable or worthy of good relationships, they may use sex to "barter" in exchange for involvement in a relationship.

According to research, many survivors resort to prostitution in adolescence and adulthood (Browne & Finkelhor, 1986; Courtois, 1988; Jehu & Gazan, 1983; Jehu et al. 1985). Jehu and Gazan (1983) state that "sexual exploitation at an early age lowers the victim's self-esteem and lessens her resistance to viewing herself as a saleable commodity" (p. 74). In other words, survivors often view themselves, sex and sexuality in less than positive terms, which can lead to self destructive sexual patterns and behaviours.

I have heard therapists and social work students discuss a survivor's involvement in prostitution in a sentence linking sexual abuse and promiscuity. I am inclined to separate these issues, in spite of the fact that they share a common theme, sex. For example, when a man and a woman become a prostitute, I want to understand his or her perception of options, or what is more likely, the lack of them. Children may internalize the trauma of sexual abuse and perceive themselves thereafter, as worthless, bad and undeserving of health and happiness. When these children reach adulthood, negative self perceptions are often reinforced by new relationships that follow old patterns of abuse. This can result in the inability of these people to recognize and attempt opportunities of personal growth and meaningful employment. The end result for many people, especially women, involves a career in prostitution. Therefore, this result has more to do with a lack of viable options, and less to do with promiscuity.

Promiscuity

The Collin's English Dictionary defines promiscuous behaviour as "indulging in casual and indiscriminate sexual behaviours" or, as "consisting of a number of dissimilar parts or elements mingled in a confused or indiscriminate manner." Many people today hold liberal views regarding sex, which may even include tolerating awareness of frequent or regular sexual encounters that take

place between strangers, or situations where partners do not know each other well, or for very long.

In the 1990's casual and indiscriminate sex has become particularly dangerous because of the rampant increase of sexually transmitted diseases, especially the HIV/AIDS virus. Survivors who dissociate are intensifying the real danger of casual sexual encounters.

Browne and Finkelhor (1986) note that promiscuous sexual conduct ranks high (25-35%) among sexual abuse victims. It should be noted that "promiscuity . . . may be more a function of their negative self attributions . . . than their actual sexual behaviour, thus researchers should be careful to combine objective behavioural measures with this type of self report" (p. 71).

Effects of Abuse on Sexual Satisfaction

Browne and Finkelhor (1985) claim that the effects on sexuality of adult victims of childhood sexual abuse have been among the most researched and best established effects. Jehu et al. (1985) identify five areas of female sexuality that are commonly effected by a history of sexual abuse. These are: impaired motivation; sexual phobias/aversions; impaired arousal; impaired sexuality

(vaginismus, impaired orgasm) and sexual dissatisfaction. They state that "some previously abused women report that they do not experience any interest in sex, they could go on indefinitely without missing sexual activity and abstinence from it is often a relief to them" (p. 40). Nearly half of the victims in Jehu's et al. (1985) study reported lack of motivation.

Secondly, Jehu et al. (1985) explain that many women experience anxiety, flashbacks and panic in addition to physiological reactions such as profuse sweating, nausea, vomiting, diarrhea or palpitations when involved in sexual activities. Nine of the 22 women in this study reported phobic or aversive reactions to sex.

Thirdly, Jehu et al. (1985) explain that excessive anxiety and the occurrence of physiological symptoms such as nausea, retching and vomiting can disrupt or terminate arousal and stimulation. For example, some women do not perceive the stimulation they are receiving, nor do they experience the erotic sensations and feelings usually associated with it (Jehu et al. 1985, p. 42). Over half of the subjects involved in this study reported impaired arousal.

Impaired orgasm involves the difficulty some survivors have with achieving a climax during sexual encounters. Jehu et al. (1985) explain that in some cases,

orgasms occur, but due to the trauma associated with sexual abuse, the orgasmic experience is not pleasurable. Seven of the 22 victims in Jehu's et al. (1985) study reported some form of impaired orgasm during adulthood.

Sexual dissatisfaction occurs in many relationships, representative of both abused and nonabused populations. Jehu et al. (1985) note that even in relationships where couples report one or more impairments in sexual motivation and performance, couples without a history of sexual abuse often report their sexual relationship to be satisfying. They state that "in the case of victimized women, there is evidence to suggest that their sexual relationships tend to be characterized by dissatisfaction, as well as other dissatisfactions" (p. 43). Over half of the victims in this study reported sexual dissatisfaction.

Finkelhor et al. (1989) also researched the impact of sexual abuse on later sexual satisfaction. Their findings support the claim that many survivors are dissatisfied in current sexual relationships. They report that sexual abuse is predictive of marital disruption for both male and female victims, and is predictive of sexual dissatisfaction for females only.

TREATMENT MODELS

PREAMBLE

Between the late 1980's and the early 1990's several books were published describing the long-term effects of sexual abuse and clinical treatment for survivors. In the beginning stages of developing therapy models, both theorists and therapists believed that survivors in therapy needed to face the task of accepting and confronting, in as much detail as they could access, memories and feelings associated with traumatic events they had experienced. Consequently, clinical work in this area focused primarily on the clients' memories of the past, sometimes through the use of hypnosis, family sculpting, or group role plays. Goals for treatment centered on adjustments of the client's perceptions of his or her trauma, and the acknowledgement of feelings of powerlessness experienced by most victims.

Confronting a painful past enabled numerous individuals to attach new and more accurate meanings to their symptomatology, which often emerged as intrusive, unexplainable or troubling expressions of emotions such as rage, anxiety, depression and fear. Survivors, their family members, and even their therapists discovered that clients were not "going crazy" or exhibiting some form of

dementia or mental illness, when suddenly, and for what seemed like no apparent reason, individuals felt anxious, panicky or experienced flashbacks of disturbing scenes. They discovered instead, that people's responses to traumatic events they experienced, even though these may have taken place several years or decades in the past and be delayed, still reflect rationality - as similar to indications of post-traumatic stress in soldiers of war or combat, victims of torture, or survivors of other forms of trauma (Briere, 1984; Dolan, 1991; Herman, 1992).

The predominant principle guiding the treatment of survivors during the late 1980's was that individuals who were sexually abused in childhood often struggle with numerous problematic effects which could be overcome if clients were willing to "recall," "rework" and "recontextualize" their trauma (Courtois, 1988 p. 167). Reworking childhood sexual trauma, in this context, became understood by popular phrases such as "deal with" or "heal from" sexual abuse, because the recovery process involved facing memories and feelings in connection to past trauma. For example, the process of "reworking" trauma involves going back in one's mind to recall and disclose what happened, where one was when it happened, who was involved, what was said, and what it felt like. Clients are encouraged to express all thoughts in as much detail and with as much emotion as possible. The theoretical rational for this painful process involves a belief that

by such expression, clients will eliminate or extinguish their need for harmful coping mechanisms and dysfunctional symptomatologies when they allow themselves to remember and "reclaim" their trauma, as opposed to denying, minimizing or dissociating from it (Clark, 1993; Courtois, 1988; Sgroi, 1988).

Walter and Pellar (1992) explain that historically, therapists believed that their clients had some "definite" problems, for which they, as professionals, could determine a "specific" cause. They state:

> *What is the cause of the problem? intimates that there is a relationship between finding the cause and solving the problem. This process is consistent with western science's idea--along with traditional descriptions inherent in the scientific model--that the way to solve a problem is to find out what the cause is so that one can effect change by eliminating the cause. (Walter & Peller, 1992, p.2).*

One can trace the existence of this belief in treatment for survivors that relies primarily on the retrieval of childhood memories, the development of insight, and cognitive reconstruction of thoughts, behaviours and perceptions. I have used the following situation to illustrate this influence.

A client reported to her therapist that she felt frustrated during her efforts to be sexually intimate, because she could not achieve sufficient vaginal

lubrication or stimulation, which she thought would make sex less painful and more pleasurable. Her inability to have sex comfortably and confidently was identified as the problem. Further assessment revealed that this client was sexually abused as a child. Memories of her abuse were the cause for her lack of interest and stimulation since the client explained that current sexual activity reminded her of her early abuse experiences. According to the literature on sexual abuse, the relationship between the cause and the solution to this problem, hinges upon the client's readiness and willingness to confront her memories of abuse and reconstruct new ideas and feelings associated with her sexuality and sexual activity.

Experts such as Briere (1984), Herman, (1992), Sgroi, (1988), Courtois, (1988) and Gil (1990), have developed treatment models for work with survivors that provide therapists and clients with a structure for understanding the relationship between the cause and the solution of problems associated with sexual abuse. Although each expert reveals a unique style both in doing the work and in writing about it, general commonalties are evident. For example, Gil (1990) outlines a three-stage model of treatment that she categorizes under headings of "beginning," "middle" and "termination phases." Herman (1992) describes her three stages as establishing "safety," "remembrance and mourning,"

and "reconnection." Miller (1990) describes treatment for survivors as involving "the outer, middle and inner circles of conversation " (p. 18-19). Bass and Davis (1988) also follow three basic stages for treatment with unique features of self help and "survivor as therapist" built in. Their headings fall under "taking stock," "the healing process" and "changing patterns." Sgroi (1988) follows a five-stage process of recovery: acknowledging the abuse; overcoming secondary responses; forgiving oneself; adopting positive coping behaviours; and relinquishing survivor identity. Courtois (1988) on the other hand does not refer to treatment as involving stages but as working toward a series of survivor goals. These goals appear to follow a natural progression of models used by Gil (1990); Miller (1990) and Herman (1992).

MEMORY-BASED ABREACTIVE MODEL

STAGE ONE

In the beginning phase of therapy it is crucial that the client and therapist get to know one another in order to establish and secure bonds of mutual trust, respect and confidentiality (Courtois, 1988; Gil, 1990; Miller, 1990). When most clients meet their therapist for the first time, they usually feel nervous, anxious and self conscious. Therefore, the very first role of the therapist is to assist

the client to feel as comfortable as possible. This task may involve the most basic of interactions, such as offering a cup of coffee, offering to help with a jacket, or perhaps initiating a casual or non-threatening conversation. The process of securing safety and trust in the therapeutic relationship varies in length of time from one client and therapist, to the next.

Courtois (1988) explains that "a warm, caring, but not overindulgent therapist provides the interpersonal environment conducive to disclosure" (p. 169). Disclosure is never pressured or forced from the client, "a nonintrusive, nonjudgemental context is established (between client and therapist) whereby the client is allowed to experience her own story without the imposition of the therapist" (Miller, 1990, p.19). When the client is ready to disclose, it is the therapist's role to "actively listen" to her client, and to abstain from judgement and intrusion.

Gil (1990) explains that during this process, therapists should . . . "allow (their) client to bring up or avoid whatever they wish. Document whatever is volunteered and what is not, and point out any glaring gaps in information" . . . (p. 71). The non-intrusive nature of the therapist not only models appropriate boundary setting, but it also establishes a cornerstone principle in treatment . . . empowerment of the survivor. "She (the survivor) must be the author and arbiter

of her own recovery" (Herman, 1992, p. 133), and should have control concerning the depth and detail of her disclosure.

Whether or not a client is ready or able to make a complete sexual disclosure, it is very important for the therapist to assess if there are any current symptoms or behaviours, such as suicidal risks or other self destructive patterns that might put the client in danger or interfere with progress in therapy. When appropriate, therapists may have to refer clients to more specialized treatment centres, or work toward helping their clients stabilize a problem or condition before the subject of sexual abuse can be fully addressed.

It is important in the beginning phase that once sexual abuse is disclosed or identified as the problem, the therapist then attempts to learn about the occurrence and its impact, including other symptoms such as eating or sleeping disorders, chemical addictions, and depression (Courtois, 1988). Miller (1990) explains that the "therapist is not just obtaining history, she is attempting to elicit a picture of the context of beliefs, behaviours, relationships, events and feelings in which the client has lived and which have been internalized" (p. 19).

Courtois (1988) also explains the importance of supplying clients with accurate information about sexual abuse. This process works toward dismantling

erroneous myths and beliefs that were taught during the abuse and may still be believed and internalized by the client.

Lastly, it is crucial for the client and therapist to establish rules and goals for therapy in order to minimize confusion and maximize efficiency. All too often therapy without focus or goals involves misspent effort and frustration for both client and therapist, making commitment to ongoing treatment difficult to maintain. It is important during contracting to keep goals and rules clear, realistic and useful.

STAGE TWO

According to the literature, it is important for clients to directly confront the details of their abuse experiences in order to reduce or eliminate the need for defence mechanisms once used to survive the events of abuse, but which presently limit or restrict life satisfaction and integration (Clark, 1993). "The client is believed and is actively encouraged to remember what happened and to experience the emotions associated with the incest, with the aim of reworking the trauma and extinguishing the need for dysfunctional defences and symptoms" (Courtois, 1988, p. 166). In further discussion of this idea, Courtois quotes Carmen (1986):

> *The core of treatment must be to help the victim, in a safe and controlled way, to recall the abuse and its original effects and to restore the accurate meanings attached to the abuse: that is, to recontextualize the trauma . . . the turning point for the patient occurs when her rage is experienced not as meaningless, but as a response to cruelty. The patient needs to understand that nothing will erase the past. The work of therapy is, rather, to reclaim that traumatic past as a part of one's history and identity. With this kind of understanding, the abused patient will be able to grieve and let go of both the trauma and the distortions in memory and affects that were necessary for survival (p. 167).*

In this phase very difficult issues are often addressed and the trust and safety previously established in the beginning phase becomes of the essence here. "In the context of the supportive relationship and environment, the survivor reconnects with the abused child and re-experiences the trauma and feelings of childhood, in particular responsibility, guilt, confusion, ambivalence, shame, anger, sadness and loss" (Courtois, 1988, p. 174).

Gil (1990) warns that "during this stage of treatment, it is imperative to assess the risk that the client may commit suicide or homicide. Clients who are unfamiliar with their own emotions can be overwhelmed by the pain they feel" (p. 110). Herman (1992) states that:

> *. . .as the survivor summons memories, the need to preserve safety must be balanced constantly against the need to face the past. The patient and therapist together must learn to negotiate a safe passage between the twin dangers of constriction and intrusion. Avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitately leads to a fruitless and damaging reliving of the trauma. Decisions regarding pacing and timing need meticulous attention and frequent review by patient and therapist on these matters, and differences of opinion should be aired freely and resolved before the work of reconstruction proceeds (p. 176).*

During the process of remembering abusive memories and the range of emotions associated with them, the client is encouraged to transform thoughts about him/herself, and about others who either participated in the abuse or failed to prevent and stop it (Courtois, 1988; Gil, 1990). Here the abused child within the survivor is purposefully integrated with the nurturing adult self:

> *As the survivor increasingly understands the societal and familial patterns and dynamics which contributed to her abuse, she is able to develop a different perspective from which to assess her reactions and adaptations. Doing so enables her to empathize with her difficult childhood position and view herself with compassion rather than self-loathing. In this way she is able to lessen her sense of badness and forgive herself. Grieving past losses sets the stage for personal development and empowerment. Old maladaptive*

> *mechanisms, patterns, and symptoms are analysed and replaced with ones that are healthier and more appropriate. A positive self concept replaced the shame and self-hatred of old (Courtois, 1988, p. 174-175).*

During the middle phase, many therapists invite their clients to attempt either symbolic or direct confrontations of their abuser or other family members (Bass & Davis, 1988; Courtois, 1988). Most authors emphasize extreme caution regarding direct confrontations, as these may have devastating repercussions for clients. Exercises that minimize risks involve using an "empty chair," writing but not mailing letters, or role playing. All options should be discussed with the client while maintaining principles of empowerment and safety.

Finally, in an effort to bring closure to a process that is often experienced as painful and turbulent, therapists encourage their clients to begin to mourn and grieve for losses. According to Herman (1992):

> *the descent into mourning is at once the most necessary and the most dreaded task of this stage of recovery . . . the survivor frequently resists mourning, not only out of fear, but also out of pride. She may consciously refuse to grieve as a way of denying victory to the perpetrator. In this case it is important to reframe the patient's mourning as an act of courage rather than humiliation. To the extent that the patient*

is unable to grieve, she is cut off from a part of herself and robbed of an important part of her healing. Reclaiming the ability to feel the full range of emotions, including grief, must be understood as an act of resistance rather than submission to the perpetrator's intent. Only through mourning everything that she has lost can the patient discover her indestructible inner life (p. 188).

Some therapists encourage their clients to use rituals to assist them in their grieving process (Bass & Davis, 1988; Winslow, 1990). Winslow (1990) states: "Ritual, a universal human mode of action that serves multiple functions in every culture, is also a powerful source of psychological healing. In recent years, therapists have drawn upon the power and creativity of ritual and the rite of passage to help people bring order and definition into their lives and to master various life transitions " (p. 27).

STAGE THREE

Having come to terms with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are

> *the tasks of the third stage of recovery. In accomplishing this work, the survivor reclaims her world (Herman, 1992, p. 196).*

Gil (1990) describes this process similarly. She explains that this final phase of therapy often represents new challenges and new anxieties. She states:

> *At this point, clients have worked through most of the acute pain and grief. Now they are starting to experiment with new ideas, new feelings, new behaviours. This experimentation, in turn, raises new doubts and new anxieties. Clients still lack the self-confidence, which is understandable. If their efforts do not produce immediate results, they may stop trying. Also, the new experiences themselves are frightening. Clients may be torn between exhilaration and despair. New memories may resurface, and the client may experience a setback. All if these issues must be dealt within the termination phase (p. 132).*

With regards to ending therapy, Sgroi (1988) describes concerns related to individuals who have identified so closely to the terms of "survivor" that they cannot let go of this form of identification. She states:

> *What remains in the recovery process is to move beyond: to see oneself in a multidimensional perspective. Now the person can say, "I am a human being, a person with strengths and weaknesses, good qualities and faults; a person who makes mistakes but*

> *also has useful and positive accomplishments. I was sexually abused when I was a child and that is an important part of my history. But that was then; this is now, and I no longer need to identify myself as a survivor. Instead it is accurate for me simply to identify myself as a person and a self---no more and no less . . .*
>
> *Relinquishing a survivor identity also means the person is ready to take responsibility for her or his own present and future happiness in totality . . . some adult survivors pursue it untiringly for years . . . the most effective way to help survivors to avoid getting sidetracked in this fashion is to encourage them to practice the skills that will enable them to have successful intimate relationships with spouses, partners, and friends, they will be able to have their needs for affection, affiliation, and nurturance met in a milieu of mutuality and reciprocity (not benevolent caretaking) (pp.128-129)*

In light of the new anxieties sometimes developed in the final phase, termination can be quite difficult. Gil (1990) suggests therefore, that termination not be rushed or abrupt. Since the bonds that can develop between some individuals and their therapists sometimes represent, for the client, the first relationship where they felt recognized, valued, supported and encouraged, therapists should take time to work through the loss. Gil also suggests that in this final phase, therapists should assist their clients to "practice" taking controlled risks in the following areas: establishing control; exercising options; seeking help;

developing problem-solving skills; seeking rewarding exchanges, seeking affiliation; transferring skills and terminating therapy.

One of the limitations inherent in the models cited involves the idea that therapy for survivors follows a linear progression. It is as though survivors begin therapy, establish safety, proceed to unravel feelings and memories associated with abuse, resolve symptoms, and when they are ready, they then terminate therapy. Most therapists would agree that long-term therapy does not follow a linear trend. In fact, therapy with survivors has been also described as a process similar to peeling an onion, not only because this kind of work is usually done in layers of uncovery, discovery and recovery . . . often with periods of time in between (sometimes years), which may be used by clients to "take a break."

A second criticism I have with this approach is directed at the idea that survivors will become less troubled by or desensitized to their abuse if they repeatedly tell their stories of abuse, and recall details of their trauma. Theorists today seem to understand the problem of traumatization more comprehensively, as well as the needs of survivors, than did the theorists of the mid 1970's and 1980's. Most therapists now recognize that too strong of focus on past memory retrieval, with too much emphasis on detail, places clients at risk of needlessly reliving old pain and also risking what I refer to as "therapeutic victimization."

Dolan (1991) explains that:

> *Abreaction simply for the purpose of desensitization is unethical. If the client were going to achieve desensitization simply by reliving the trauma. She would not be in a therapy office requiring assistance, nor would she be exhibiting obviously overwhelming terror and physical discomfort. Moreover, if an event is sufficiently traumatic, retelling it over time is not, in and of itself, going to desensitize and relieve the client of all of the pain and fear evoked by the experience (pp. 28-29).*

SOLUTION-FOCUSED BRIEF THERAPY MODEL

Even though ideas and techniques commonly associated with brief and solution focused therapy have existed for many years (de Shazer, 1986), the popularity of this model did not really flourish until the mid 1970's or early 1980's. One of the significant distinctions between the solution focused model, and the memory based, abreactive model, is the fact that therapists using a solution focused approach are not necessarily interested in the cause of the problem and are, therefore, less inclined to explore it. Walter and Peller (1992) explain that "an entirely different direction began to be defined as modellers

changed the primary question, "What is the cause of the problem?" to "What maintains the problem?" (p. 3).

The shift in focus from problem causation to the maintenance of problems is based on the assumption that the problem and the underlying causes do not have to be known in order to find a solution. It assumes instead that whatever the cause, the continuation of the problem is related to the context in which it occurs, and in the expectation that the problem will continue (de Shazer, 1988). Problems, therefore, are assumed to be maintained by repeating interactional patterns, and solutions can be developed by interrupting these patterns (Haley, 1987).

de Shazer (1988) defines the problems or complaints of clients as involving a limited and structured set of behaviours, perceptions, thoughts, expectations, and feelings. Potential solutions, on the other hand, are believed by de Shazer, to exist outside of these limits, even though the client may not perceive these patterns of interaction.

The role of the brief therapist is to assist clients to discover what lies beyond the boundaries of his or her complaint, "the exceptions to the rules rather than the rules of the problem itself" (Molnar & de Shazer, 1987, p. 350). Miller

(1992) explains that by "generating discussion about such exceptions to the complaint, the clinician and client system create the opportunity for solutions to completely emerge" (p. 3)

Walter and Peller (1992) explain that solution focused therapy is guided by twelve basic assumptions. "Without these 12 assumptions, our actions would be only a collection of techniques, and we could easily become robots in spitting out tasks and suggestions" (Walter & Peller, 1992, p. 10). These are:

"Focusing on the positive, on the solution, and on the future facilitates change in the desired direction. Therefore, focus on the solution-oriented talk rather than on problem-oriented talk," (p.10).

"Exceptions to every problem can be created by therapist and client, which can be used to build solutions," (p. 12).

"Change is occurring all the time," (p. 15).

"Small changing leads to larger changing," (p. 18).

"Clients are always cooperating. They are showing us how they think change takes place. As we understand their thinking and act accordingly, cooperation is inevitable" (p.21).

"People have all they need to solve their problems," (p.23).

"Meaning and experience are interactionally constructed. Meaning is the world or medium in which we live. We inform meaning onto our experience and it is our experience at the same time. Meaning is not imposed from without or determined from outside of ourselves. We inform our world through interaction" (p. 24).

"Actions and descriptions are circular" (p.26).

"The meaning of the message is the response you receive" (p. 26).

"Therapy is a goal- or solution-focused endeavour, with the client as expert" (p. 28).

"Any change in how clients describe a goal (solution) and/or what they do affects future interactions with all others involved" (p. 30).

"The members in a treatment group are those who share a goal and state their desire to do something about making it happen" (p. 31).

Many of the above principles provide a sound and useful foundation for work with survivors. The ideas that client and therapist can coauthor change and solution to problems, that change is always occurring, that small change leads to larger change, that clients are always cooperating, all grant wonderful optimism in the context of a very difficult and disturbing treatment process. Many survivors have been conditioned to feel stuck, powerless, damaged and problematic and these treatment principles serve a useful cause of highlighting contrary views of clients and their ability to overcome problems or complaints in therapy.

On the other hand, one of the problems most people have with solution focused ideas or assumptions, at least in the context of work in the treatment of sexual abuse, is the notion that the past is not relevant, nor does it have purpose for discussion in therapy. de Shazer (1985) explains that in doing brief therapy:

> *first we connect the present to the future (ignoring the past), then we compliment the clients on what they are already doing that is useful and/or good for them, and then- once they know we are on their side- we can make a suggestion for something new that they might do which is, or at least might be good for them (p. 15).*

de Shazer (1985) explains that people come to therapy because they want something in their situation to change, but whatever it is that they have done thus far to attempt change, has not worked. He states:

> *our view holds that clients already know what to do to solve the complaints they bring to therapy; they just do not know that they know. Our job as brief therapists is to help them construct for themselves a new use for knowledge they already have (de Shazer et al. 1986, p.220).*

Therefore, change in the way clients construct their present experiences, as reflected in how they report it or talk about it, will promote them having a different experience, which in turn, will prompt different depictions or reports in subsequent sessions (de Shazer, 1988, p. 77). Therapists treating survivors of sexual abuse may add that change in the way clients construct their past, present and future experience is vital to resolution of many problems brought to therapy. In fact two significant changes most therapists hope to witness in survivors include a cognitive as well as an emotional acceptance of the fact that as victims of past sexual abuse they were not to blame, nor should they be held accountable for what was done to them.

Another purpose past experience serves in therapy with survivors involves the empowering feature inherent in the client's ability to give voice to her/his past trauma. Part of the problem associated with sexual abuse is denial, silence and dissociation from trauma. Ignoring the past in this context may actually serve the purpose of "maintaining the problem." Dolan (1991) states:

> *The seasoned clinician will not need to be reminded that initially it is very important that the client be given an opportunity to tell the therapist details of her victimization in a context of warmth and support and that her disclosure be treated compassionately and respectfully. To fail to have the client adequately share the details of the abuse may not only play into the secrecy and stigmatization so often characteristic of sexual abuse, but also lead to the client's feeling discounted and inadequately supported. (p.25).*

A common complaint regarding solution focused brief therapy in context with, but not exclusive to the treatment of sexual abuse involves the problem that some therapists "focus exclusively on the technique and neglect the actual flesh and blood client sitting with them" (Lipchik, 1994, p.37). Lipchik (1994) explains that a therapist's unwillingness to hear the client's full expression of feelings and conditions of the problem may result in the client's belief that the therapist does not understand him or her. A consequence of this lack of understanding can result

in the client's loss of confidence in the process and the premature termination of therapy.

Perhaps consequences more devastating than this evolve when therapists hastily redirect the focus of discussion on the solution rather than the problem. It is fairly common that individuals with a history of sexual abuse perceive their personal identity as so closely tied to their past trauma and to their label of "victim/survivor" Sgroi (1988), that the minimalization of the problem may give rise to the minimalization of the person, even if the therapist keeps the distinction. Lipchik (1994) states that:

> *It is important to remember that an understanding of human systems is fundamental to solution-focused thinking and that the therapist and client together create a therapeutic system. Collaborative thinking between therapist and client, both of whom bring their own expertise to a common endeavour, is the key to continuing progress (p. 37).*

Therefore, while it is true that brief therapists do not encourage the ventilation of feelings, or a detailed description of the past, especially as they relate to problems, therapists "must allow clients to tell their story in their own

way so they can join with them and demonstrate acceptance and understanding (Lipchik, 1994, p. 37).

A BALANCED APPROACH BETWEEN CONTRASTING MODELS

Dolan (1991) introduced a meaningful way of using solution focused therapy techniques with survivors of sexual abuse without running into the risks and dangers of minimizing the past, discounting the significance of the problem, and simultaneously guarding against unnecessary retraumatization of clients.

Dolan (personal communication in Winnipeg, 1994), suggested that it is likely more respectful, more balanced, and the least risky to follow a "three-pronged approach" to therapy with survivors. Each prong represents a focus on either the past, present or future conditions of the client's life, while respectfully blending pleasant, neutral and painful experiences and memories. In this way, the client will recognize that his or her existence is not defined exclusively by abuse, or by the past experiences and an integration of these experiences are more readily accepted by him or her.

Dolan (in Winnipeg, 1994) used a wonderful metaphor which I believe captures the process of recovery of survivors in therapy. She drew from her own

memory a beautiful view from her grandmother's window that revealed, for Dolan, the splendour of the sun glistening on water from the lake below. This view represented the joy and splendour of life for Dolan. Unfortunately, one day she looked out from the window and saw that some careless individuals had dumped leaking oil drums into the lake, polluting and spoiling the previously untouched beauty. Dolan explained that the discarded oil drums represented personal experiences of sexual abuse. She explained that for a while all she could see from the window was the ugliness of the oil drums, and this created feelings of hopelessness and despair. Dolan added that when survivors can only see the ugliness of their abuse, without memory or recognition of the positive experiences they have also had, they continue to be victims, which may include experiences of post-traumatic stress. If all they see is the beautiful sun shining on the lake, when the oil drums are floating on the surface, they are likely in a state of denial. Neither of the above conditions are healthy depictions of what is real and therefore, Dolan explained, the goal of recovery is to look out the window, and within the same visual frame, acknowledge but move past the sight of the rusting oil drums, and capture the beauty of the sun's reflection on the lake.

An ironic and yet somewhat humorous comment was given to Yvonne Dolan by one of the persons responsible for bringing her to Winnipeg to present

ways in which solution-focused ideas can assist treatment for survivors. The comment reminded me of how important it is not to minimize the past experience of clients when they describe their abuse story . . . as the solution-focused model is commonly criticized for. This person said that she wished to thank Yvonne for helping us, the audience, see, during her presentation, the beauty of the sun amid the devastation of oil "drops," instead of oil "drums."

One of the fundamental principles upon which brief therapists and Dolan (1991) formulate ideas, includes:

> *the concept of co-creation of solutions by client and therapist. This is based on the respectful assumption that clients have inner resources to construct highly individualized and uniquely effective solutions to the problems that bring them to therapy. Solution-focused therapy assumes that the construction of a solution is a joint process between client and therapist, with the therapist taking responsibility for empowering the client to create and experience her own uniquely meaningful and effective therapeutic changes (Dolan, 1991, pp. 29-30).*

Another basic principle driving this approach includes the belief that the expertise clients have, which can be used to create unique and individualized solutions are stored, in part, by the unconscious mind and can be accessed and utilized, both with and without bringing them into consciousness. For this

process, Dolan (1991) and de Shazer (1986) follow the teachings of Milton Erickson.

Erickson is best known for his development and use of naturalistic, hypnotic trance states in his subjects. He developed a way of speaking directly to the unconscious, self-protective and self-solution-generating mind. Solution-oriented therapy owed its origins to Ericksonian principles and techniques.

Dolan (in Winnipeg, 1994) explained that in her work with survivors, she used techniques and exercises that she believed could be placed along a continuum of conscious and unconscious thought processes: "primarily consciously oriented techniques"; and "primarily unconsciously oriented techniques" (taken from workshop handout). The following examples are some, but certainly not all of the techniques Dolan (1991) uses.

PRIMARILY CONSCIOUSLY ORIENTED TECHNIQUES

Symbol for the Present:

Dolan (1991) explains that therapists should encourage and assist clients to identify something in the therapy room, or some form of personal belonging

that he or she will recognize as a symbol for the present. Therefore, if the client begins to re-experience the trauma when she discloses it, he or she will use this symbol as a centre of focus, and reconnect with the present.

> *...external focus on a visual and then verbal descriptive task provides a conscious break from the memory of the trauma and reduces the emotional impact of talking about the abuse . . . the client should be protected from needless revivifying of the trauma (Dolan, 1991, p. 28).*

First Session Formula Task:

Dolan (1991) explains this task was developed by the Milwaukee Brief Family Therapy Centre to assist clients who were initially vague in their description of their goals for therapy. The assigned task is: "Between now and the next time I see you I'd like you to think about the things in your life that you would like to have continue" (p. 35). Dolan adjusted this task for survivors by asking clients "to make a written list of things in your life that you would like to have continue" (p. 35). She claims that this written list can strengthen the client's awareness of aspects of her life that she can literally "hold onto" . . . especially when "focusing on the past trauma may tend to eclipse the client's awareness of the safety, comfort, and support available in her everyday life in the here and now" (p. 35).

SOLUTION FOCUSED QUESTIONS:

Dolan (1991, and in Winnipeg, 1994) has taken some of the classic questions developed by brief therapists (particularly from the Milwaukee Brief Family Therapy Centre) and revised them to fit the context of treatment for survivors. Some examples are the following:

Constructive individual questions:

- "What will be the first (smallest) sign that things are getting better, that this is having less of an impact on your life?"

- "What will you be doing differently when this (sex abuse trauma) is less of a current problem in your life?"

- "What will you be doing differently with your time?"

- "What useful things will you be in the habit of saying to yourself?"

- "What will you be thinking about (doing) INSTEAD of the thinking about the past?"

- "Are there times when the above is already happening to some (even a small) extent?"

- "What differences will the above healing changes make when they have been present in your life over extended time? (weeks, days, months, years)?"

Constructive systemic questions:

- "What do you think that your (significant other) would say would be the first sign that things are getting better? What do you think she or he will notice first?"

- "What do you think your (friends, boss) will begin to notice about you as you heal even more?"

Scaling Questions:

Dolan(1991) explains that traditionally "scaling questions" are used to "help clients rate the degree of problems she is experiencing on a scale from one to ten, and then identify solutions through further ratings on the scale . . . " (p. 87). She explains further, that she adapted this technique to assist clients to rate their level

of safety in their current situation, and by identifying risks or danger, she can move to respond to the situation or hopefully prevent it. Her example of a scaling question is:

> *On a scale of one to ten, how safe do you feel your family is from sexual and physical abuse? Zero would mean that it is happening now, and the family is not at all safe. One would mean it has happened in the past and could happen again, five would mean that it is about as likely to happen as not, and so on, all the way up to a level of ten, where all family members feel safe and secure that sexual abuse is not happening now and will not ever happen in the future (p. 86)*

I have successfully used "scaling questions" with survivors in more instances than assessing safety and risks of further abuse. I have used these questions to assess one of my client's perception of her own hopelessness and depression, and I have also used this technique in helping a client work through feelings of taking blame or feeling responsible for her abuse.

The Miracle Question and the Noticing Task:

de Shazer (1988) developed the concept of the "miracle question" to assist clients in the establishment of goals and the recognition of times when their situation is improving. The role of the therapist is to encourage the client to

imagine what would be different in his or her life if the problem that brought him or her to therapy was solved. Dolan (1991) revised the question:

> *if a miracle happened in the middle of the night and you had overcome the effects of your childhood abuse to the extent that you no longer needed therapy and felt quite satisfied with your daily life, what would be different?*

The purpose of this question is to elicit information from the client concerning identifiable changes in his or her behaviour and perception that would result from the solution of the problem. Dolan (1991) claims that:

> *Once these perceptions and behaviours have been identified, the client can be asked . . . to notice the times that she does these healthy behaviours and has these healthy thoughts between sessions. Noticing these self-identified moments of healthy functioning can help the client realize that she is already in control of her life in some areas (p. 34).*

Four Step Approach for Dealing With Flashbacks in Daily Life:

Many survivors of sexual abuse are troubled by intrusive flashes of past traumas, and when this occurs, people can feel tremendous fear and anxiety. Dolan (in Winnipeg, 1994) outlined four steps therapists can follow to assist clients to experience more understanding and control of the flashbacks:

1. "Describe what you are experiencing. When have you felt this way before? What situation were you in last time you felt this way?"

2. "In what ways are this current situation and your past situation similar? For example, is the setting, time of year, or the sights, sounds, sensations in any way similar to the past situation where you felt this way? If there is another person involved, is she or he similar to a person from the past who elicited similar feelings?"

3. "How is your current situation different from the situation in which you felt similar feelings in the past? What is different about you, your sensory experience, your current life circumstances, and personal resources? What is different about this current setting? If another person or persons are involved, what is different about them compared to the person(s) in the past situation?"

4. "What action, if any, do you want to take now to feel better in the present?" For example, a flashback may indicate that a person is once again in a situation that is in some way unsafe. If this is the case, self protective actions should be taken to alter the current situation. On the other hand, a flashback may simply mean that an old memory has been triggered by an inconsequential, but highly evocative resemblance to the past, such as a certain colour, smell, sound, and so forth. In such cases, corrective messages of

> reassurance and comfort need to be given to the self to counteract old traumatic memories. Associational cues for comfort and security are useful for this purpose (taken from workshop handout).

PRIMARILY UNCONSCIOUSLY ORIENTED TECHNIQUES

Associational cues for comfort and security:

Dolan (1991) defines an associational cue as "a signal that elicits an unconscious response"(p. 100). She provides an example of this phenomena in a quote from Marcel Proust (1928): "As he ate a lemon-flavoured 'Madeline' cookie with a cup of fragrant jasmine tea, he felt transported back to the comfort of his aunt's kitchen, where he had enjoyed the same treat as a child."

Dolan (1991) explains that these associations can be both useful and problematic, depending on what memory is evoked. She provides examples of situations where disturbing flashbacks, triggered by a familiar sight, sound or scent, have created painful feelings and sensations in the individuals experiencing them. However, according to Dolan (1991):

> *An experience that vividly recalls a time of comfort and well-being is likely to re-elicit the feelings of security associated with that calm, pleasant state. This experience can be used to develop an associational cue for comfort and security (p. 100).*

Ideomotoric signals "yes," "no" and "not useful to learn consciously":

Dolan (1991) defines an ideomotoric signal as an unconscious response that often feels effortless to the client, as it were occurring "all by itself." Eye closure and arm levitation are examples of ideomotoric responses that commonly occur in response to hypnotic requests (p. 144). She explains that the use of these signals can facilitate unconscious learning for clients, as well as aid in an informal retrieval of repressed memories. The process begins with practising the following three steps:

i. Begin by asking the client to identify something that reminds her of safety of the present, and then take a moment to recall and enjoy the Associational Cue for Comfort and Security. If trance deepening is needed, the Externally oriented Ericksonian Relaxation technique can be employed, or a metaphor can be told.

ii. Now ask the client to take a moment to enjoy this state, and then when she is ready, to "notice which finger lifts first, knowing this finger will be the "yes" finger, signalling readiness to work, and also a way to signal "yes" in response to questions." Once the finger lifts the client can then "test" it by asking a question to which the answer is "yes."

iii. The client is now directed to "notice which finger lifts next-- this will be the "no" finger and after that, the next finger to lift will be the "not useful to know/learn consciously" finger." These fingers can also be tested by having the client ask each finger to raise in appropriate response to "yes," "no," and "not useful to know consciously." (taken from workshop handout).

Dolan (in Winnipeg, 1994) explained that when assisting clients with memory retrieval, the purpose for the retrieval should always benefit the client and assist him or her to resolve symptoms. She provides the following example of what she says to clients during the retrieval process. I have included this example because it effectively demonstrated the permissive qualities of Ericksonian Hypnosis:

go inside and ask yourself what you need to learn in order to resolve this . . . You can understand this at whatever distance is most helpful, learning only what is helpful for resolving the problems that brought you here, and leaving anything best left unconscious to the unconscious. And perhaps you will choose to learn only the information now, separating the understanding from the feelings, almost as if you're learning the information about another person, feeling compassionate but calm, sorting out the feelings that go with understanding so very gradually, over time. Or maybe you will prefer to work very quickly, making the understandings, feeling the feelings just to the degree that it is necessary for resolution even as you sit here today. Or your unconscious will choose yet an appropriate time in the future to let you understand only the information that is necessary in the way that is most helpful . . . (taken from workshop handout)

When reorienting the client to consciousness, Dolan suggests to her clients that he or she "will bring back only what information is helpful, and leave behind all that is left behind." (taken from workshop handout) Dolan (1991) adds that therapists can also provide the suggestions that the client will remember the details in the future if there is something she needs to add, or if she simply needs to look at it again (p. 156).

Age Progression to Instill Hope for the Future

The idea of inviting a client to revisit a younger version of ones current self is not foreign to treatment for survivors. Bradshaw (1991), Bass & Davis (1988)

and Courtois(1988) describe techniques therapists use to establish compassion and support for the "inner child," which is believed by many therapists to exist within individual clients. This exercise often reconnects clients to feelings of pain, sadness and fear, and can be powerful experience when written in letter form.

Dolan (1991) takes this idea and shapes it to reconnect the client to feelings of hopefulness and positive emotions. She achieves this by requesting clients to write a letter form "an older, wiser self." For example:

> *Imagine that you have grown to be a healthy, wise old woman and you are looking back on this period of you life. What do you think that this wonderful, old, wiser you would suggest to you to help you get through this current phase of your life? What would she tell you to remember? What would she suggest that would be most helpful in helping you heal from the past? What would she say to comfort you? And does she have any advice about how therapy could be most useful and helpful? (p. 36).*

CHAPTER 3

PRACTICUM PROJECT

ORGANIZATIONAL CONTEXT, METHODS AND EVALUATION PROCEDURES

Clinical Setting

This Practicum was completed at the Family Centre of Winnipeg. This agency is a not-for-profit organization that provides counselling and family support services to Winnipeg residents through programs designed and facilitated by three separate departments: Counselling and Community Services, Family Support Program, and Special Needs Daycare.

Over the years Family Centre has demonstrated leadership to the community, by providing professional development training in newer treatment strategies such as Solution Focused and Brief Therapy models. Consequently, clinicians from this agency are strengthening their skills and broadening their experience.

The counselling department at Family Centre is well known in the community for affordable and quality individual, couple, family and group therapy. Therapists treat a wide range of issues and problem areas, therefore,

various professionals and mental health organizations make frequent and regular referrals of clients to this agency for counselling and/or group training.

Committee Members

During the development of this thesis, my primary advisor was Shirley Grosser, my clinical supervisor was Sara Alexrod and Diane Hiebert-Murphy provided insight and assistance with the selection and interpretation of evaluation instruments and data.

Clinical consultations were available as often as I requested them, with either Sara or Shirley. I met at least once every two weeks with either one or the other, to discuss the clinical and academic aspects of my Practicum.

Client Screening

Participants for this project were extracted from the agency's existing waiting list. Since intake procedures in the counselling department involve gathering a brief description of problems for which clients are seeking counselling and since many individuals offer a disclosure of childhood sexual abuse during intake, identification of potential participants was very straightforward.

The intake coordinator of Family Centre agreed to assist in my screening process by choosing ten clients, for me, who identified themselves as survivors of childhood sexual abuse and who also fit the remaining criteria for involvement in this project.

The remaining criteria were as follows:

1 Clients must be aged 18 years or older.

2 Clients must offer informed consent to the following terms and conditions:

   a. being seen by a graduate student therapist

   b. allowing the ongoing involvement of and supervision by the Practicum committee

   c. consenting to the student's use of session contents in her written report (with reasonable precautions to protect client anonymity)

   d. agreeing to the use of clinical instruments for the purpose of evaluating therapy and measuring change between pre and post-testing

3 Clients may be male or female

4 Any stipulations in the agency policy regarding clients' eligibility were upheld during screening

Methods

I contacted each of the ten referrals I received from the intake coordinator, by telephone, provided them with a brief description of my Practicum project, and invited them to attend a screening interview. Four of the ten either were unreachable or seeing another therapist in another organization. The remaining six clients were willing to attend an assessment interview to learn more about my project and to determine if they wanted to participate. I also received a referral from my Practicum advisor, and I scheduled an in person intake assessment interview with the referred individual.

In the first interview with each client, I stated my purpose for developing this project, and outlined the criteria for client participation. I explained the role of my committee members, and the nature of my evaluation instruments.

I also provided a brief description of some of the common ideas or expectations clients have, regarding survivor therapy. For example, I explained that treatment for survivors often requires a long period of time, in some cases years, before individuals feel their recovery is complete. I highlighted the fact that many survivors do not do this kind of work from beginning to end without taking breaks or pauses in between. I explained that it is common for some people to

take a break of several years before they begin to explore another layer of their abuse.

I gave clients a brief description of some of the techniques used in therapy to address issues relating to childhood sexual abuse. I explained that in some instances, clients experience great difficulty giving voice to their traumatic experiences, and this alone can be a significant task. I also described other techniques, such as inner child work, journal writing, role playing, artwork, and relaxation exercises.

I also explained to clients that this encounter may or may not proceed into the more challenging aspects of reclaiming control over their experience of abuse and eliminating problematic symptoms. I added that sometimes it takes individuals a long period of time before they develop trust in relationship, because they were violated in past relationships. Therefore, this process in therapy may simply involve the beginning stages of establishing trust with a therapist.

If clients were interested in participating in the project, we rescheduled a second appointment. In the second interview I requested that clients complete pretesting with the evaluation instruments, and in the time remaining I gathered information concerning the clients' histories.

The remaining sessions for each of the seven participants involved my effort as therapist to address and develop the following components of therapy:

1 building a trusting relationship between client and therapist

2 allowing clients to disclose as much of their stories as they felt comfortable with

3 assisting clients to realize that the difficulties they were experiencing are common effects of childhood abuse

4 assisting clients to dismantle erroneous beliefs concerning their abuse that may have damaging effects on self esteem

5 identifying problematic patterns and symptoms, and assisting the client to find the most helpful and realistic means for eliminating problems or managing symptoms

Duration

The Practicum consisted of a six-month placement at the Family Centre of Winnipeg, within the Counselling and Community Services Department. The placement began on September 1, 1993 and was completed on March 31, 1994. The Practicum involved full time study and practice five days a week over the full six month period.

Recording

I used the recording procedures and format set out by the Family Centre of Winnipeg. This format includes:

1. record of dates and primary treatment orientation for each session
2. consumer perception of the problem, including the identification of the client, the onset of the problem and the attempted solutions
3. worker assessment of the problem(s), individual functioning, systems functioning, and the client's own strengths and resources for dealing with the problem
4. worker's assessment of changes required
5. significant historical factors or events (such as family of origin, genograms, marital or developmental history)
6. description of the contract agreed to by the client and the worker, including goals, frequency and duration of therapy
7. brief description of the treatment plan
8. record of other organizations currently involved
9. additional information, such as: history of abuse; suicide ideation; medical problems (including alcohol and drug abuse); psychiatric history (including medication currently used)
10. record of consultations with supervisors
11. summary of progress made regarding goals

Criteria for Evaluation

Mental health organizations are under increased pressure from consumers nd funding sources to demonstrate the effectiveness and efficiency of service provided to clients. Slonim-Nevo and Vosler (1991) states that "examples of empirical practice that demonstrate the feasibility of integrating an evaluative

component into the assessment and intervention process, particularly for behavioural and cognitive models of practice, are appearing in social work literature. However, in order to enable clinicians whose theoretical orientation is not behavioural or cognitive to effectively utilize single-system evaluation, successful use of these techniques with a variety of other practice theories and models need to be demonstrated" (p. 38).

One of the goals of this project was to demonstrate and evaluate my ability to integrate and use existing ideas from various models concerning the individual treatment of adult survivors. In order to evaluate my intervention I selected the use of a single system, A-B research design, because it required the least amount of time and energy from clients. Complex and time-consuming questionnaires can interfere with the clients' interest and participation (Bloom & Fischer, 1982). "In the design, the 'A' symbolizes the baseline, the period prior to the intervention, and the 'B' symbolizes the period during which intervention is provided" (Slonim-Nevo & Vosler, 1991, p.40).

All participants were requested to participate in the evaluative procedures used in this project. This included the completion of both a pre and post-test measure of the Brief System Inventory and the Hudson Index of Self Esteem.

Bloom and Fischer (1982) suggest that the practitioner should select a primary measure that is closest to or the most direct expression of the problem. It should also be one in which one would most expect change to appear, and has the highest priority for change. I selected the use of the Brief symptom Inventory and the Index of Self Esteem because the symptoms identified and measured by these tests, are commonly associated with survivors of childhood sexual abuse. However, since many survivors struggle with the symptom of dissociation, I added four questions, designed by Briere (1989) to compensate for the fact that the brief symptom inventory did not identify or measure this symptom.

My values regarding the evaluation of therapy do not permit me, as therapist, to assume what factors ought to be measured in terms of useful change in clients and their situation. I was concerned that ideas or goals that clients recognized or identified as significant may not be captured by standardized tests. Therefore, I suggested to each client that they consider or identify change they observed in themselves or their situation after therapy. I also asked that they share their views concerning aspects of therapy that were particularly meaningful, useful or perhaps lacking. I asked each of them to share this information with me verbally, visually or in written form, during the meeting which represented the termination of therapy.

Evaluation Instruments:

BRIEF SYMPTOM INVENTORY

The Brief Symptom Inventory (referred to herein as BSI) is a self-report assessment tool which measures nine symptom constructs, using a 5-point scale of distress, ranging from no distress to extreme distress. The symptoms measured are: somatization; obsessive/compulsive tendencies; interpersonal sensitivity; depression; anxiety; hostility; phobic anxiety; paranoid ideation and psychoticism.

According to Derogatis and Melisaratos (1983) the BSI has a strong internal consistency reliability for each of the nine constructs, ranging from a low of .71 (psychoticism), to a high of .85 (depression). It also has strong test-retest reliability for each construct, ranging from a low of .68 (somatization), to a high of .91 (phobic anxiety).

The BSI is used extensively by clinical researchers because normative data is available from four sample populations. These are: a non-patient; a normal sample; a psychiatric outpatient sample; a psychiatric inpatient sample; and an adolescent non-patient sample.

Scores are calculated for each of the nine symptom sub-scales, as well as for the general severity index. The general severity index provides an overview of the individual's level of general distress.

All of the sub-scale scores, including the general severity index range between zero and 4.00. The highest level of distress measured by the BSI is represented by a score of 4.00.

HUDSON INDEX OF SELF ESTEEM

The Hudson Index of Self Esteem (referred to herein as ISE) is designed to measure the degree or magnitude of the problem the client has with self esteem. The scale consists of only 25 questions, and the client uses a 5-point rating scale to indicate his or her responses. The scale is easy to administer, score and interpret.

Scoring procedures for the ISE produce a minimum score of zero and a maximum score of 100. The higher scores indicate a higher degree of problem with self esteem. The clinical cutting score, which is 30, is intended to provide clinicians with a rough guide to the existence or absence of problems with self esteem.

> *"A score of 29 does not mean complete absence of problems, and a score of 31 does not mean that intervention is absolutely necessary . . . higher scores should be seen as probably deserving of intervention to reduce those scores too at least below the 30 level." (Bloom & Fischer, 1982, p.151).*

The ISE has an internal consistency reliability and test-retest reliability of .90 or better. It is also reported to have high face, concurrent and construct validity (Bloom & Fischer, 1982).

Table 1. Client Data from the Brief Symptom Inventory (BSI) and the Index of Self Esteem (ISE)

	ALICE		DEBBIE		LIZ		ROY		JANICE		BETH		SANDY	
BSI SYMPTOM	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
SOMATIZATION	2.00	1.57	0.42		2.42	0.00	3.71	4.00	1.80	1.28	2.14	1.85	2.57	1.17
OBSESSIVE / COMPULSIVE	3.66	3.50	1.66		3.16	0.33	4.00	4.00	1.83	1.16	1.50	1.83	3.66	3.16
INTERPERSONAL SENSITIVITY	4.00	3.75	2.25		3.75	0.00	4.00	4.00	3.25	0.50	2.25	2.00	4.00	2.75
DEPRESSION	3.50	2.66	0.83		3.16	0.33	3.33	3.33	2.33	1.33	2.83	2.33	3.83	3.66
ANXIETY	3.16	3.50	1.66		3.33	0.00	4.00	4.00	3.00	0.83	3.00	2.16	3.16	3.00
HOSTILITY	1.20	1.60	0.60		3.80	0.00	1.80	3.00	1.40	0.60	1.80	1.00	2.60	3.00
PHOBIC ANXIETY	3.80	2.60	0.60		3.60	0.40	3.80	2.60	1.20	0.00	1.80	1.20	3.00	1.20
PARANOID IDEATION	2.80	3.20	1.20		3.20	0.40	3.80	4.00	2.00	0.40	1.80	1.40	2.80	1.80
PSYCHOTICISM	2.40	3.40	0.60		2.60	0.40	2.40	3.20	3.00	0.80	1.80	1.60	3.60	3.20
* DISSOCIATION	2.50	2.25	1.25		1.00	0.00	3.00	2.75	1.50	0.25	2.25	2.50	4.00	1.50

	ALICE		DEBBIE		LIZ		ROY		JANICE		BETH		SANDY	
HUDSON INDEX OF SELF ESTEEM (ISE)	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
	71.00	65.00	42.00		70.00	20.00	94.00	72.00	46.00	20.00	74.00	64.00	76.00	78.00

CHAPTER 4

CLIENT CASE STUDIES

Case Example 1 - Client A - "Alice"

Alice, age 62, was referred to the Family Centre of Winnipeg for individual counselling by her medical doctor, who was treating and monitoring her symptoms of depression. Alice took leave from her housekeeping duties at a geriatric hospital because she was struggling with depression, anxiety and fatigue. She explained to her physician that distressing memories of sexual abuse experienced during her childhood are resurfacing, and for this reason, he recommended that she seek counselling in addition to the use of antidepressant medication. He also stated that she should report to him once each month so that he could monitor any changes and advise her employers if continued disability claims were warranted.

Alice contacted the intake department at the Family Centre of Winnipeg in July 1993. At this time she had been on disability insurance and had been using antidepressant for one year. She explained to the intake worker

that her depression was due to memories of her childhood, and that she would like individual counselling with a female therapist.

Description of the Problem

Alice claimed that while she was at work one day she witnessed one of the hospital staff abusing an elderly patient. She believed that this incident triggered memories of sexual abuse which she experienced during her childhood. Subsequently she experienced symptoms of depression, increased anxiety and distress. Her performance of workplace tasks was affected: she noticed that she was unable to perform physical tasks as well as she was used to. She felt physically ill if she saw a patient naked. She struggled with a sudden loss of appetite. She began to withdraw from friendly exchanges with co-workers.

When Alice came to the agency, she reported that at home she lacked motivation to do her usual housekeeping tasks, she did not want to interact with family or friends, she avoided her husband, and continued to struggle with loss of appetite and lack of sleep.

Alice reported that while viewing television, she felt distressed during any program or commercial depicting nudity or sexuality. She was also disinterested in sex and felt uncomfortable when her husband attempted to be affectionate.

Alice complained of several body aches and pains, ranging from her neck, shoulder, chest, abdomen, knee and feet. She also described periods of dizziness, and a ringing in her left ear. She faithfully reported all of these ailments to her physician, but she also indicated that she believes the doctor never takes her complaints seriously. She claimed that most of these aches and pains developed at the same time as her depressive symptoms.

Client Biography

Alice was raised by her parents in a traditional family setting. Her father (Stanley) worked for the railroad and was often away from home, and her mother (Irene) provided foster care to young boys while raising her own family. Irene currently resides in a nursing home in Winnipeg. Alice assists her mother financially and by running errands for her. Alice usually feels criticized and unappreciated by her mother. Alice recently told Irene incidents of child

sexual abuse by a neighbour and Irene responded with anger and blamed Alice for always wanting to go over to the neighbour's place.

Alice felt particularly close to her dad while growing up. She recalled spending time with him, going for car rides and running errands. She also remembered her father bathing and supervising her as a child. In his elder years, Stanley experienced health problems for which he required hospitalization. Alice grew very close to him during this time and visited him regularly each week. Her father passed away in 1980. Alice was very distressed by her father's death and remembered feeling depressed for several months following it. During this depression, Alice experienced a loss of appetite, difficult sleeping patterns and uncontrollable urges to cry.

Alice was one of five children; her birth order was second from the last child to be born. She had an older brother who died at the age of 10 from drowning and an older sister who died at the age of five from pneumonia. Alice was an infant when her sister's death occurred, and she believed that natural bonding between her mother and herself was interrupted at that time and never took place.

Alice has an older brother living in British Columbia and a younger brother living in Winnipeg. Relationships between Alice and her brothers are somewhat strained. Both men hold strong religious beliefs, and practice lifestyles very different from hers. Alice feels that she does not "measure up" to her brothers or their wives, and she feels put down by them not only because she does not live by their moral standards but also because she has very little education.

In school Alice struggled with learning and she was openly ridiculed by teachers; she quit school in grade five. Ever since then, Alice has referred to herself as a dummy and demonstrates very little confidence in anything related to reading, writing or mathematics.

In her late teens, Alice became pregnant by her boyfriend. Both of her parents were very angry with her for becoming an "unwed mother" and turned her out of the house. Alice went to live with another family during her pregnancy. After she gave birth to her son Henry (currently 36 years of age), she found her own apartment and raised him alone. The father of the child did not continue the relationship with Alice and later he married another woman.

Alice married her first husband when she was 24 years of age. The marriage was problematic from the beginning, as her husband (Tom) was frequently out of work, a heavy drinker, and physically and verbally abusive. Alice and Tom had a daughter together, but she died three days after birth. Several years later, they had a second daughter, Carol (currently 24 years of age). Both Henry and Carol live in Winnipeg. Henry is employed in an office, is married, and has children of his own. Carol remained single and is working toward a career as a medical secretary.

After fifteen years of marriage Alice separated from Tom. During their separation, Tom would frequently harass Alice and threaten her life. During this time Alice "buckled under" the pressure and deliberately took an overdose of Valium. She was admitted to St. Boniface Hospital for one week, then transferred to Grace Hospital at the recommendation of her brothers, because they were Protestant and they were uncomfortable with the Catholic influence of the St. Boniface Hospital.

Alice raised Henry and Carol as a single mother, with no support from Tom and limited support from her parents. Several years later (1988), Alice married her current husband, who is the biological father of Henry.

Presenting Concerns

When Alice arrived at the Family Centre of Winnipeg for the assessment interview, she was very prompt, meticulously groomed, and very nervous. I took time to help Alice relax by engaging her in a casual conversation, and by making a gentle inquiry concerning her present feelings. Alice responded to all questions and comments in a soft, timid voice and avoided eye contact. I shared my understanding of the difficulties involved in meeting a counsellor for the first time, often without knowing how to begin, or what to expect. Alice nodded in agreement, and began to show signs of settling in by removing her jacket and scarf.

Alice completed the first interview demonstrating in numerous ways her struggle with low self esteem. Throughout the process of sharing her history and voicing concerns, she shed many tears and her mouth and hands trembled. I assured Alice that throughout our work together, we would proceed at a pace that would be most comfortable for her. She was complimented for showing courage in coming a long distance to share so many important feelings and concerns. Alice explained that she has never gone for counselling before this year. A few months ago, however, one other attempt had been made to seek

professional help. At the request of her physician, Alice was interviewed by a male psychiatrist. She described this experience as "disastrous." She complained that she could not talk to him about her abuse because she did not feel comfortable at all in his presence. I made every attempt to keep my voice very soft and my manner very calm, in hope of aiding Alice in her ability to feel safe and relaxed.

Description of the Client/Therapist Contract

At the conclusion of the first interview, I noted several possible areas for therapeutic intervention:

1. assist Alice in building self esteem;
2. provide a safe environment for Alice to give voice to her experiences of sexual abuse;
3. assist Alice in developing better relationships within her family of origin;
4. assist Alice in improving communication and mutual understanding between herself and her children;
5. help Alice improve her relationship with her husband; and
6. help Alice manage or perhaps reduce symptoms of depression and possible somatic illnesses.

I summarized these goals for Alice and she agreed to either consider them or add to them if she thought it was necessary. She also agreed to inform me at a later date what she chose to focus on in therapy.

Alice and I agreed to meet once each week for one hour, for at least six sessions. If Alice wanted to continue beyond six interviews, I assured her that recontracting would be possible.

Description of the Intervention

I chose to use a non-directive approach for the first few sessions, with the intention of empowering Alice to determine issues most relevant for exploration. Depending on how Alice would respond to the questions "what brings you here today?"; or "what are some of the things you have thought about since I last saw you, that you feel comfortable sharing with me?" I hoped to identify and clarify client-initiated goals for therapy.

As she freely took the lead being offered her in determining the content of each interview, Alice demonstrated a growing trust and increasing safety. Many feelings of anger and sadness became evident as Alice began to recount in detail painful experiences from the past as well as the present. For example, Alice vented

during one session the extent of her frustration, disappointment and despair in connection to numerous attempts she had made to reach her mother and receive acknowledgement, acceptance and love from her. She moved from one period of her life to another, the common thread being instances of similar disregard or lack of acknowledgement from someone: her son on some occasions, her brothers on others, and from her first and second husbands as well. I noted that even though much of the content of Alice's stories flipped from one decade to several decades later, certain themes were surfacing, and could be briefly summarized at the end of each interview, so that Alice would not feel confused or overwhelmed by the process, and would feel confident that I was able to discern issues and clarify them.

In the first session, Alice described briefly the circumstances surrounding her sexual abuse. Due to her mother's involvement in church women's groups and sewing circles when she was a child, she was often sent to the neighbour's house to be looked after. She recalls befriending the man next door so that even when she did not require baby-sitting, she would go over there and he would take her horseback riding, for car rides, and on occasion, he would even take her to an office where he worked.

In time, this man began to kiss her on the mouth, fondle her, have her fondle him, and ask her to perform oral sex on him. She complied with all of his requests without struggle, and force was not used. Alice believed she was seven or eight years old when this occurred.

Alice also described an incident of sexual abuse from a teenage, male cousin. This memory is sketchy, but Alice recalled him telling her that she could do anything with him that she wanted to. Alice remembered undoing his tie, but her memory ended there. Alice was approximately 10 years old during this incident.

By the third session, Alice had developed enough trust with me that she began to describe the nature of her childhood relationship with her father in more detail. She remembered being teased by her family that she was spoiled, or was "Daddy's favourite little girl." She remembered that her father used to take her for car rides and leave the others behind. She also remembered that sometimes her father gave her "wet kisses" which made her shiver because he put his tongue in her mouth. I began to suspect that Alice had been sexually abused by her natural father, but waited to see if Alice would disclose this. In this session, Alice admitted that she "thought" her father may have abused her, but before I was able to respond, she had already taken back her suspicion, and rebuked herself for even

having this thought. I chose not to challenge Alice for denying her suspicion because it was very clear that Alice was very upset, and felt very vulnerable. Instead, I congratulated Alice for having the courage to share her memories with me, and validated the frightened, confused feelings she expressed. I explained to Alice that from my experience as a therapist, detailing the memories of abuse is often upsetting, alarming and confusing for people, and I hoped that Alice would not feel ashamed of the thoughts and feelings she shared, even if she was not completely sure that everything really happened the way she remembered it.

In the fourth session, Alice returned to the Family Centre feeling very tired and expressed numerous physical aches and pains. She described all of these in great detail, then, after a brief pause, I made a simple comment that sometimes it feels so easy and so natural to describe physical pain, whereas it is sometimes more difficult to describe emotional pain. Alice established eye contact with me, and responded with the explanation that when people reach Alice's age, they expect to have physical problems. I asked Alice to tell me what she does when she noticed her physical pain intensifying. Alice explained that she had a high tolerance for pain, but when it reached a certain point, she did something about it - either tell doctors, take Tylenol, or talk about it with others. Once again, I

drew Alice's attention to the fact that she made a very wise decision to respond to her emotional pain in a similar fashion.

At this point Alice appeared to be very annoyed with me, and voiced her concern that she might be cut off from her disability benefits because her doctor thought she was making her symptoms up. She added that when she spoke with the psychiatrist, and when she came to see me, she wanted someone to tell her what to do. "It is not useful to me just to talk about my abuse. I need to know what to do!" I responded to Alice with an explanation that my role in therapy is not designed to tell her what to do, but to assist her to discover her own solutions. Alice appeared to have some acceptance of this explanation, but she did not seem convinced of the fact that I was not the "expert" concerning action for her problem.

Alice took the lead for the remainder of the session. She said, "I do not want to talk about anything upsetting today. I have got things to do when I leave here, and I cannot go home for a nap." For the time remaining, Alice and I discussed Christmas preparations. Alice shared some of the activities she really enjoys, such as shopping for gifts, decorating her Christmas tree, and playing with the little village she designed below her tree. To close this somewhat difficult session, I suggested that it is very healthy and important to give attention to the

"little person" inside of us, and it can be great fun to let her out to play on occasion. Alice smiled at me and left the office.

Alice explained at one of our sessions that two days previous to this marked the anniversary of her father's death. She shared with me that she had purchased a small electric train set for herself, and she placed this train around her village underneath the Christmas tree. She also mentioned that she painted the local railroad logo on each train, in commemoration of her dad. I was moved by this gesture and knew, intuitively, that it had some symbolic meaning. Alice did not share with me what meaning, if any, applied to her healing process.

In this session, Alice described the problems within her current marriage. She appeared to show some signs of discomfort around the fact that Husband was her first boyfriend, and the father of her eldest child. She expressed some feelings of guilt for having an affair with Her husband while he was still married to his first wife, and then quickly changed her focus to discuss the fact that she is disinterested in sex, and she wonders if He cares.

Alice explained to me that she overheard her husband talking to one of his male friends on the phone, and from what Alice heard, she thought He might be bisexual and having an affair with this friend. I asked Alice what she would think

and feel if her husband was bisexual and she explained that she would not want him to be bisexually active at present, but she would not be affected if he had been in the past. Alice did not want to explore this subject further at this time, and described her feelings of discomfort and disinterest with sex.

Alice mentioned that most of the time, she avoided her husband or left the room if a love scene developed on television when they were watching it together. Alice explained that sometimes she had a few drinks with her husband, and with alcohol she could engage in sex, but felt anxious for it to be over with. I thanked Alice for sharing very personal information, and suggested that the following session continue to explore the present dynamics of Alice's marriage, with the intention of working toward improving their relationship.

I took note of the fact that up to this point, Alice kept every appointment promptly, and I was somewhat concerned when Alice cancelled the next session, without requesting another. After a week, I contacted Alice by telephone and asked her if she was feeling okay, and inquired if she would like to have another appointment. Alice hesitated, then agreed to come the following week.

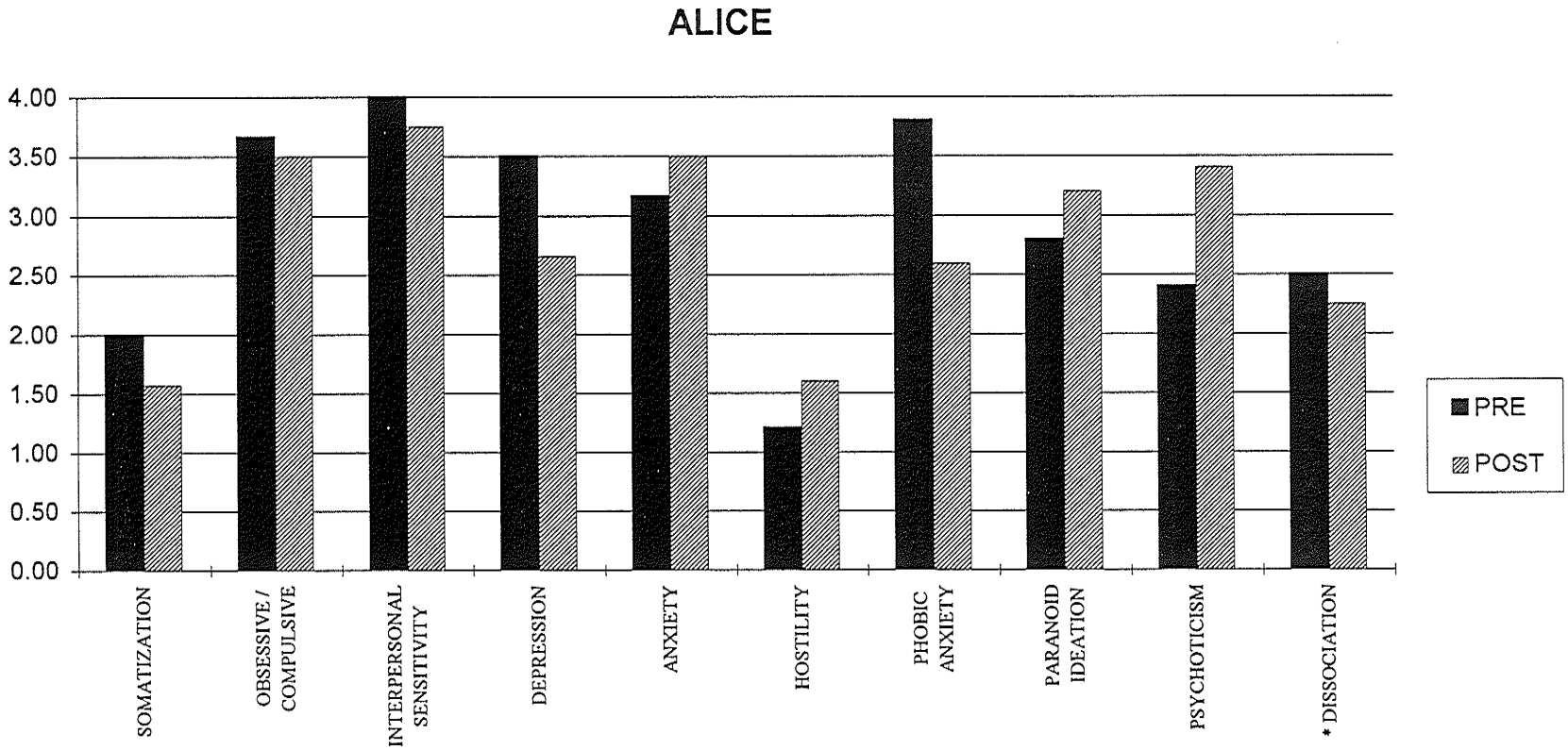
I was concerned that the reason why Alice cancelled her appointment with some hesitation to reschedule might have been tied to the possibility that she was

frustrated with me or that perhaps she no longer felt confident that therapy would help her. I consulted with my agency supervisor and discussed my concern about whether Alice was getting her counselling needs met at this time. My supervisor suggested that I use a list of questions in the next session to ascertain what problems might be developing between my client and me, and what might be done to resolve them. These are some sample questions I considered: "Has this experience in counselling been useful to you thus far?"; "Are there things you want us to talk about, that we have not discussed yet?"; "Is there something you wish we could do, or talk about, that we have not yet covered?"

Unfortunately, Alice cancelled the next session, and advised me that she would not be returning. She explained that she had been invited to attend a group counselling program at a local hospital, for adult survivors of sexual abuse. In preparation for group, Alice had been attending individual sessions with a female therapist at the hospital. I expressed to Alice that I was sorry that our work had to end this abruptly, but I was very happy that Alice felt confident to begin a group approach to healing. I explained to Alice that group intervention offers a wonderful dimension to healing that cannot be experienced in the same way during individual therapy. I highlighted once again that Alice was demonstrating great courage and wisdom in choosing the path that was most comfortable and

most useful for her in order to attain her goals. Alice offered me reassurance that the work we did together was very useful to her, and that she credited these efforts with her readiness for group. Alice and I spoke on the telephone one week later for the purpose of completing the post-test requirements of this project.

Figure 1. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores

According to both pre and post-test scores taken from the BSI, Alice was, in general terms, highly distressed. Her general severity index scores, before and after therapy, were at least two standard deviation units higher than normative data extracted from an outpatient population.

Indications that Alice struggled with depression, somatization, phobic anxiety, interpersonal sensitivity (see figure 1.) and low self esteem (see figure 8) were consistent with her initial complaints and problem identification.

Post-test scores revealed very little change. Since many of Alice's troubling issues were in the beginning stages of exploration and disclosure, it seemed understandable that levels of fear and anxiety would either remain unchanged or intensified.

Alice's post-test score from the ISE was improved and consistent with her self reports of feeling more confident. This renewed confidence was evident in Alice's ability to initiate the termination of our contract and proceed toward group intervention. Since the post-test score from the ISE was still well above 30,

the need for further intervention in the area of self esteem, was certainly apparent (see Table 1).

Reflection of the Client's Evaluation

Alice shared her disappointment with me, that I did not provide as much clarity and direction as she hoped. She added, however, that she benefited from my support and understanding. She explained that as a result of therapy, she felt confident to enter a group treatment program. Alice believed that she would not have been able to register for, let alone participate group therapy prior to counselling.

Reflection of the Therapist's Learning

The most profound learning I encountered from this experience, had more to do with what did not happen in therapy, than what did. Alice explained that she wanted more direction from me concerning what she should do differently, and I responded with ideas that Alice either did not understand, or did not believe. It was not part of her self perception, that she was the "expert," in bringing to light thoughts or behaviours she could experience differently, now that

she was "dealing with" her sexual abuse. She was convinced instead, that I should direct these changes for her.

Upon reflection, my intervention with this client may have been more successful if I had used Dolan's techniques. For example, when Alice told me that she did not feel it was useful enough just to talk about her abuse, and she wanted to know specifically what she should "do" differently, I could have used some of the following questions: "Well Alice, perhaps you can help me understand what would be different about you or your situation if your past abuse was having less of an impact? What might others notice about you that would be different?"

My handling of Alice's request for more direction was to shift the responsibility and the expertise from the therapist to the client. This seemed to exacerbate Alice's feeling of frustration and despair. Solution focused questions, especially as Dolan (1992) uses them, have the potential to elicit the cooperation of the client in identifying goals and creating change which is meaningful to the client.

Case Example 2 -Client B - "Debbie"

Debbie, age 24, was referred to the Family Centre of Winnipeg by the Women's Post Treatment Centre, for the purpose of resolving problematic issues from the past and present.

Debbie disclosed to the intake worker that she was sexually abused as a child by a priest as well as by family members. As a result of the abuse, she believed that she did not know what was appropriate in relationships. Consequently, she struggled with confusion, difficulties with trust, problems with sex, and an inability to discern the difference between right and wrong, normal and abnormal behaviour.

Description of the Problem

Debbie explained that although she had made progress in improving her self and her situation during her recovery from alcoholism, she believed that she still had a tendency to blame others for her problems. She explained that she wanted to take more responsibility for her present life by increasing her understanding and awareness of her past.

Debbie expressed a belief that she struggled in current relationships, especially in terms of boundaries, trust and sexuality as a result of unresolved issues stemming from sexual and physical abuse. Debbie added that she had not explored these issues in therapy previously, and she hoped that she would improve her relationships if she examined her abuse history more fully.

Client Biography

Debbie was raised in a northern town in Manitoba, in the presence of 25 of her immediate and extended family members. There were only four bedrooms in the house and therefore many children and adults were huddled together to sleep. Throughout the day and into the night, people were constantly coming and going, drinking alcohol, partying and fighting. In this environment, many children were physically, emotionally and sexually abused by adults and sometimes by the older children, without anyone taking notice.

Debbie explained that she was four years of age when she was sexually abused for the first time, and this abuse continued until she was 15 years old. Perpetrators ranged from a brother, several cousins of varying ages, and on one occasion, she was fondled by a priest. Other forms of abuse, such as physical beatings and emotional assaults were administered frequently by Debbie's

alcoholic mother, and some aunts, uncles and cousins used excessive force and violence against her as well.

Debbie experimented with alcohol and solvent sniffing when she was approximately seven years of age. By the time she was 12 years old, she was drinking alcohol and skipping school regularly. At 12 years of age, Debbie ran away from home, without being missed by her family, until she was caught by police and delivered to Child and Family Services. At this time Debbie was apprehended by child welfare workers, and was shuffled from one foster home to the next.

Three years later, Debbie made arrangements through her Native Band Council to relocate to Winnipeg in order to improve herself and attend school. In Winnipeg, Debbie continued to struggle with her studies, teachers and peers, and eventually dropped out of school and ran away. She continued to live in foster care until she reached 17 years of age.

At 18 years of age, Debbie married and months later the couple moved to a European country, her new husband's original home. Both Debbie and her partner struggled with alcoholism, and they also used narcotics both frequently

and heavily. During this marriage of four years, Debbie was physically abused on a few occasions and was emotionally abused several times each day.

At 22 years of age, Debbie left her partner in Europe and returned to Winnipeg, where she continued to drink very heavily for one more year. She began to make positive changes in her life by attending Alcoholics Anonymous meetings and Adult Education courses. At the time of contact with Family Centre, Debbie had been sober for one and a half years, attended AA meetings at least once, sometimes twice each day, and maintained a romantic relationship with a man from her AA peer support group.

Presenting Concerns

When Debbie arrived at the Family Centre of Winnipeg for the assessment interview, she presented herself with confidence and with a calm disposition, even though she warned me that she was feeling quite nervous. She listened carefully and with interest to my brief explanation of my role at this agency and my area of study for this Practicum project, and nodded her head with approval that she would like to continue.

Debbie appeared to be very used to telling her story, and she did so with me without any apparent discomfort. Much of her family history, as chaotic and dysfunctional as it was, was described without emotion, and without apparent concern for how I might react.

When I asked Debbie what brought her for counselling at this time, she became noticeably less sure of herself in her answer. She used very vague or general descriptions for what she was looking for in therapy, and what she hoped to accomplish. She explained to me that she had changed very much in the past year and a half, due to the challenge and support she had received from her 12 step group, but she wanted to take more responsibility for problems and difficulties in her life and relationships. She admitted that she has never really looked into her issues related to sexual abuse, and when I inquired about her contact with the Women's Post Treatment Centre, she responded with a glib comment such as "it was fine."

Debbie also explained that she was afraid of pain in therapy, and warned me that when she encounters emotional pain, she tends to bolt. I asked if this is what happened at the Women's Post treatment Centre, and she just laughed and said "No."

I held a few concerns with proceeding with Debbie at this point:

1 I was uncertain of Debbie's purpose for counselling;

2 Debbie was very absorbed, if not obsessed with the 12 step process (attending meetings 1-2 times each day, 6-7 days each week), therefore, what time or energy would be left or required for this individual process?

3 I was also unsure of what issues remained untouched from her involvement with the Women's Post Treatment Centre, and why was a referral to this agency necessary after her treatment there?

I shared these concerns with Debbie prior to contracting for more sessions, and she responded to me, stating that she had time to commit to individual therapy since she was not working, nor was she attending any courses. She also stated that she thought individual work would be useful for her to examine her past, including sexual abuse, more closely. She added that she was on a waiting list at the Women's Post Treatment Centre as well as at the Family Centre of Winnipeg, and she would commit to therapy wherever it was offered first.

A Description of the Client/Therapist Contract

When Debbie and I began contracting rules and goals for therapy, we were both unclear about what Debbie wanted to accomplish in counselling. Debbie explained that she had not explored issues related to sexual abuse in counselling before and she was unsure what to hope for or expect.

Even without clearly defined goals, Debbie and I agreed to meet for one hour sessions each week for approximately six sessions. I suggested that to begin the process, Debbie and I could use as many of the sessions as we needed to get to know each other better and establish safety and comfort between us. When Debbie was ready, she could describe in as much detail as she found useful, information relating to herself, her past and her experiences of sexual abuse.

I asked Debbie if it would be okay if I telephoned here if she were to cancel any sessions so that we might determine if she was "bolting from pain." Debbie laughed in a way that seemed to indicate to me that she felt comfortable and challenged. She agreed that I should call her until I reached her.

Description of the Intervention

When Debbie came for her first session following the assessment, I proceeded to strengthen the connection we established previously, using humour, casual conversations, and compliments for Debbie's clothing and hairstyle. Debbie responded favourably to these gestures, but continued to show ambiguity around her expectations for our meeting. I broke the silence to offer Debbie some thoughts I had after she left our last session concerning some of her past history. I stated that I was really struck by the courage she demonstrated in leaving the country at 19 years of age, leaving behind everyone she knew and loved, and moving to an entirely new country with a new husband and a new culture to adjust to. I explained to Debbie that this task would be difficult for me to do now, let alone when I was 19 years old.

Debbie agreed that this was a big step for her, then proceeded to explain some of the pressures and problems she encountered with the language barriers, going places, getting lost, and being alone. She also explained that while living in Europe, the couple lived with her in-laws, and this was difficult, especially in light of the fact that her partner left her alone frequently, and cared so little for her feelings.

Debbie expressed very strongly that one of the things she liked the least about her husband was the way he criticized everything she said and did. She believed that it was impossible to please him. She also expressed much regret for having become so addicted to substances, and commented on how these chemicals kept her in a vulnerable state, in addition to numbing her feelings. I validated Debbie's feelings and complimented her for having insight regarding this period of her life. I also commended her for finding her way back home to Winnipeg, and making so many responsible and mature decisions once she was back. Debbie objected by admitting that she continued to waste another year of her life to booze before she got on the right track. In response, I offered the suggestion that it is very important to pace ourselves and the changes we make to our lifestyles, even when the changes are healthy. I stated that we can commit to a journey toward healing old hurts when we know we are ready. This statement served the purpose of reframing a negative statement as well as planting the suggestion that she needed to recognize her signs of readiness concerning a journey toward healing she may make with me.

When I asked Debbie if she had any thoughts or questions to share with me since we last met, she reported that she was unable to think of any. I explained to her that it is very important to me to know what our work will involve, so that

together we might establish some goals for therapy. Debbie agreed to think this over carefully before returning.

When Debbie returned, she was visibly upset, even when I greeted her in the lobby. Her mannerisms in the therapy room, including the way she seated herself, threw her coat to the side and sighed deeply, revealed anger and hostility. She did not offer any explanations in the beginning, as to why she was so clearly upset, but with a few gentle inquiries as to how she felt when she got up that morning and when she first noticed the feelings she was demonstrating to me, she started to unravel the clues. It became clear to both of us that Debbie was reacting to the fact that for the past few days, her mother was staying at Debbie's apartment, while visiting from the north.

Debbie's mom also quit drinking, and has been sober for five years. During this visit, her mom went on and on about how she set the pace for Debbie and her other children in giving up alcohol. Debbie also explained that her mother still criticized every single thing she did and she could not stand this anymore. I asked Debbie if she recalled these conditions or feelings at any other time in her life, and of course she had numerous stories to tell about her mom, her ex-husband, and even her current boyfriend. I asked her if she dealt with these situations

differently when she was sober, as compared to the times when she was used alcohol and drugs heavily. After some thought, Debbie explained that in all situations where she felt strongly criticized and unable to please, she found some way to escape. She used alcohol to escape in the past, she ran away from home and from Norway, and while her mom was at her house she looked for any reason to leave, or to "escape." I asked if there was anything else she would like to do besides leave the house or escape from her mom's criticism. Debbie explained that she would like to stand up to her mom and tell her to shut up for once. When I asked Debbie if she attempted to try this option, she explained that she tried, but her mom went on and on about how difficult her life has been, how ungrateful her children were, and how thankful they should be for her example of sobriety. Debbie got very emotional at this time, and proceeded to voice anger and disgust for her mom. "How dare she claim the credit for our recovery, she is the one who got us used to drinking in the first place! If anything I blame her for my alcoholism, and certainly not for my recovery!"

In response to this discovery, I suggested to Debbie that she honour her feelings at that moment, and allow herself to be in touch with her anger and her hurt. In closing, I suggested to Debbie that she revisit the strong and determined

part of herself, so that when she returned home to face her mother, she would feel able to withstand her criticism, and respond to her effectively.

In each of the following sessions Debbie took the initiative by reporting to me the events of the previous week. Each time, she described some situation or event that was troublesome to her, and proceeded to vent about it. I deliberately chose to respond to Debbie's lead each time she arrived and attempted to use problem solving techniques to assist Debbie in finding a useful solution to whatever the problem might be.

After Debbie left each week, I spent a few minutes on my own trying to trace any connections between one week's problem and the next. My concern at this time was that Debbie and I were not focused in our work, and not moving towards a clear and established goal. I could see a common theme developing in problems Debbie was describing in her current relationship (which had progressed to common law status) which seemed to parallel problems with her mom and with her first husband. In all three of these relationships, Debbie encountered someone else controlling her, criticizing her, and shaming her. However, I was uncertain as to how I could assist Debbie in recognizing this dynamic and changing her role.

I was also concerned about how to get her to focus on a goal for our process, without coming across as minimizing or limiting her complaints.

In consultation with my supervisor, I discussed my concern that I was not sure what Debbie and I were working towards, and that I was unsure if it was okay for us to still be in the "relationship building" phase after four sessions. My supervisor suggested that I accept and respond to the pace that Debbie was setting, and assured me that Debbie may be looking for someone to whom she can "report" at this time. Perhaps this would be the service I provided her, and that I ought not pressure her toward goals just yet. I agreed to relax, and continue to follow Debbie's lead.

The next report from Debbie involved her recent discovery that she was pregnant. The news was complicated because she referred to the pregnancy as planned, even though the relationship was only six months old and struggling seriously. I validated feelings and concerns as Debbie shared them with me, and once again attempted to problem solve various complaints she voiced regarding their relationship. I also invited Debbie to bring her partner to sessions if she thought this would help. He did not attend any sessions. I also inquired about Debbie's options concerning this pregnancy and the ongoing threat of separation

between herself and her partner. She responded to all of my explorative questions with a clear conviction that whether her relationship lasted or not, she would carry the child full term and raise it alone.

Debbie felt very confident in her skills as a mother since much of her childhood involved mothering younger siblings and cousins. I recognized my own concern escalating as she described her belief that this baby would help her be more responsible, mature and independent. I shared my own belief that it is a parent's role to help her children behave responsibly, maturely and to become independent, not the other way around. I also chose to share my own experience of the difficulties and sacrifices involved with raising a family in an unstable marriage and then eventually alone. Debbie did not appear to appreciate my comments, even though she stated that she believed my words. She held her plans to raise the baby steadfast, while I stated that my role would be to respect her decision and assist her in any way I knew how.

For the next few sessions, Debbie either cancelled or failed to show without warning or explanation. I called Debbie several times to determine whether or not she was "bolting from pain." After four attempts of trying to reach her by phone, I finally contacted her and we rescheduled an appointment. When she arrived,

she took the lead and described in detail the ways in which her partner was abusing her trust, and assaulting her emotionally. Her partner was sleeping with other women, most of whom were friends of Debbie or members of their AA peer support group. Debbie was crushed, and made a decision to separate from him for a while. She returned to him after a few days, but found that trust between them was becoming more of a problem, as he began to accuse her of "trapping" him with the pregnancy, and refusing to settle down with a job or to plan for the future.

Throughout frequent arguments about the future, Debbie admitted that her partner was becoming verbally abusive to her. I asked Debbie to describe what happens for her when he makes a hurtful comment or action against her. She explained to me that she follows the following process:

1 I just take it;

2 I get angry;

3 I feel bad about myself;

4 I get confused;

5 I feel like an idiot.

She proceeded to add, "Dave goes on and on about himself in positive ways and then proceeds to criticize me and say negative things about me . . . He reminds me of my mother!" At this point Debbie was crying steadily. I attempted

to comfort her with words of encouragement and praise for understanding and identifying that pattern so well.

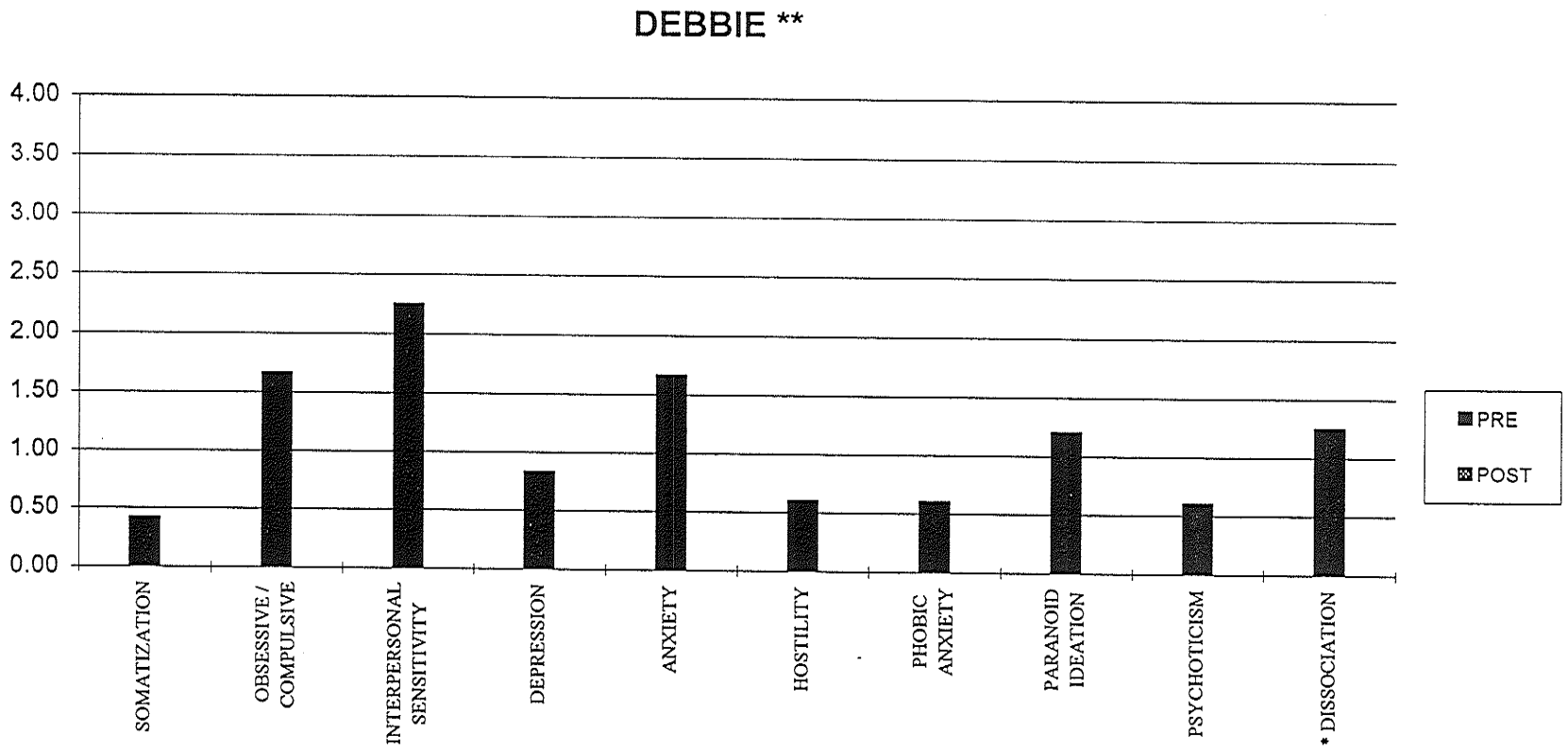
At this time I attempted to use Debbie's past experience as a metaphor for her current situation. I described Debbie as a little girl who was forced into the "roles" of an adult woman, both as a sexual object and as a mother. I highlighted for her the idea that her relationship was still only a few months old, and yet it had been thrust into very serious and complicated circumstances. In spite of her relationship's early stage of development, she and her current companion were struggling with negotiating commitments, handling differences, and preparing for a family. I suggested that perhaps these matters imposed too much pressure for their relationship. I asked Debbie if she thought it might be possible for her and her partner to back up just a bit, and allow their relationship to develop at a more natural pace. She shrugged her shoulders, as if to say she did not know. I asked if it made sense for her and Dave to return to dating for a while, and to see if they could take some of the pressure off the relationship. I worked towards helping my client to avoid internalizing her difficulties with Dave as a sign that she was inadequate or a failure. I suggested to Debbie that couples who have been married for several years often struggle with conflict and stress and that she had made

good progress in the few months of knowing Dave, especially in the area of setting boundaries and recognizing differences.

I inquired if she would find it useful to begin preparing herself for being a mom, and developing a plan to stabilize her situation. She agreed that adding some structure to her life would help her to feel stronger, and more capable as a mother. She provided me with a list of things she wanted to do to add more structure and get her life going in the right direction.

Debbie did not show up for the next session. When I called her home, she was not there, so I left a series of messages, using humour to address her tendency to "bolt from pain." Debbie left some messages for me to call a new number and we talked on two occasions. Unfortunately, Debbie cancelled each of our rescheduled appointments. I was not able to terminate with her or complete the post-testing, since she left a brief message for me explaining that she had moved away from Winnipeg.

Figure 2. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

** Post-test scores are unavailable for Debbie.

Pre and Post-Test Scores (Figure 2.)

Before therapy, Debbie reported mild to moderate levels of distress. Her general severity index score was lower than the normative outpatient data, but were at least two standard deviation units higher than the non-patient sample.

According to pretest scores from the BSI, Debbie was most troubled by symptoms of interpersonal sensitivity; obsessive/compulsive tendencies; anxiety; and paranoid ideation (see figure 2). Interpersonal sensitivities were probably the most evident in Debbie's statement that she did not feel confident in her ability to discern the difference between "right" or "wrong" behaviours in relationships. Consequently, she was frequently abused, either physically or emotionally during relationships with men, and relationships from her peer support group.

Obsessive/compulsive traits were evident in Debbie's involvement in Alcoholics anonymous meetings. She attended meetings as many as 2-3 times each day, 6-7 days each week.

It is also likely that Debbie's experience of sexual abuse in addition to physical abuse and neglect, would contribute to what may be symptoms of post-traumatic stress. This might account for some of Debbie's feelings of dissociation, anxiety and paranoid ideation.

Debbie's ISE pretest score revealed that Debbie had a relatively healthy level of self esteem. It was likely that Debbie's positive self esteem was in some way tied to her mastery of alcoholism. This achievement provided Debbie with insight regarding her abilities to overcome difficulties and improve her situation.

Unfortunately, Debbie moved away from Winnipeg before we were able to terminate therapy and complete the post-testing. Consequently, I was not able to measure change in scores from the BSI or the ISE.

Reflection of the Client's Evaluation

As previously stated, Debbie's sudden departure from Winnipeg did not facilitate a verbal or written review of the usefulness of this intervention for my client. I consider the fact that Debbie attended seven sessions, participating freely and with interest, to be an indication that she perceived some value in the process.

A Reflection of the Therapist's Learning

I learned from my intervention with Debbie that treatment for survivors can involve very little discussion or disclosure of abuse. Some clients appear to benefit from having a safe environment, where he or she can "report" day to day occurrences to a supportive therapist.

My active listening to Debbie's thoughts, suspicions and dreams set the stage for the development of trust. This trust provided foundation for my challenge to Debbie, to recognize old harmful patterns in current situations.

Case Example 3 - Client C - "Liz"

Liz, age 41, was referred to The Family Centre of Winnipeg for counselling by the Women's Centre for Substance Abuse (Christy House). Liz had been involved in an alcohol abuse program at Christy House when she began to struggle with memories of childhood sexual abuse perpetrated against her by her older brother.

Liz contacted the intake worker at Family Centre in June 1993, and at that time, she had been sober for twelve months. She indicated to the intake counsellor that she began drinking in the latter periods of her life, and would like to deal with problems she believed led her to alcoholism.

Description of the Problem

During alcohol abuse counselling, a therapist explained to Liz that it was important that she examine the cause or problems that led her to drink excessively. At that time, Liz disclosed to her counsellor that she was sexual abused during childhood. The counsellor recommended to Liz that she seek individual counselling after her alcohol treatment program.

Following detoxification at River House, Liz began to reconnect to feelings and memories from her past. Consequently, she developed symptoms of depression, anxiety and an increase in problems with low self esteem.

Client Biography

Liz was the third of four children, who was raised primarily by her father since she was seven years of age. While struggling with alcoholism, Liz's mother decided that she could no longer remain married to her husband, and provide care for her children and therefore left the family without further contact.

Liz was born with heart problems that required surgery when she was a child. Liz described this situation as creating a great financial strain for her family and additional stress for her father. She was not sure of her age when this surgery was performed, but she guessed she was six years old.

Liz believed that her heart problems increased the amount of attention she received from her dad, since he often blamed the other children for causing skirmishes and for being too rough with her. She also believed that her siblings

were jealous of her added attention and protection and did not like her because of it.

Liz explained that the financial strain of medical costs related to her surgery made her feel as though she needed to "constantly prove to her dad and others that she was worth the expense." For this reason, Liz became an "over-achiever," performing well in school and in sports. She noted that she continued to struggle with high expectations of herself to be successful in a career as well as in social interactions.

Liz reported that when she was approximately seven years old, her older brother (Danny) molested her. Her memories of this were sketchy. However, she remembered lying down in the back of a truck at Danny's request, and focusing on a jar of Vaseline. When this occurred, she remembered feeling afraid and ashamed, although she did not remember what happened, or what purpose the Vaseline served. She believed that whatever took place between her and Danny in the truck was the reason her brother was sent away.

Liz's father died of a heart attack when she was 15 years old. She described feeling very sad and afraid when her dad passed away, and even

though she went to live with an aunt and uncle, she felt as though she was all alone. Her older sister (Agnes) chose to live independently at the time of his death; she did not know where Danny was living; her younger brother (Nick) went with Liz to stay with their paternal aunt and uncle.

Liz explained that she did not have very fond memories of staying with her relatives, and felt very anxious to leave. She became pregnant at 17 years of age, and decided to move out on her own.

When she was 27 years old, Liz felt pressure from friends and relatives to marry a man she had dated for a long time. After eight months of marriage Liz left her husband because he was an alcoholic. Following her separation, Liz dated several men, most of whom mistreated her emotionally, physically or both.

Liz was involved in an extremely violent relationship with a man when she was approximately 30 years old. For 1 1/2 years, she did absolutely everything he told her to do in order to please him, pacify him and prevent him from beating her. Liz sustained numerous injuries from countless beatings, and genuinely feared for her life. She escaped this relationship by

marrying another man, even though the period of time she had to get to know him was very brief.

Liz divorced her second husband two years later, and had been living alone since. Currently, Liz dated a divorced man (Ken) and complained that although Ken treated her well, she did not always trust him to refrain from violence.

Presenting Concerns

When Liz arrived at The Family Centre of Winnipeg for the assessment interview, she appeared to be anxiety and nervous. Her movements appeared to be somewhat animated as she flung her arms while speaking, spilled her coffee, then knocked some magazines and a jar of coffee whitener off of a table in an attempt to tend to the coffee spill. She spoke in a loud voice as she apologized for the accidents and continued to struggle with balance.

In the therapy room, Liz continued to behave in a manner that seemed to reflect inebriation. She made an effort to relax by commenting on how nice I seemed to her, and how pleasant and reassuring my voice sounded.

Once Liz was more calm, she began to explain that the slur in her speech was caused by dental problems she had. All of her back teeth on the top and bottom had been removed due to gum disease. She also explained that she was having difficulty adjusting to the antidepressant medication she had been taking for two weeks. She explained that she experienced mood swings several times throughout each day and believed this to be a side effect of her medication.

When questioned as to what purpose Liz was seeking counselling at the present, she responded with an explanation that ten years ago, an alcohol abuse counsellor "told" her that sooner or later she was going to have to deal with her past issues of abuse in order to stop drinking. She said she believed this was true, and since she had been dry for one year, she thought she was ready to explore past abuse issues.

Liz explained that she was keeping herself very busy with various groups in order to get past her problems and depression. For example, she was waiting to begin the screening process at Christy House for a residential program for substance abuse, she was attending Alcoholics Anonymous and Emotions Anonymous meetings weekly, and she was also planning to begin a job search so that she could get off welfare and start feeling better about herself.

Throughout this first interview, Liz demonstrated the "roller coaster" effect of her mood swings as she changed from laughter and smiles to shedding tears and sobbing, sometimes without changing subject. I explained to Liz that I needed to think about the information she shared, and asked her to return in two weeks when she might feel more used to her medication, so that we could make a good decision regarding individual counselling. She agreed to return in two weeks.

When I greeted Liz in the waiting room the second time, she appeared to be much calmer, and her appearance was neat and attractive. Her movements and gestures were not exaggerated, and her tone of voice was soft. However, in the therapy room, she seemed confused by my familiarity with her, and asked me if she knew me or met me before. At this time it became very clear that she did not remember the session we had two weeks prior, and she seemed genuinely surprised when I described our first meeting. Liz concluded that her lack of memory was explained by her difficulty adjusting to medication. She mentioned that she asked her doctor to reduce her dosage of diazepam, but he maintained that the dosage was correct, and suggested to Liz that she continue the prescription and expect to see the side effects improve.

Description of The Client/Therapist Contract

When questioned as to what role or purpose therapy would play in dealing with her past issues and memories of sexual abuse, Liz explained that she did not have full memory of what happened to her during abuse, and she thought that until her memory was restored, she would not put these matters to rest fully, and heal from her pain of abusing alcohol.

At this time I shared with Liz my concern with using a memory retrieval approach to healing, suggesting that this was not a good idea since she was involved in various forms of treatment (Alcoholics Anonymous, Emotions anonymous, and the program at Christy House) in addition to beginning a job search. I added that while all of these efforts demonstrated her great courage, adding to this list might overwhelm her, and increase her depression and anxiety. I suggested that perhaps her old pattern of wanting to "prove her worth" was driving her to take on more tasks than were either physically or emotionally healthy.

Instead, I offered Liz the option of taking a very slow approach to individual therapy. The focus could be to assist Liz to feel stronger and more

confident in herself as she became more used to her medication. I also suggested that our therapy could be an exercise in self care, helping Liz to be more kind and compassionate toward herself, instead of driving herself so hard. Once again Liz began to cry, as she explained that she could see that she was taking on more than was necessary.

Liz and I agreed to meet once each week for at least six sessions. At the end of six sessions we would review our goals and assess the need for more sessions. Liz also agreed to my suggestion that we would not attempt to recover repressed memories, but instead, therapy would provide her with an opportunity to express and honour the memories and emotions she could remember, and throughout this process we would work toward improving Liz's self esteem.

Description of the Intervention

Liz was ready to begin treatment the week following the second assessment interview. Her reaction to medication stabilized and I noticed that each time she came for a session, her presentation was neat and her mannerisms were calm and controlled. Liz's only complaint regarding side

effects to this drug was fatigue, but she explained that she could manage this problem.

Liz explained that she still felt rather nervous about therapy, and did not really know where to begin. I reminded her that it was okay for her to take as much time as she wanted to establish safety and trust here, and that my role was to support her. Much of the content during the first few sessions involved reports of weekly activities or events, and filling in details of Liz's life story.

For example, Liz described some of the problems she was having with her teeth and gums, and explained that these problems made it very difficult for her to eat solid food, and speak clearly. Liz also explained that she was going to be fitted with partial dentures soon.

Liz also reported to me some of the ideas she had for employment, and some of the applications she had made. My responses to all of Liz's weekly reports were aimed at complimenting and encouraging her for her accomplishments and achievements and validating her feelings of fear, frustration and disappointment.

Liz also described some of her friends who had really supported her. She claimed that two female friends had seen her and talked to her when Liz was at her very worst, and they never abandoned her. I confirmed the importance of good trusting friendships, and complimented her for having qualities that attract good people. Liz shed some tears as she told more stories of ways in which her friends had not let her down. I purposefully phrased my responses to her positive descriptions of various people in ways that reflected positive qualities in her; with suggestions that "special people earn quality relationships," and "it takes hard work and dedication to maintain love and trust between friends," and "Liz must have been a good friend in order to have good friends."

Liz arrived late for her fifth session. She explained that she had just come from the dentist. She had her new partial dentures on. I also noticed that Liz had paid extra attention to her hair and make up. She added that she missed a few days of her medication before she could refill her prescription. Consequently, she noticed the old side effects once again and felt very tired and emotional.

During this session, Liz described her fears of being with other people. She felt very conscious of people looking at her and she believed everyone was assessing her physical appearance. She expressed concern that strangers on a transit bus, or anywhere for that matter, often stare at her, and she believed this meant they were critical of her. I asked Liz to consider the possibility that people who stare at her are thinking that she looks interesting and pretty (Liz was a reasonably attractive woman, especially on this occasion). Liz displayed strong emotions of anger and sadness as she strongly emphasized her belief that she was not at all pretty, and that she was sure strangers were critical of her.

She added a concern that she was not comfortable with her boyfriend's former wife (Tannis). Ken (her boyfriend) had mentioned to Liz that when Tannis saw her for the first time, she thought Liz looked like a prostitute. Liz demonstrated strong emotion as she described the circumstances surrounding Tannis' comment, and she gave more reasons explaining why she felt threatened when strangers look at her.

At this point I was very concerned about Liz because she was crying very hard and did not seem to respond favourably to anything I said to reassure or

comfort her. It seemed to me that Liz wanted me to listen to her more than she wanted me to comfort her, so I chose to remain very quiet. After she described her concerns regarding Tannis, she suddenly shifted her focus to other social events where she felt very self conscious. After many tears she explained to me that she had been involved in prostitution for five years during her early thirties.

I reassured Liz that I did not feel critical or think less of her because of her involvement in prostitution. I thanked her for sharing such personal information with me especially if this was something she felt ashamed of. I explained to Liz that I suspected that there were reasons why she got involved with prostitution and that under the same circumstances, perhaps others would have done the same.

Liz confirmed the fact that this was an aspect of her past for which she felt tremendous shame and embarrassment. She added that much of her shame was tied to her concern over the reactions of others regarding this matter than any sources of humiliation she might connect with the experiences themselves. She stated that she could understand the events that lead her to

prostitution: the opportunity offered her a source of income, and she felt good about herself because she performed well.

I offered Liz my belief that women throughout the ages were conditioned to find their value and worth in their ability to please men sexually. Prostitution is one example of this conditioning, childhood sexual abuse is another. I added that many adult and adolescent survivors of sexual abuse have used prostitution to support themselves. These were messages they were given about themselves concerning their bodies and their ability to amount to anything in the future. Liz appeared to understand and accept this message as she nodded her head and smiled faintly.

Liz described, in our next session, her fear of meeting a former "customer" while out somewhere. She added that this was one factor that led her to drink at parties and social events. Alcohol would numb her feelings, and she would relax. I complimented Liz for having this insight, and asked her if there was another way for her to relax at parties without alcohol. Liz responded with two possible methods: 1) to say positive things to herself (self talk); and 2) to stay close to Ken so that she can feel his support.

Ken knew about Liz's past involvement as a prostitute but this was not an issue for him. She described him as being very understanding and supportive of her and she was glad to have him in her life. This discussion was reframed once again to reflect the good that others saw in Liz, even though there were aspects of her past for which she felt ashamed.

Liz shared some concerns that Ken might get impatient with her mood swings and leave her. She said that she was so angry about past relationships when she was abused that she used aggressive and harsh behaviour with Ken, just to assure herself that no one will ever abuse her again. I asked Liz to describe the events where she used this behaviour, and asked her what triggered her feelings. Liz explained that she got aggressive with Ken as a way of maintaining control over situations. I asked if she felt that it was necessary to always have control over events. She explained that she needed control to prevent herself from being vulnerable to men. When she felt vulnerable with men, she feared abuse. I validated Liz's feelings, recognizing that the two factors often go hand in hand.

Liz and I continued to explore the dynamics of her relationship with Ken. We looked at possible options for her to identify situations where she

needed to have control from those situations where it would be okay if Ken had control. We also explored the use of effective communication skills in handling issues, so that Ken would not feel threatened, and Liz would not feel harsh. Liz responded favourably to these exercises, and felt very proud of herself for refraining from the use of alcohol at Ken's Christmas and New Year's Eve parties.

During the 8th session, Liz announced that she had secured a job as a waitress, serving at banquets for a catering company. She felt very good about herself for this, but recognized that it was going to take more energy and she was likely going to feel more tired than she was used to. She also shared some concern with serving alcohol. Problem solving strategies were used to notice and prevent her urge to drink.

Liz came to her 10th session feeling very depressed. She explained that when she got up the previous day she "knew" she was going to the liquor store to buy booze. She explained that she needed cooking wine, and while she was at the liquor store she bought a six-ounce bottle of vodka, which she drank alone in one sitting. I commended Liz for choosing to buy such a small bottle, and asked her how she managed this. She explained that this was all she could

afford, and she felt very guilty, especially when Ken came over. She claimed he knew she had been drinking, but he did not say a word to her about it. I asked if she thought she might do this again, and if she did, what could she do to fight the urge? She stated that she did not think she would do it again since she felt so horrible. She added that she also believed that she was testing herself to see if she could have just one drink. She reassured herself that she cannot control her drinking, and this increased her motivation to remain in contact with Alcoholics Anonymous. I suggested to Liz that it is very good to know one's limitations and to reach out for help when it is needed. I also addressed the issue of "control" in context with alcohol. While Liz claimed to feel strong physiological and emotional dependencies on alcohol, she demonstrated control over this problem over the past year. She either abstained from the use of it or stopped drinking before she became intoxicated.

In the 11th session, I reminded Liz that we agreed to review our goals for therapy after six sessions, and that we needed to decide whether or not she needed to continue. Liz's response to this appeared to be anxiety, and she voiced a strong desire to continue meeting, adding that she still felt very weak, meaning, that she was still troubled by her past and vulnerable to her feelings associated with it. I responded to her statement with the suggestion that Liz

did not need to end therapy, even if she felt strong. She relaxed, and we decided to continue meeting once each week, possibly until the end of March (which involved six more sessions). Her focus would be to explore her experiences of childhood sexual abuse and her feelings about her brother Danny.

Liz explained that she still did not remember what happened in the truck, but she felt confused about the fact that she did not feel angry toward her brother. She described him as a very sweet, gentle boy and she felt guilty when he was sent away. I explained to Liz that her mind may be blocking her from remembering the details of what took place that day, and could be providing a protective mechanism. This might be taken as a signal that this is not a good time for Liz to remember. I also explained to Liz that it was perfectly okay that she was not angry with her brother, and that she described him so favourably.

Liz explained that she had never asked anyone from her family when she was older in an attempt to understand what happened to her brother after he was "sent away." She felt remorse and guilt about this because Danny died in

a car accident when he was 20 years old, and her lack of knowledge was unfinished business for her.

I validated Liz's feelings, and thanked her for telling me how she really felt about her brother instead of what she thought I expected her to say. I suggested to Liz that she take some time to write a letter to Danny so that she might tell him how she felt about him and about what happened between them. I explained that "healing letters" are good exercises for people to get in touch with their feelings, even when the person they are writing to is no longer living.

This exercise helped Liz bring closure to the guilt and remorse she felt regarding her brother. She was able to tell him that she was very confused and unsure of what happened in the truck, but she did not hate him for it. She also told him that she loved him and felt sorry for all of the times when their father blamed him for fights she started. She told him that she saw him as a sweet gentle guy who never meant to hurt anyone and that she wished he was still alive. I thanked Liz for sharing her letter with me, and suggested that she may want to write to him again when and if other feelings or memories surface.

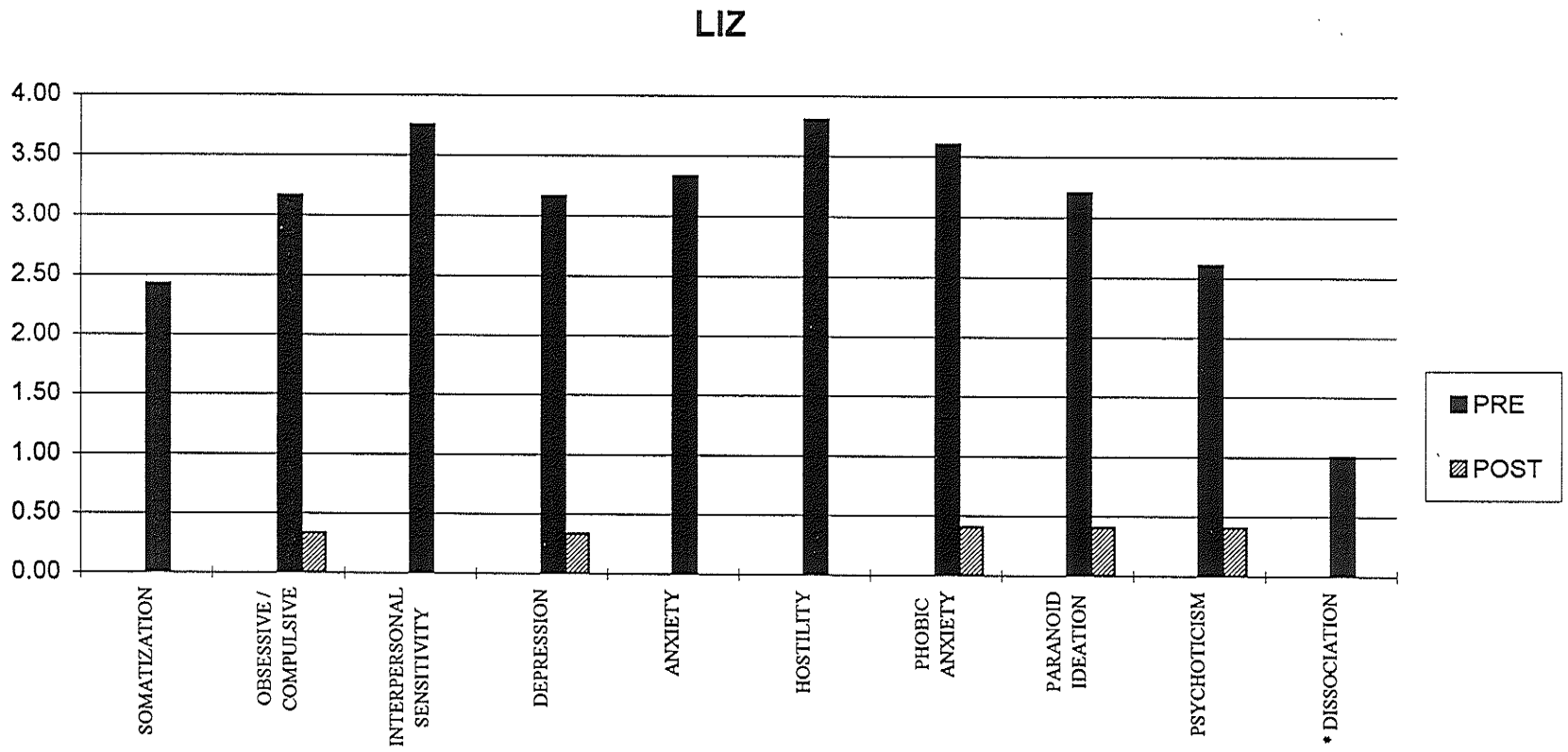
Liz cancelled the next few sessions. I was not sure if her cancellations were due to the content of the last session, or if they were explained by other events in Liz's life. When she returned, she explained that things were very hectic in her life at that time. For example, she had been working at another restaurant during the day and she was not sure if she liked the new job. She was considering giving it up, since the wages were low and her tips were not very good.

Liz and I spent the next two sessions debriefing the events of the previous week. She quit the job at the restaurant and signed up for a course at the Women's Employment Counselling Centre. Liz explained that she was interested in finding a job related to selling arts and crafts, since she was good with people, and also because she had talents in craft work.

Liz and I completed the post-test assessment and terminated counselling on March 21, 1994. She mentioned to me that she planned to continue her Alcoholics Anonymous and Emotions Anonymous meetings although she did not expect to follow through with the residential program at Christy House.

In the last session, Liz reported that she had ended the relationship between herself and Ken because they were drifting apart. She maintained that this was a good decision and she felt good about the fact that she was not falling apart without him. Liz and I terminated counselling as we planned, on March 31, 1994.

Figure 3. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores (Figure 3)

When Liz began therapy, she was severely distressed. For example, her general severity index score was at least two standard deviation units higher than the normative inpatient data. Some of the most severe scores revealed symptoms of obsessive/compulsive tendencies; depression; paranoid ideation; phobic anxiety; interpersonal sensitivity and hostility (see figure 3). All of these symptoms are consistent with long-term effects of abuse, which was part of Liz's history.

Perhaps some of the severe indications of Liz's hostility were connected to her involvement with prostitution. Some of her experiences with men in this context were terrifying and humiliating.

Symptoms of depression and anxiety were consistent with her background of abuse. Liz's former boyfriend beat her so viciously that she sustained broken bones and other wounds that required stitches to close. She stated that in an effort to maintain power in her current relationship, she sometimes behaved irrationally, aggressively and with open hostility. This was

a pattern Liz wanted to change, but at the same time, she thought that her demonstrations of hostile aggression protected her from further abuse.

Liz also explained that ever since she was a child, she felt the need to "over achieve" or prove her worth to her father. Perhaps this helps to explain indications of obsessive compulsive tendencies: she was being screened for involvement in a group for chemically addicted women, she was presently attending regular meetings of both Emotions Anonymous and Alcoholics Anonymous, and she added that in addition to this, she wanted to begin looking for work.

Perhaps some of Liz's depression could be explained by the abuse she experienced, but I also believe that it was linked to the high expectations she had for herself, and which she believed others had for her as well. At the time of pretesting, she identified with a negative image of herself, and say herself as destined toward failure. She expressed her fear of becoming a "bag lady " if she did not start making positive changes.

Liz's experiences with phobic anxiety and paranoid ideation, and low self esteem were evidenced by her belief that wherever she went strangers were staring at her with criticism and judgement. Sometimes she felt that strangers

on a transit bus were thinking negative thoughts about her based on her physical appearance.

Post-test scores were extreme in the opposite direction of pretest scores. Four of the nine symptoms scored a "0", and the remaining five symptoms registered at ".40" or less. Improvement in Liz's situation and outlook was self reported and consistent with improved scores and my weekly observations. However, I do not think these post-test scores provide an accurate account of Liz's symptomatology. BSI scores taken from a normal sample (Derogatis, 1982) rarely registered below ".40" on any of the symptom categories. I think it is possible that Liz responded to items on the questionnaire with exaggerated answers, to gain my approval, "prove" her worth and justify the time and energy used in treatment.

Reflection of the Client's Evaluation

Liz offered a verbal evaluation of the usefulness of therapy. She explained that when she began counselling, she felt guilt and shame in relation to her feelings of love and forgiveness toward the brother who sexually abused her. She believed that friends, relatives and therapists expected her to feel

hatred and rage toward her brother, and guessed that she was in denial of her "real" feelings.

Liz explained that the letter writing exercise was particularly useful in helping her gain more insight and acceptance of feelings she expressed. She added that the letters also helped bring closure to the issue of sexual abuse and the death of her brother. Liz claimed that she planned to write additional letters to her deceased brother and father.

A Reflection of the Therapist's Learning

I was reminded during this intervention that it is vitally important to assess the client's readiness to participate in "memory-based" and "insight-oriented" work. In this situation, it was clear to me that a missing factor in Liz's life was self care. In light of her involvement in so many treatment programs, it did not make sense to overlook self care in this intervention. For this reason, Liz and I approached therapy at a very gentle pace. For the first few sessions Liz detailed pleasant memories and positive feelings, in addition to more information about herself and her family. I believe this process helped Liz to feel more stable emotionally. My client established feelings of safety

and trust which may have facilitated her readiness to describe other details which were more painful and distressing for her.

Case Example 4 - Client D - "Roy"

Roy, age 28, was referred to the Family Centre of Winnipeg for individual counselling by his probation officer. He contacted the intake department on March 3, 1993 requesting counselling for issues related to molestation experiences he had as a child. These events involved a stranger and his older brother.

Roy explained to the intake worker that he has not received counselling for sexual abuse before, and his doctor recommended that he should.

Description of the Problem

Roy explained that he felt very depressed and unhappy recently. He described himself as having distressing thoughts about his childhood abuse, and sometimes felt rage towards his brother for having abused him. He did not feel supported by various professionals to whom he disclosed his experiences of sexual abuse, and this reinforced his belief that he must have either deserved it or caused it.

Roy complained that everything going on in his life at the time was negative and difficult. He hated being unemployed and dependent on his mother and the social assistance program. He described himself as an alcoholic and drug addict, even though he had refrained from the use of either substances for several months. He complained of low self-esteem that prevented him from moving past his problems and developing meaningful relationships with others.

Roy complained of depression, loss of appetite, sleep disturbance and a lack of social support. He reported feelings of hopelessness, powerlessness and overwhelming rage.

Client Biography

Roy was adopted by his parents when he was an infant, as was his older brother Kevin. Roy and Kevin had different biological parents, and although they were adopted, they kept the last name of their biological parents.

Roy claimed that his childhood was not very happy, since he and Kevin did not get along. Kevin was 10 years older than Roy, and used to taunt him and beat

him up daily. Roy used to leave the house, even if he didn't have a reason or a place to go, so that he could escape his brother and avoid his abuse.

Roy stated that his father seemed to favour Kevin, even though Kevin always got into trouble in school and at home. His mother, however seemed to pay more attention to Roy.

Roy claimed that when he was seven years old, his brother started sexually abusing him by fondling his genitals while they were in bed and by digitally penetrating his anus. His brother threatened him not to tell anyone or else he would kill him. He told a male cousin about the abuse when he was a teenager, but he did not tell his parents.

Roy also reported that when he was 12 years old he experienced other incidents of sexual abuse. He used to have a paper route, and the man who supervised his route used to take him to an abandoned building and give him drugs and alcohol. When he was under the influence of these substances, he would tell Roy to have sex with his friends, all of whom were strangers to Roy.

When he reached his teens, Roy was drinking heavily and regularly, and he dropped out of school in Grade 9. His brother left home when Roy was 16 years old, and Roy continued to live with his parents.

In his early twenties, Roy was convicted of a simple assault charge as well as for fraud. He was not sentenced to jail, however, he was given a few years of probation. The assault charge was filed against him by his brother and sister-in-law. He claimed that they got into an argument while drinking one night, and Roy attacked his sister-in-law, pinning her up against a wall with a broom handle. Roy mentioned that there was a restraining order filed against him by his brother and sister-in-law at this time.

Roy also reported that he has seen five psychiatrists over the past 1 1/2 years. He claimed that he was admitted to a psychiatric ward at two acute care hospitals on seven different occasions in the past few years. His last stay at one of these facilities, in 1991, lasted for three months. All hospitalizations were self-initiated, for reasons related to depression and suicidality.

Roy also stayed in residence for seven days at the Addictions Foundation of Manitoba. He reported that he has abstained from the use of alcohol since that

time (approximately seventeen months). He used to attend Alcoholics Anonymous meetings until a bad rapport developed between him and some of the members. He discontinued the meetings because he no longer trusted the program.

While coming to Family Centre, Roy was in the Municipal Income Assistance Program and lived with his mother. He had been unemployed since his driver's licence was suspended at least seventeen months prior because he was caught driving while impaired. Roy's father had passed away from natural causes three years earlier.

Presenting Concerns

When Roy arrived for the first interview, I was immediately aware of his large stature, and his rough appearance. His hair was long and hanging over the rim of his eyeglasses, and he wore a fairly long beard and moustache. Consequently, not much of his face was revealed. While in the therapy room, Roy appeared to be nervous about our meeting, but leaned forward as though he was prepared to listen intently.

When I asked Roy what brought him in for counselling, he mentioned that he was referred to the Family Centre by his probation officer. Roy explained that it was not part of his probation order to have counselling, but his officer suggested to him that he try it out since Roy was having problems with anger and depression.

When Roy described the details of his conviction for assault and the anger he held inside, I cautioned him that the use of violence at Family Centre would not be tolerated should he become angry during our sessions. Roy seemed surprised by my concern for safety, and apologized profusely for having said anything that frightened me. I attempted to explain to Roy that he did not owe me an apology, and that I did not feel afraid at the moment, but he continued to say "sorry" throughout the session at inappropriate times.

The psychiatrist he was seeing at this time was meeting with Roy once each week for one hour sessions. Roy claimed that he had trouble getting along with psychiatrists, and this was why he had not maintained the same doctor. He mentioned that he had a nasty argument with his current doctor in their last meeting, but he did not want to explain the nature of the argument.

Roy said he did not think that professionals took him seriously when he disclosed sexual abuse. He attempted to tell the police, but they did not investigate. He told his probation officer, and although the probation officer recommended that Roy go for counselling, Roy did not think he was concerned. He also stated that his sessions with the psychiatrist had not focused on sexual abuse, even though he disclosed to him. He added that the psychiatrist knew of and supported Roy's decision to attend therapy at Family Centre.

Throughout the session Roy frequently lost track of his thoughts and asked me to repeat my questions several times. I commented to Roy that he seemed to be distracted by something, and he explained that he was on medication that made him a little "dozy," and once again he apologized several times for being dozy and distracted.

Roy explained that he used prescribed sleeping pills, antidepressant and another drug to alleviate anxiety. He believed that these drugs produced a drowsy or dazed effect on him. I validated his concern, and asked if he could deal with his problems with less medication. He assured me that the dozy symptoms were minor compared to the problems he encountered without medication.

Description of the Client/Therapist Contract

Roy explained that his goals for therapy were to find "peace and serenity." He did not explain very clearly what this meant to him, but he offered a sketchy description of having more peace of mind and less anger inside. I explained to Roy that I was not sure that we would accomplish those goals in therapy, since it often takes people a long time to establish peace of mind when they feel disturbed and angry. I added that it might take time before he felt safe and trustful enough with me to explore his concerns fully. I explained that working through issues of sexual abuse has taken some people a very long time, and since I had only six months to work with, he may want to consider waiting for the next available staff member.

Roy expressed very clearly that he did not want to wait for another counsellor because he felt very safe and comfortable with me already. I suggested to Roy that we keep our goals very simple and manageable for the time being, so that we did not create more confusion and disappointment for him.

I Roy could not come up with an alternative goal other than to find peace and serenity, so I suggested that we focus therapy around:

2 establishing trust between Roy and me, and giving Roy an opportunity to tell his story to someone who would believe him and validate his feelings.

Roy agreed to focus on the goals I suggested. He also recognized that this process may in fact offer him some peace of mind, since my believing him and validating his feelings would be an indication to him that I was taking his story seriously.

Roy and I agreed to meet once each week from November 16, 1993 to March 31, 1994. Sessions were scheduled to be one hour long.

Description of the Intervention

When Roy began therapy, I noticed that often he arrived 15 to 30 minutes early. He explained that his arrival time depended on the transit.

Roy stared at the floor most of the time, but every now and then he looked directly at me. On occasion, he apologized for not establishing eye contact and offered me assurance that he was being truthful. I asked him if someone accused

him in the past for not being truthful when he is not looking at the person to whom he is speaking. He reported that his mother usually thought he was lying. I validated Roy's hurt feelings and frustration, and commented that it did not occur to me that he might not be telling me the truth.

Roy spent much of the first few session, reporting to me the events of the previous week. He talked about his mom, describing how worried he was about her health and how fortunate he was to have her. He also talked about problems between himself and his next door neighbour. Roy also described the problems he had getting to sleep at night and getting up the next day.

My responses to Roy's description of daily events involved validation, positive reframing and problem solving strategies. Roy grew to feel more comfortable in my presence, and seemed to enjoy instances when casual humour slipped into the conversation.

During the 4th session Roy reported feeling very sad and depressed. He also stated that these symptoms were getting "worse" each week, but he could not identify what signs told him that symptoms were getting worse. He assured me

that he was not suicidal, but he repeated several times that he felt all alone. Other feelings he described were, fear, anxiety, guilt, shame and inferiority.

I responded to Roy's expression of sadness with concern and empathy. I assured him that I believed he had reasons for these feelings, and added that when I feel really sad and depressed, I usually feel lonely too. Roy explained that he does not have any friends and believed that he was not worthy or capable of having friends. Roy offered various stories of being betrayed and used by people he thought were friends when he was drinking heavily. He added that he had similar experiences with members of Alcoholics Anonymous.

The more detail Roy provided concerning his sadness and despair, the more emotional he became. He took long pauses between words, bit his lip and shed a few tears. Throughout this presentation I was struck by the small little boy sitting before me. I shared my observation with Roy, and he said that he felt like a little boy stuck inside a man's body.

When I asked Roy what was going on the last time he felt like a sad little boy, he described the circumstances before and shortly after his dad died. I suggested that perhaps he was more aware of feeling like a small boy at that time

because he was afraid that he might have to take dad's place looking after mom. This would be a big undertaking for anyone.

Roy responded to this comment with anger. He voiced strong resentment against Kevin for being Dad's favourite even though he was such a "trouble maker." He was angry at Kevin for borrowing money from his mom without paying her back. When I validated Roy's frustration with his brother and his concern for his mother, he shed a few more tears and expressed concern that he was just like Kevin.

In the 6th session I inquired for more detail as to why Roy thought he was just like Kevin. He had various reasons:

1 he also had an outstanding financial debt owed to his mother
2 he caused his parents grief when he was drinking
3 he got into trouble with the law, and
4 he was unemployed and irresponsible.

I validated the feelings of remorse and embarrassment Roy demonstrated, then asked him to tell me about the various ways in which he was different from Kevin.

Roy explained that he was different from Kevin since he stopped drinking, began helping mom more around the house, and became more sensitive to others. I congratulated Roy for having the strength and determination to become so different, since this probably helped him to feel better about himself. Roy nodded.

I asked Roy if anyone else noticed the changes he made. He explained that his mom gave him some praise, however he wished that she would do this more. Roy claimed that his mother was getting very old and she often complained about him more than she praised him. I reassured Roy that many people experience the same problem as he was describing, and I hoped that he would not think that he was not useful or important to his mom.

In the next few sessions, Roy continued to describe situations at home that troubled him. These were problems with the neighbour, problems with house repairs, and frustrations with his mother. I continued to notice and guess Roy's feelings when he frowned or punched his fist against his hand. This appeared to help Roy become more aware of his feelings and improve his ability to identify them for himself.

For our first session in January, Roy arrived 1 1/4 hours early. When we were seated in the therapy room, he described incredible anger toward his neighbour. He explained that the relationship between them had become worse. Roy described himself as obsessed with keeping an eye on him.

Earlier that week, Roy's neighbour made a threatening gesture at him when while looking at him through a window. Roy wanted to retaliate by beating him. He discussed the problem with his probation officer, who told him to ignore his neighbour. He also talked to his psychiatrist about the problem and his doctor told him that he should not have any physical contact with his neighbour unless his neighbour invaded his home. I asked Roy if he knew what caused all of the tension and hatred between them.

Roy explained that he and his neighbour used to be good friends and they used to drink beer together frequently. Roy added that an argument erupted between them regarding money the neighbour owed Roy, and it got steadily worse. Roy claimed that his neighbour recently accused him of sexually abusing his nine year old daughter. At this point Roy became enraged. His face changed colour, then he became very sullen.

I commented that I would be very frightened by a serious charge like that. Roy sat motionless and did not respond. I asked him why his neighbour would make an accusation like this. Roy responded in anger, and stated that this was just a trick his neighbour used to get him mad.

Roy adamantly denied that he molested or hurt the girl next door, and insisted that he could never do such a thing. I asked Roy if he was afraid of other people finding out about this accusation and he explained that other neighbours seem to know about it because they are not friendly to him anymore. Some neighbours used to ask him to baby-sit their kids in the past, but no one had asked him since. He explained that his mother did not know about this and no formal charges or investigation ever took place.

Roy explained that this was another situation where he felt like a little boy stuck in a man's body. He said he felt afraid, lonely, and very sad. In this situation Roy claimed to feel powerless and defenceless, and this triggered his anger once again.

I asked Roy to try and remember any other time when he felt helpless, afraid and sad. At this time he described the times when Kevin would come into

his bed, fondle his genitals and penetrate his anus with his finger. Roy spoke very softly when he described these events, and I listened and praised him for telling his story so clearly even when it was difficult. I suggested to Roy that I thought I would have been very confused if I did not know what sex was and my brother did those things to me. I added that most seven year olds think that those parts of the body are for going to the bathroom . . . and nothing else. Roy agreed that during the abuse he was also confused and scared. He said he wanted to cry out but his brother told him to "shut-up," or he would "kill him."

I asked Roy to consider what would have happened if he had cried out, and told his mother and father what was going on. Roy stated that he thought his mother would have believed him but his father would not. I suggested to Roy that he write a letter to his mom telling her what happened to him when he was a child. I strongly advised against showing this letter to his mother until he was sure he was ready.

In the next session (15th) Roy explained that he did not want to write the letter to his mom because he believed it would destroy her. I reminded Roy that he did not have to show his mom the letter, but he still claimed that he could not bring himself to write the letter. I asked Roy if he feared his mother's reaction so

strongly that he did not even want to imagine it, and he repeated his concern that this news would destroy her. I validated his concern that the loss of his mother at this time would be incredibly painful, and I believed that she was very important to his survival.

Roy described what it was like to lose his dad. He became very sullen, and did not say very much. I commented to Roy that he looked very sad, and I thought this might be because he missed his dad right then. Roy started to cry again, and shared another story.

When Roy's father was dying in the hospital, Roy used to visit him every day. Shortly before his death, his father instructed Roy to change his surname from his birth name to his father's last name (Roy used his birth name even after adoption). Roy discussed with me what purpose his father had in making this request:

1 Roy was worthy of his father's family name;

2 His father accepted Roy as his son;

3 Roy's father loved him.

Before Roy left, I told him that he must be very special to have earned so much acceptance from his dad before he passed away. Roy told me that he did not feel very special and could not see himself as special. I commented that it might take more time before he felt better about himself, but asked him to consider for now, the idea that other people, including myself, thought he was special.

When Roy returned, he talked about feeling like a little boy again. I asked Roy what was the one thing he wished he could do for the little boy inside of him. Roy paused for a while and seemed to grow uncomfortable as he shifted in his chair. He looked at me and then quickly looked away again, as if he was embarrassed. I shared my observations and asked him to comment. Roy told me that there was something he would like to ask me but he felt too shy.

At this time I used some solution focused questions to help Roy focus on his goals. I asked the question "If a miracle took place while you were sleeping tonight, and you did not know the miracle was taking place, but when you woke up your problems were solved; what would be the first thing you would notice was different?" Roy did not appear to understand my question, and I had to repeat it three times, each time making it more simple, before he gave me an answer. He

said the first thing he would notice was that he would feel good about himself, and he would be happy.

More questions from the solution focused model evolved from Roy's answer to the "miracle question." For example, when I asked him what he would be doing differently if he felt better about himself, he explained that he would have a driver's licence, a truck, a job, and more financial freedom.

Roy did not seem to like my new style of questioning. Each time I asked a question framed from a hypothetical position, he needed the question repeated several times before understanding me, and then rebuked himself for being slow and stupid.

For this reason, I decided not to use the solution focused model with Roy. I continued, however, with the theme we had developed with it. I asked him what he would do with more money if he had it. He stated that he would get married and have children.

In the following sessions, I helped Roy explore his thoughts about women, relationships and sexuality. Roy shared with me how he first learned about sex,

what he feared about dating, the problems he had feeling confident, and some bad experiences he had with women in the past. Throughout this process, Roy got in touch with some confusing thoughts and feelings he had regarding affection. For example, he expressed that he wished he could have been given more affection from his mother.

During this discussion, Roy reminded me of an earlier session when I asked him if there was something he wished he could do for the little boy inside. He told me that what he wanted was a hug from me. I explained to Roy that if he truly was a little boy, I would not hesitate to give him a big hug, but since he was an adult man, I was not sure how his adult self would receive and interpret the hug. I explained that I needed to be very careful about these matters since I did not always think it was best for female therapists to give hugs to male clients.

Roy insisted that he could not ask his mom for a hug, so I suggested that we do some role playing in the next session, to help Roy find a good way to ask his mom for a hug.

When Roy returned, I noticed immediately the dramatic change he made to his physical appearance. He shaved off all of his facial hair and cut his hair in

a very short and trendy style. All of Roy's face was visible, which was completely opposite to his former look. He wore a large smile on his face and seemed to enjoy my reaction (which was to walk by without recognizing him).

Roy explained that he did not want to role play. I told him that I thought it was okay if we did not do this, because I understood that it is sometimes awkward acting out a discussion and possibly troubling if we uncover hidden fears and anxieties about people we love. I suggested that if Roy became interested and less anxious about doing role plays, we could attempt one. I explained that this exercise might assist Roy in expressing his needs clearly and effectively to his mother, and he may even receive a long overdue hug.

Roy asked me at this time if we could continue being friends after therapy ended. He said that he was feeling much better about himself, and he thought this might be because winter was drawing to an end. He added that he would like to take me out on a date or at least for a cup of coffee.

I explained to Roy that I was very pleased that he was feeling better about himself. I added that I could see why he had more confidence, he had a very handsome face. As gently as I could, I explained to Roy that I did not feel

his interest, and offered my understanding of how attractions sometimes develop during therapy.

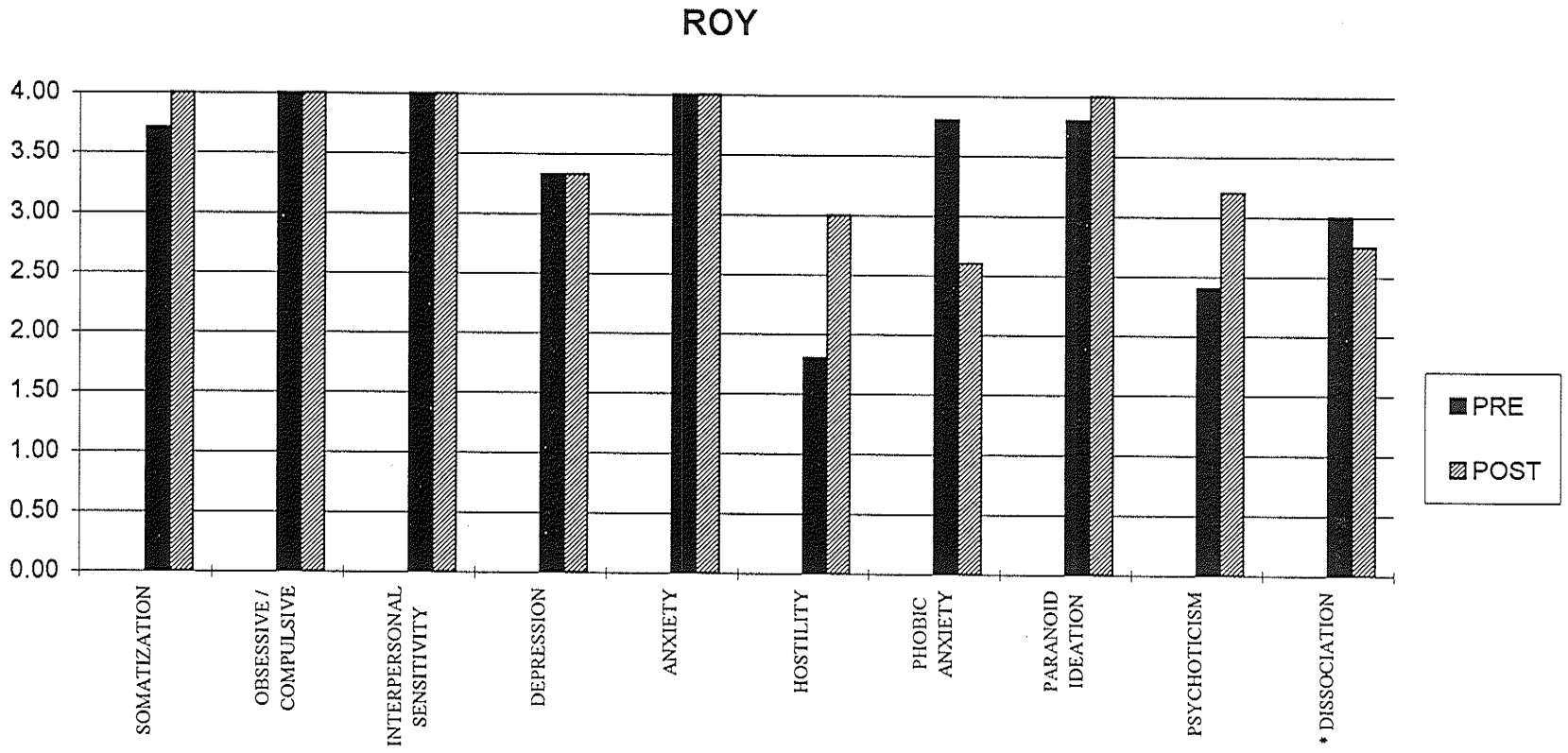
The remaining sessions were used to discuss:

1 Roy's ongoing concern with his neighbour;
2 problems developing between Roy and his psychiatrist;
3 problems developing with a house insurance claim;
4 health concerns for Roy's mother; and
5 whether or not Roy needed to continue in therapy.

Roy did not seem to be too disappointed that I would not have a personal relationship with him after therapy. He agreed to a transfer to a male therapist, which I framed as holding an opportunity to establish a different way of working and trusting someone.

Roy completed the post-testing in our last session together. On this day he brought me a basket of silk flowers and a thank you card. He returned to Family Centre three weeks later for one session with his new male therapist. He did not return after that.

Figure 4. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores (Figure 4)

Before and after therapy, Roy was overall, extremely distressed. His general severity index scores from pre and post-testing were at least two standard deviation units higher than normative inpatient data. He experienced the maximum, or at least, near maximum difficulty in all of symptom constructs. Three of the nine symptoms measured, scored a "4.00": obsessive/compulsive tendencies; interpersonal sensitivity; and anxiety. The symptom of interpersonal sensitivity was clearly evident when Roy claimed that he did not have one friend in the entire world. He shared his belief that he was neither worthy, nor capable of friendships, and used experiences of betrayal and criticism from members of his peer support group (Alcoholics Anonymous) as his most recent experience that seemed to be proof of this.

Feeling friendless and lonely fed into feelings of depression for Roy, and on a couple of occasions I needed to contract with him against suicide. Roy's depression score could be traced throughout his feelings of despair that he might not get his life going in the direction he wanted. He wanted to have a wife, family, friends, stable employment and financial security.

In therapy, Roy expressed a desire and a need for more affection from his mother, but his lack of confidence and low self esteem seemed to prevent him from asking for it directly. He seemed to feel confident that his mother loved him on some days, but at other times he could not get past the idea that his brother was "the favourite son."

Roy's symptoms of somatization, phobic anxiety and paranoid ideation were likely indications of Roy's perception of himself as having a mental illness. This idea was consistent with seven self initiated hospitalizations into a psychiatric ward.

Roy attempted disclosure of childhood sexual abuse to the police and to his psychiatrist, but on both occasions he felt he was disbelieved or unsupported. It is possible that Roy may have exaggerated his symptoms during testing because he believed that signs of severe mental and emotional disturbances were necessary in order to be taken seriously.

Post-test scores remained unchanged for four out of the nine symptoms: obsessive/compulsive tendencies; interpersonal sensitivity; depression; and anxiety. There was an increase in three of the remaining five scores: somatization; hostility

and paranoid ideation. I believe the increased scores, especially in relation to hostility, were consistent with the escalation of tension and threats exchanged between Roy and his neighbour shortly before we terminated therapy. An increase in hostility could also be explained by Roy's feeling that he was not ready to terminate therapy and compounded by the uncertainties involved with his transfer to a new therapist.

Roy's Post-Test score measuring self esteem showed improvement and was certainly consistent with the dramatic change he made to his appearance. For example, he kept his posture more upright, and maintained eye contact more often, after he shaved off his beard and moustache and cut his hair. These changes seemed to be indications of renewed confidence and improved self esteem.

A Reflection of the Client's Evaluation

Roy provided me with several pages of writing that he used to express his evaluation of therapy. Here is a short excerpt:

> *As we got started, I told her how I felt scared, angry, guilty, ashamed, full of rage and had suicidal thoughts. I was avoiding my purpose, by talking about something else (beside the abuse) because I was very scared and angry and I felt dirty inside . . . Once I had full trust with her, I found I could discuss these issues*

> *. . . if I started to talk about something else, she gently brought me back to deal with the problems I was trying to deal with . . . I hesitated to discuss (the abuse), but Darlene said "Roy, I believe you." And I said "Thank God, somebody believes me, this is a miracle . . . " At the beginning of our sessions I would be angry . . . by the end of the session I would leave confident and happy because Darlene said the abuse and rapes were not my fault . . .*

At the end of Roy's written evaluation he drew a before and after picture of himself. The before picture depicted an oddly shaped head with a sad mouth. The after picture showed a round head with a large smile.

A Reflection of the Therapist's Learning

One of the most profound lessons I learned from this case was that sometimes counsellors need to work very slowly with clients and keep goals manageable. Roy was a very complicated man, and perhaps it would have been unfair to both of us if I had attempted to address all of the issues and concerns that he carried with him. For example, Roy was used to treatment modalities reflecting the medical model of the psychiatric community, and he strongly believed that "he" was the problem. Psychological testing likely proved this to him. Although Roy seemed to accept the idea that systemic factors contributed to or

influenced the problems he had, he also seemed fixed in his belief that the root of his problems originated with himself, and some form of defect in his person. I knew, for example, that I could not successfully change or challenge all of the ways he blamed and rebuked himself for his sexual victimization, but I could let him know that I believed that he was abused and that he did nothing to deserve it.

Another important part of learning involved recognition of various techniques and language that were not useful for my client. The use of some models, and the trendy jargon associated with them, can certainly reinforce a client's belief that he or she is stupid and may help maintain low levels in the client's self esteem. For example, when I tried to use solution focused questions with Roy, they seemed to be so foreign to him that he required me to repeat them several times before he attempted an answer. I believe that this process was difficult for Roy, and if I had continued to use the "hypothetical" line of questioning, I think I would have reinforced if not added to the preexisting belief Roy held, that he was unintelligent and slow.

Case Example 5 - Client E - "Janice"

A public health nurse referred Janice, age 36, to my Practicum advisor, for individual counselling on issues related to Janice's childhood experiences of sexual abuse. The advisor recommended to the nurse that I contact Janice, since I was screening for clients who were survivors of childhood sexual abuse.

Janice was cautious in her selection of therapists because she had experienced rejection from a counsellor in the past when she disclosed to the counsellor that she was lesbian. She needed assurance from me in the beginning that her sexual orientation would not jeopardize or affect her experience in therapy.

Description of the Problem

Janice believed that she was born with a lesbian orientation. She claimed that throughout her school age years, she felt attractions for girls, and saw boys as buddies. Janice told her family that she was gay in her mid twenties; her mother scorned her; her father badgered her, but her siblings, Rose and Steven were understanding and accepting of her. Janice's grandmother was also

accepting of Janice's sexual orientation, whereas her other brother, Chris and sister, Laurie were somewhat indifferent.

Janice reported that her relationships with family members improved over the years. She explained that her parents were very accepting of her lesbian lifestyle at the present, and expressed interest and support of her relationships with women. Janice believed that her parents' change of heart developed as Janice matured, and as they grew used to the idea.

Janice reported spending time with prostitutes and madams. She stated that some madams kept Janice under their wing, and provided her with expensive clothing and exposure to symphonic music and ballet. Janice explained that she did not provide prostitution services for clients, but she had several sexual encounters with madams.

Janice explained that she had several years of individual therapy with the psychiatric nurse she met years ago in the psychiatric ward. She expressed strong feelings of trust and support in her therapeutic alliance with this person, and reported that she lived with her and the nurse's partner for a while. Janice claimed that this nurse treated Janice like her own daughter.

Janice held numerous jobs in her life, most of which fell in the category of "traditional male jobs." For example, she worked as a security guard and a private detective; she also worked in electronics and mechanics. Currently Janice works as a mechanic.

Janice has held several serious relationships with women, however she expressed feeling used and taken for granted by most of the partners she had. Some of her relationships involved violent partners, and Janice claimed that she suffered low self esteem as a result of abuse.

Janice explained that she recently ended a common-law relationship with a woman named Lisa. Janice explained that Lisa was the first woman she allowed to make love "to" her, and she felt strong feelings toward her. Janice was very hurt when she discovered that Lisa lied to her on numerous occasions, and when she discovered that Lisa was sleeping with a mutual friend of theirs. Lisa often kept Janice dangling on a promise of renewed commitment, but would not see the promise through. Janice reported feeling manipulated and taken for granted before she ended this relationship.

Janice's most recent roommate was a gay male named Rick. Rick and Janice have been very good friends for several years, and Janice enjoyed living

with him. This relationship also allowed both Janice and Rick to keep a facade of being heterosexual with co-workers and family members who did not know their sexual orientation. Rick left Winnipeg to pursue a career outside of Manitoba one week after Janice began therapy. She felt a great loss when he left.

Client Biography

Janice was raised in a family which consisted of her father, mother and five children; Janice was the second eldest child. Her mother had a history of mental illness which Janice believed to be schizophrenia. Her mother struggled regularly with mood swings and violent rage. Some of her mother's medical treatment involved shock therapy which resulted in partial memory loss. She was treated with numerous forms of prescription drugs as well.

Janice's father worked as an auto mechanic, and helped out in the home as much as possible. Janice stated that he was frequently overwhelmed by her mother's illness and sometimes used violence against his wife and his children.

Janice's older brother had some form of developmental delay or disorder. Janice explained that she did not know what his problem was specifically, but

everyone knew that he was slow to understand concepts, and seemed to be limited in his ability to function independently. Janice believed that his problem stemmed from a genetic disorder, as some of her brother's behaviour was passed on to his own biological family.

Janice also had two younger sisters and one younger brother. All of these siblings were married and had children of their own. Janice also explained that she was particularly close to her youngest siblings, (her brother Steven and her sister Rose). She believed that one of the reasons why she was so close to them was because she bore so much responsibility for them while they were growing up. She often took harsh treatment from their mother for trouble they started.

Throughout her childhood, Janice endured several forms of abuse. Most of the abuse came from her mother, and involved severe beatings, an attempted bathtub drowning, and malicious emotional torment. For example Janice was disallowed from attending summer camp minutes before departure for no apparent reason. Janice was crushed by disappointment. She was sent to her room when she cried. Janice described being forced to stay in her room for three days, being allowed to come out only to use the washroom.

When Janice reached her teens, she attempted suicide by overdosing on drugs she stole from her mother. After she swallowed several pills (she did not remember how many, but believed it was a lethal dosage) she phoned a psychiatric nurse, whom Janice had befriended previously while she was a patient in a children's psychiatric ward. An ambulance was rushed to Janice's house. She was taken to the Health Sciences Centre where her stomach was pumped, and she was admitted again.

During these episodes, Janice was apprehended by the Child and Family Services and she resided in several foster homes after that. Janice reported several forms of cruel abuse suffered at the hands of some of her foster parents, and for these reasons, she frequently ran away.

Janice explained that her paternal grandmother was a strong support to her. She explained that she was sent to live with her grandmother on a farm, and this was one of the best things that happened to her. Her grandma was gentle and loving toward Janice, and when Janice disclosed to her that her uncle and cousins sexually molested her, her grandma protected her.

Presenting Concerns

When Janice arrived at Family Centre for the assessment interview, she brought her friend, the public health nurse, with her. At this time, I proceeded to fill out the agency's intake form, since this referral had not followed the standard intake procedure. The health nurse explained to me that since Janice had a bad experience with a counsellor rejecting her in the past, she needed to know that I could accept her sexual orientation before she would proceed in the interview. At this time, I assured both Janice and her friend that I did not have any problems with Janice being gay, and I would certainly not refuse her service for this reason. After validating Janice's concern with this issue, I asked her directly if she had any other questions or concerns about this agency or myself before we continued. Janice had no other concerns at that time.

I asked Janice what influenced her decision to come for counselling. She stated that recently a friend loaned her the book "The Courage to Heal," and suggested to Janice that she seek counselling. Janice explained that her friend was sexually abused as a child, and knowing that Janice was also abused in this way, she hoped that Janice would gain insight into various problems she had in relationships.

When I asked Janice what she thought about counselling, she explained that she had been in therapy several times in the past. She described some of the crises she endured as a child and mentioned again that when she was in her teens, she was admitted into the psychiatric ward at the Children's Hospital of the Health Sciences Centre.

Janice did not appear to have any difficulty describing numerous painful and frightening events of her life. Even though she stated that she found it somewhat difficult to trust people, she offered information with very little prompting. I described my observations that Janice seemed reasonably calm during this interview, and complimented her for speaking with confidence. She stated that she learned to judge when it is safe for her to speak openly, especially since she developed trust with her last therapist (who had since relocated to the United States).

During the interview, Janice described a work related injury she sustained in the past year. This injury severed nerves and caused some muscle damage in part of her body. She had surgery to correct the damage but was not yet able to return to work. Janice was collecting disability benefits from Worker's Compensation, and received ongoing treatment to manage pain and discomfort.

My concern regarding this matter was more financial than anything. I understood that Janice was receiving disability payments from Worker's compensation, and I was concerned about her ability to pay the agency's weekly counselling fee. I resolved in my mind however, to follow the lead of my client and invited her to inform me if or when her fee became a matter of concern.

In this interview I was also curious about the role the nurse would play in therapy, if she played any role at all. I congratulated Janice for bringing a support person with her to this agency, since it is often difficult to meet a therapist for the first time. Both Janice and her friend nodded in agreement. I asked the nurse if she had questions or concerns regarding anything discussed thus far.

The nurse voiced concern over the fact that a fee would apply to Janice, based on the Centre's sliding fee schedule. She explained that she did not think Janice should have to pay for service since she was assigned to a student. I explained that the agency always used the fee schedule when clients were seen by students, since the service provided was both supervised and professional. Janice interjected that she did not anticipate difficulty with the fee.

In closing of the first interview, I summarized for Janice and her friend what I understood as being the reasons why Janice wanted counselling:

1 Janice recently ended a relationship with a woman she loved. She thought that some of her difficulties in relationships may stem from her experiences with sexual abuse. She added that she has never explored sexual abuse issues in therapy before;

2 Janice had a distressing dream recently, that she was drowning and struggling. She thought that this dream might represent a repressed memory of child abuse from her mother since her sister claimed that when Janice was a child, their mother tried to drown her in the bathtub;

3 Janice does not feel any compassion for her "inner child," and she felt that this was wrong.

Before they left, the nurse told me that she would keep in touch with Janice to see how therapy was progressing. I nodded in response, and directed a comment to Janice, that I was comfortable with her sharing her thoughts and concerns about counselling with her friend, and added that she was fortunate to have her support.

Description of the Client/Therapist Contract

In the second interview I summarized once again the three areas Janice wanted to explore in counselling. I added some information to each concern, explaining:

1 that many survivors of sexual abuse struggle with relationships and with their ability to trust others;

2 the human mind does have the ability to block out memories of traumatic events, which may resurface in dreams. The dream she described could be a sign, that her mind is getting ready to confront the memory of abuse from her mother; and

3 many survivors progress in their ability to heal or resolve painful effects of sexual abuse when they are able to accept the small, vulnerable person they once were.

In acceptance of the "inner child," survivors learn to listen and respond to feelings and anxieties experienced within, thereby overcoming some of the fears and emotions that block them from getting on with their lives.

Having validated all three areas, I explained to Janice that in order to address her previous concern regarding difficulties trusting others, we could begin therapy by establishing safety and trust between us. Then, once trust was established, we could move toward one or more of those goals she mentioned. Janice agreed.

We agreed to meet once each week, or possibly every two weeks, depending on Janice's finances and her need. After six sessions, we would review her goals and possibly continue until the end of March.

Description of the Intervention

Janice seemed to be a little more shy and nervous in our second meeting. She avoided eye contact with me and shifted in her seat several times. I shared my observations with her, and she confirmed the fact that she was feeling uncomfortable. She explained that she felt afraid to look at me because she felt that I would see right through her. I asked her what she thought I might see if I could see through her, and she expressed concern that I would see how afraid she is. I validated her concerns.

Janice added that she also felt afraid to let someone get close to her. I responded to this by highlighting my understanding of fear involved with this process. For example, she developed safety and trust in therapists in the past and was either rejected or left behind. I also suggested that in keeping distance from me, she was exerting some control. Considering the fact that people have used both power and control against her in the past, I thought that it was appropriate for her to have control over how close I could get.

Janice seemed to appreciate these words, and she began to reveal more personal information. She explained that she saw a psychiatrist in her teens, to gain some insight as to why she assumes so much control in intimate relationships. The psychiatrist told her that he thought that she was "a man stuck inside a female's body." I asked what meaning this statement held for her, and she expressed some frustration with the comment, but also believed it held some truth.

I questioned Janice about her views of men and women. She described many of the common stereotypes: men as being powerful, hard and controlling; women as fragile, sensitive and emotional. Janice added that she also knew men who could discuss feelings and show emotion, just as she knew women

who were distant and controlling. She did not, however, explain why she felt she was more like a man than a woman.

Janice added that she felt very emotional in the past week. She explained that her Worker's Compensation benefits were terminated, and she had to return to work; secondly, her roommate (best friend) moved out of town and she felt at a loss. I validated Janice's feelings.

At the end of the session, I asked Janice if she had any questions or comments about this session. She responded with the comment that she felt anxious and concerned about how I saw her, she was curious as to what I thought about her. I explained to Janice that I saw her as a very strong woman who has been through several difficulties, who also has fears and weaknesses, just like I.

Janice called and cancelled the next session due to pain and discomfort in her arms.

When she arrived for the next scheduled appointment, she was very pale and in great discomfort. Janice explained that she was feeling pressure at work

because of her injury and the subsequent difficulties she had performing intricate tasks at work, with fine electrical equipment.

She added that she was feeling pain in her arms, all of the time, and because of this, she had trouble concentrating. She also described medical procedures she received at the pain clinic, which were supposed to alleviate pain (nerve blocks) but were very painful, and often affected muscles around her eyes.

I mentioned to Janice that I was very surprised that she came to this appointment, since she was obviously not feeling very well. I added that I hoped that she would feel comfortable cancelling as many sessions as she needed in order to deal with her condition. Janice explained that it did not matter where she was because she was always feeling pain. She did not want to miss two consecutive sessions.

When I inquired what method Janice used to manage her pain when she was at home, she explained that she liked to relax and listen to nature sounds combined with classical music. I complimented her for being so kind and nurturing to herself, rather than rebuking and driving herself to do more than she was able. I invited her to bring her music with her to a session, so that we

might listen to it together, and I might assist Janice to relax. She said she would like to try this idea.

Janice added before leaving that she still did not feel sure of her trust in me. She wished that she could put me through some form of test that would help her discern trustworthiness. I invited Janice to put me through whatever test she could think of that might assist her to trust me. She stated that she would trust me more if I would share some information with her about myself.

At this time, I provided Janice with some personal information such as what led me to choose a career in clinical social work. I told her I was a single mother of three children, and that I have been through many struggles throughout my lifetime. Janice listened intently to my story, and indicated before she left that my willingness to share personal information with her aided her trust in me.

Janice cancelled the following three sessions by calling the agency and leaving a message for me. In the last message, she asked that I return her call.

When I telephoned Janice, she indicated that there were reasons why she missed several appointments. Her voice did not sound comfortable as she

continued to tell me that the main reason for cancelling had to do with "me." Janice did not sound comfortable at all with adding to this explanation, and I began to suspect that she was struggling with a sexual attraction.

I asked Janice if her discomfort with me was related to sexual attraction. Janice sounded relieved that I had guessed this, but then immediately apologized and rebuked herself. She said that she had sexual dreams and waking fantasies involving me, and was worried that I would refuse to see her again. She also explained that she did not feel confident in her ability to continue without confiding in me regarding her attraction. She said she was confused about this since she has never felt an attraction to her therapist before.

I normalized Janice's feelings, and asked her not to feel ashamed. I complimented her for having the courage to discuss this with me, and assured her that I was not angry or surprised, since it is common for clients (especially survivors of sexual abuse) to develop sexual feelings for their therapists. Survivors are sometimes conditioned to confuse intimacy, closeness and nurturance with sexual arousal. I added that in the last session I shared information about myself, which perhaps influenced Janice to see me as a "real

person with feelings," and perhaps this triggered feelings in her that she thought were sexual.

Janice asked me if I would continue seeing her after this disclosure. She added that she did not want to terminate with me, but would much rather find a way to redirect her feelings. I explained to Janice that we could continue in therapy as long as she understood that we would never act out her sexual fantasies. I defined the boundaries of our therapeutic relationship, and explained that we would need to stay within these boundaries at all times. I added that I was willing to work through these issues with her, and that this could be part of the therapy itself.

Janice expressed feelings of relief that I would not give up on her and she stated that she would like to work this through. We set up another appointment for the following week.

When Janice arrived for the fifth session, she appeared to be embarrassed about our last telephone contact. Once again I assured her that feelings like this develop from time to time, and that I felt confident that we could work it out. Janice continued to avoid eye contact.

I complimented Janice again, for having the courage to share her feelings with me, and for demonstrating courage and determination in keeping the appointment. I highlighted the fact that her keeping the appointment in spite of the embarrassment and discomfort she was having, indicated to me that she has developed some trust in our relationship. I stated that I thought this was significant. Janice smiled at this comment, and established eye contact.

Janice explained that she did not feel any need at that time to discuss her feelings of attraction further. I agreed that we could lay the issue aside for the time, but suggested that should she begin to struggle with these feelings again, I would rather discuss them than cancel appointments. Janice assured me that she would raise the issue when, and if, it became necessary, and would not cancel sessions for this reason anymore.

Janice began telling me about her memories of being a little girl. Many of these memories were difficult for her, but she described them with confidence. She explained that she was a tom boy while growing up, and maybe this was the reason why her mother directed rage at her. She suspected that her older brother was protected by her mother because of his mental disorder; and her younger sisters and brothers were protected by her mom

because they were younger. Janice believed that she was singled out by her mother as the one to pick on because she acted tough.

I asked Janice if she thought that the little Janice felt tough when she was feeling hurt and picked on by her mom. Janice responded with "no." She explained that she usually pretended that she was tough and that her mom was not hurting her. In fact, however, she really was hurting very much and felt very frightened. She added that when her mom swung her around by her hair, or when she spanked her on her bottom, she would not cry. Her mom thought that since Janice refused to cry, she was not succeeding in hurting her, so she would intensify her cruelty in order to inflict pain.

I responded to Janice's description by suggesting that "Little Janice" must have been very brave, and very determined. Janice nodded without making a comment. I shared my observation that the adult Janice seems to deal with physical pain similarly. When her arms were very sore, she found a way to tune it out with relaxing music. Tuning out pain is common, and helps many people cope with both pain and trauma.

I asked Janice if there was anything else useful that she learned from her "inner child." Janice thought for a few minutes, then she explained that when

her grandmother died a few years ago, she felt tremendous loss. Janice's grandmother was a powerful source of love and support throughout many of Janice's childhood difficulties. When she died, Janice felt very alone. She added that during her grief and mourning, Janice felt aware of her "inner child" assuring her that "she will see Grandma again" when she, herself dies and goes to heaven.

I highlighted the fact that the "child within" Janice had a positive attitude, which seemed to help her along with feelings of grief and loss. I also complimented Janice for "listening" to her inner child, remembering what she said, and allowing herself to be comforted by the hope her "inner child" had. I suggested to Janice that she may be more "in touch" with her inner child than she previously thought. Janice shed a few tears, but did not say anything.

In closing, Janice shared some feelings of loss regarding her inability to have children of her own because of internal injuries she sustained as a child from a automobile accident. I suggested to her that we could find a way to mourn this loss through some form of therapeutic ritual, if she was interested. She responded with the statement, "I may not have any kids, but I have me . . . and I am a big kid." I suggested to Janice that this was a healthy response,

since many survivors find it useful to allow their adult selves to "reparent" their child selves.

The 6th session took place on December 22. Janice arrived for the session with a Christmas gift for me. The gift was comprised of a relaxation music cassette; a scented candle with a fancy holder, and a small basket of bath oil pearls. Janice explained that she had never given a counsellor a gift before, but she felt a strong urge to give something to me.

I was very surprised by this gesture, but also felt caught off guard. Even though I felt fairly sure that this act had sexual significance that needed to be addressed, I was unsure at that time what I should do. I felt sure that Janice would be needlessly crushed if I refused to accept the gift, and yet I felt very uncomfortable keeping it.

Janice seemed intuitively aware of my discomfort, and she responded to it by talking incessantly. The content of what she said and the manner of her speech resembled a conversation one would have with a casual friend. For example she talked about activities she had with various friends, some who were gay, others who were straight. She described various jobs she held in the past, she described her plans for the Christmas holidays, she described pets,

and then talked about gay people getting married. All of this "monologue" rambled on and on without hesitation, and when I tried to respond (in an effort to regain control of the session) she interrupted me. I felt somewhat rattled, so I let this session follow her direction, with the intention of returning to all of the issues at hand in the next session.

In the 7th session (one week later) I had a list of issues I wanted to address:

1 Was her gift a reflection of her attraction to me? ;

2 Why was Janice addressing my need for relaxation when we were there to address her needs? ;

3 Did she realize that she was making a role reversal?

4 Is this a sign of Janice's discomfort with receiving support and nurturance without giving something in return?

5 Was this an indication of "control" issues Janice experiences with women as she had highlighted during her description of her relationship with Lisa?

I attempted to address all or at least most of the above issues at a slow pace because I was worried about overwhelming Janice and making her feel uncomfortable. I began by expressing my surprise by the gesture, suggesting that it is not common for clients to give their therapists such extravagant and personal gifts.

Janice blushed and explained that she just wanted to give me something to help me relax, give me a break from my children, et cetera. I asked Janice why she thought it necessary to address and provide for my self care. I laughed warmly, and suggested that this seemed to be a role reversal. Janice laughed too, but we both seemed to be aware of some tension.

I asked Janice if she thought that this gift had something to do with her sexual attraction to me. She responded defensively, and explained that she did not have sexual feelings for me anymore, and that I was reading that into the gift. I calmly assured her that she was probably right, since she was most qualified to identify her own feelings and motives.

I suggested that we leave the matter of the gift to rest for the time. However, I asked her if she would think it over a little more after she left, and

if she thought it was necessary, she could bring it up again in the next session. She agreed.

Janice used the remainder of the session to describe an incident in the last week where she vented rage against her mother. Apparently her mother telephoned Janice to tell her that she made cinnamon buns and perogies for her. For some reason she could not explain, Janice lashed out at her mother.

Janice explained that her mother's abuse of her during her childhood was related to her mother's mental illness which was treated with medication. She added that even though all of her siblings encouraged Janice to give up on her mother and let go of her expectations of a healthy mother/daughter relationship, she never gave up. She made several efforts to reach her mom in a positive way, and overlooked numerous acts of physical and emotional cruelty, always hoping that her efforts would be rewarded.

In the past ten years, Janice's hope of rewards became real. Her mother's illness grew progressively better, and although she did not remember details concerning much of the cruelty she inflicted on Janice, her mother began to treat her with kindness and make loving gestures toward her.

I asked Janice what she would expect her "Little Janice" to feel when the adult Janice ignored her hurt and overlooked her mother's cruelty. Janice explained that she expected that "Little Janice" felt angry and resentful. I asked her if she had worked toward resolving some of "Little Janice's" feelings, and validated her anger and resentment. Janice stated that her adult self felt threatened by "Little Janice's" anger, thinking that it might sabotage her efforts to improve the relationship with her mom. I suggested that ignoring strong feelings must have felt like a pretty big sacrifice to "Little Janice," and I asked if she thought it was necessary to acknowledge the sacrifice. Janice shrugged.

I concluded the session with a suggestion, to Janice, that she may want to help "Little Janice" resolve feelings, or at least get to the phone before she does. Janice and I laughed at the humour in this suggestion.

In the next session, Janice and I reviewed her goals for therapy. She decided that she was not ready to terminate and wanted to continue meeting at least biweekly. We had some difficulties finding a suitable time to schedule appointments however, because Janice was assigned to the day shift at work, and was not comfortable booking time off for counselling.

Our next appointment was three weeks from the last. When Janice arrived, I noticed from her pale complexion and her slow movements that she was not feeling well. She explained that her arms were giving her pain and she expected to have another nerve block. She also stated that problems at work were getting worse.

I asked Janice what would she find most useful in that session, based on her feelings and her needs. Janice spoke in a flat monotone, when she explained that she really did not feel up to therapy, and would rather just sit with me and talk about something uncomplicated. For the remainder of this session, Janice and I visited. She talked about her pets at home, her youngest sister and her family, and her animal science correspondence courses.

In two weeks we met again for our 10th session. At this time Janice appeared to feel considerably better. She began the session with a detailed explanation of her medical problems and the fight she was embroiled in with the Worker's Compensation Board. Janice was very frustrated with the fact that she was experiencing severe pain especially when doing intricate machinery repairs. In spite of her pain the Worker's Compensation Board expected Janice to continue working, and refused to pay her benefits. Janice expressed anger and despair with her claims officer and her supervisor at work,

since both of these men were, in her mind, unreasonable and unfair. I validated the feelings Janice expressed, but had very little input in finding a solution concerning her problem.

At this time I decided to use some solution focused questions. I asked her my variation of "the miracle question," which was "What would be the first thing you noticed that was different about yourself or your situation, if one day you woke up in the morning only to discover that a miracle had solved your biggest worry." Janice looked at me with an annoyed expression and did not answer. I attempted to try the question again, with a cheerful tone in my voice. Janice answered my question that time, explaining that she would not have pain in her arms.

Recognizing that I could do very little with this answer in terms of the solution focused model, I simply said, "yes, and what else would you notice?" At this point Janice seemed to accept the idea that we would not "visit" for the whole session, as we had two weeks prior. With a little gentle prodding, Janice provided answers that seemed to follow a natural progression: She said, "I would smile at myself when I looked in the mirror. I'd be happy. I would have confidence in public." I asked Janice "what would be the signs you would recognize, that would indicate to you that you were happy and had more

confidence in public?" Janice responded with the answer, "I'd socialize more. I would have fun. I would be in a committed, monogamous relationship. I wouldn't care so much about what other people think. I would express my feelings to others."

At this point, I commented to Janice that I was aware of the fact that this was a different way for us to use time in therapy, and I wanted to know what she thought about the questions I asked her. She said that she liked to come and visit me more than she liked to do work. I asked her if she felt as if she was visiting a friend more than coming for therapy, and she explained that she wanted very much to be friends with me. I stated that I was aware of the change in our work, and I felt as though we were not working toward her goals as diligently as we once were. I explained that I was comfortable with the idea that she would "visit" me in therapy from time to time. I added that I did not think that therapy had to be hard, grueling work every step of the way. However, I was concerned that some of the boundaries between client and therapist were becoming blurred; I was not sure if we needed to change the way we interacted in therapy so that boundaries between client and therapist were clear and hopefully we would be less likely to steer away from Janice's goals for therapy.

Janice did not really seem to understand fully what I was saying, and I could feel some tension. I asked Janice if she would spend some time thinking about what she really wanted from me. Did she want me to be her therapist? or did she want me to be a personal friend. I suggested to Janice that both of us needed to spend some time thinking about our relationship, so that we would protect the professional context. I asked that we talk about this again in the next session.

Janice brought a brief note she wrote to me while she reflected on the nature of our relationship. In the note she explained that she wished that she and I could be personal friends. She listed various qualities she values in friendships, and she believed I possessed many of these. She wrote that although friendships are very important to her, she understood that she had come here for counselling. She expressed gratitude that therapy could involve some aspects of friendship, but she understood that the therapeutic relationship needed to take precedent.

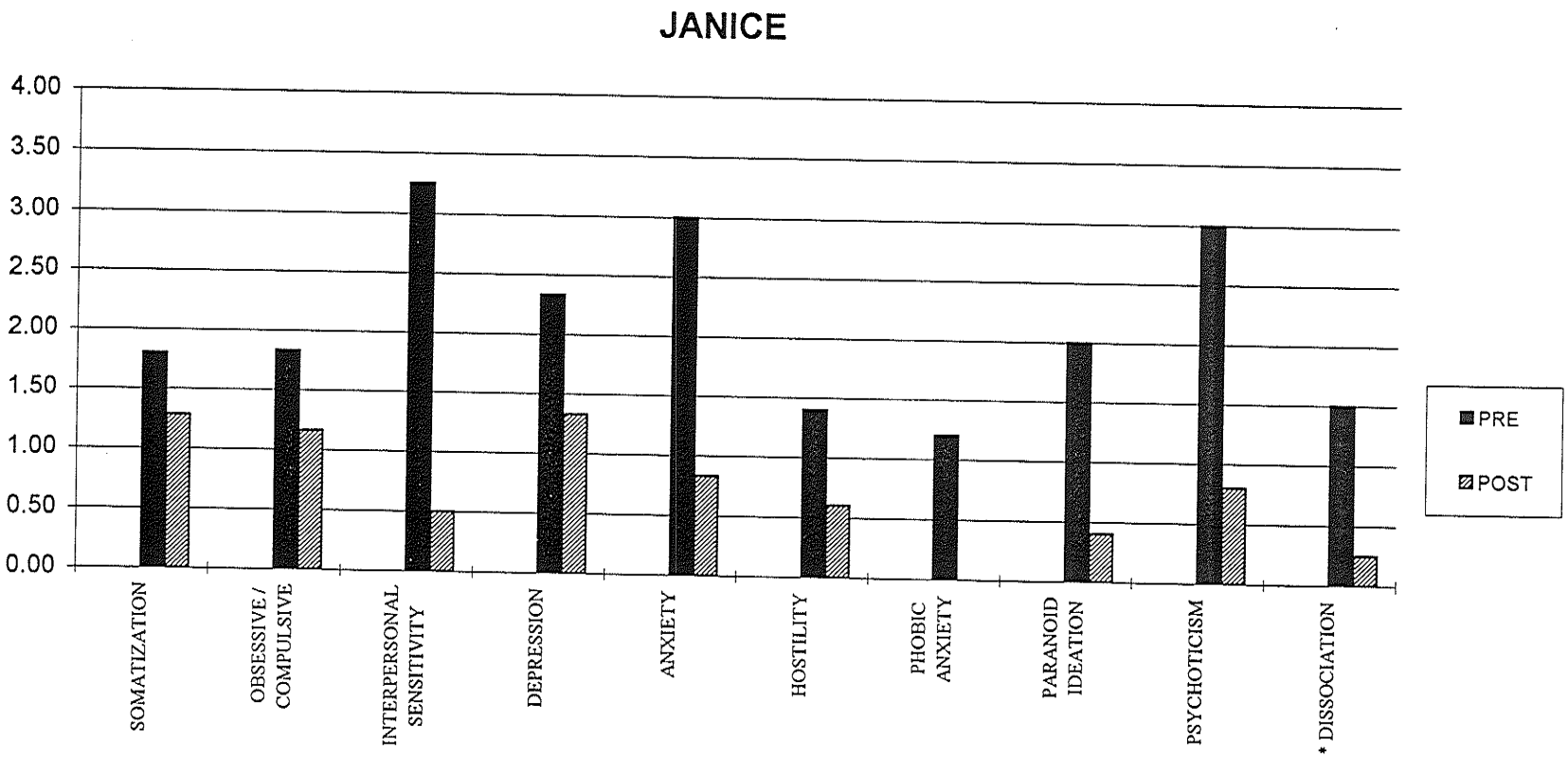
Janice and I spent the remainder of this session redefining friendships in both professional and personal contexts. She cancelled the next two sessions, and I suspected that the cancellations were related to a distancing that seemed to be required.

There were two sessions remaining in our contract. Janice attended both of these sessions and we used this time to review themes and issues we had discussed, thus bringing closure to our therapeutic relationship. Janice asked me if I would consider meeting her for coffee or lunch some time after therapy ended, and I found myself in a dilemma.

I consulted with my supervisor as well as my advisor. Both individuals shared from their own experiences situations where former clients invited them for a social visit. I understood from these consultations that individual therapists need to make decisions for themselves on this matter, based on their level of interest and comfort. Therapists also need to consider the repercussions of developing friendships with former clients, since reconnecting in the professional context would no longer be possible, should clients want to return for therapy.

Janice and I agreed that once therapy ended, I would call her at home and see how she was doing. Perhaps at that time, one or both of us would have reached a decision as to meeting for lunch.

Figure 5. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores (Figure 5)

When Janice began therapy, she was highly distressed. For example, her general severity index score was at least one standard deviation unit higher than the normative inpatient score. Indications of her interpersonal sensitivity could be traced in the way Janice described her history of relationships with women. She did not feel satisfied in relationships and usually accepted blame and responsibility for things that went wrong, even when she was not to blame.

Some of her sensitivity and mistrust toward others was likely linked with social prejudice and stigmatization experienced by many homosexual people today. For example, Janice was rejected by one therapist because of her sexual orientation. She also described several incidents at work where people who suspected that she was lesbian, teased her, or made lewd comments and remarks about her. Her parent's reaction of shame and disapproval towards Janice's preferred lifestyle may have added to her feelings of shame and self abasement.

Janice's anxiety was consistent with a history of childhood abuse and abandonment. Much of this abuse was physically painful. However, Janice seemed more troubled by the emotional impact of cruelty. Therefore, when significant relationships ended (Rick moved away, therapist left the country, Lisa broke off relationship), Janice reconnected with feelings of isolation, alienation, and abandonment, originally experienced during her childhood.

It is also likely that Janice's anxiety was linked to high standards she maintained for herself. Accomplishments and promotions related to work were important to her, but difficult to achieve because she was a female operating in a traditionally "male career." Her place of employment seemed to prefer to hire and promote males.

Janice's pretest score on the BSI, measuring psychoticism, indicated that Janice sometimes felt different from others, in addition to feeling powerless and isolated. For example, Janice indicated on the BSI test that she was either "extremely," or at least, "quite a bit" distressed by the idea that someone else could control her thoughts; feeling lonely even when she was with people; never feeling close to another person; and the idea that something was wrong with her mind. Much of Janice's childhood was kept in isolation from others, because her mother banished her to her room for days at a time, or used other

forms of severe punishment, which may have produced an isolating effect. Excessive abuse and cruelty, received in her formative years, may have taught Janice to believe that something was wrong with her. Janice explained that sometimes her mother's irrational behaviours caused Janice to think that perhaps she was going crazy herself.

Pretest scores on the ISE revealed that Janice's self esteem was reasonably intact; likely because Janice had completed much growth and healing in previous counselling experiences. For example, Janice expressed at the beginning of therapy, that she had interests and hobbies that she enjoyed, and she felt confident in her abilities to do these well. Janice's self esteem improved during therapy and was reflected in her ISE post-test score.

Post-test scores revealed significant improvement in Janice's level of distress. For example, Janice's post-test score measuring her general severity index dropped from an inpatient range, to within two standard deviation units of a non-patient sample score. Perhaps the most startling improvements, were: interpersonal sensitivity; anxiety; psychoticism. It can also be said from the data, that Janice felt less hostile, less depressed, and less paranoid after therapy.

Perhaps some of the improvement in Janice's overall symptomatology was related to the relief that winter was drawing to a close. The change in the season usually brought a noticeable decrease in pain Janice experienced in her arms. I noted that on the day of post-testing, Janice felt very positive, she smiled throughout most of this session.

Reflection of the Client's Evaluation

Janice explained in our last session that she felt very satisfied with her therapy experience at Family Centre. She added that she was satisfied, and she explained that she felt much more aware, accepting and respectful of her inner child than she thought was possible. She wrote the following poem to reflect this change . . .

To Little Janice

I love you . . .

There is a much greater motivation

than simply my spoken words.

For me to love is to commit myself,

freely and without reservation.

I am sincerely interested in your

happiness and well being . . .

Whatever your needs are, I will most

definitely try to fulfil them, and will

bend in my values depending on the

importance of your need.

If you're lonely and need me, I will always

be there . . .

If in that loneliness you need to talk,

I will listen. If you need to be held

I will hold you . . .

You are very special to me, because

You are a part of me

Reflection of the Therapist's Learning

From this case I learned that some clients have social experiences that therapists may not completely relate to. Therefore, it is very important to listen actively and to respond with sensitivity to issues clients bring with them. For example, it would not have occurred to me to begin therapy by establishing my acceptance of Janice as a client and a person in relation to her sexual

orientation. I understand my acceptance of this as automatic and without question. This was however, a vital issue for Janice to address before she disclosed information concerning herself. I believe that Janice would not have returned for a second interview if she did not believe that I heard her concern, felt sensitive toward it, and readily accept both her disclosure and her lifestyle.

I also learned from this experience that if clients bring support persons with them to therapy, it is very important to legitimize this person's presence and at some point offer the friend or relative an opportunity to express his/her concerns or comments. It is more important, however, to identify the client as the primary source of information, and to direct most questions and comments to her. Giving too much attention to the support person may diminish the client and either create or reinforce a lack in the client's self confidence.

A third aspect of my learning is that female therapists and lesbian clients must exercise caution when a sexual interest or attraction develops. Person (1983) explains that "in homosexual women erotic transference may be extremely intense and occur with some regularity" (p.170). She adds that this form of transference is difficult to interpret or manage and often leads to the disruption of treatment. Elise (1991) states:

> *We are not totally in the dark. In looking at our clinical work, the central point to remember with regard to an erotic transference is that it has some meaning. When present, an erotic transference not only needs to be acknowledged, but should be seen as reflecting some very important, and personally specific information which needs to be explored, understood, and worked through (p. 62).*

I believe that sorting out feelings of closeness and attraction was an important part of Janice's purpose in therapy, and my role as therapist. Boundaries between client and therapist can be easily transgressed, if people are not mindful and cautious of verbal and nonverbal communication.

Case Example 6 - Client F -"Beth"

Beth, age 33, was not referred to Family Centre of Winnipeg by anyone in the professional community. She independently recognised a need to resolve personal issues from the past, and called the intake department to request individual counselling. Beth disclosed at intake that she was sexually, physically and emotionally abused during childhood.

Description of the Problem

When Beth contacted Family Centre of Winnipeg, she explained that she wanted to "work through her childhood traumas of physical, sexual and emotional abuse". She had read several books related to child abuse and had recognised a link between her low self-esteem and her abuse history.

Beth perceived her regular use of marijuana to be the matter of grave concern. She stated that while under the influence of drugs, her anxiety "intensified" and completely "paralyzed" her. She expressed strong self hatred for being addicted and desperately wanted to stop using "pot" for good.

Beth also described herself as feeling depressed and anxious most of the time. These conditions kept her isolated from life outside of her apartment and prevented her from finding solutions to her financial and emotional dependency problems. At night she remained awake (afraid or unable to sleep); during the day she felt exhausted and desperate.

Client Biography

Beth was an only child of her parents, and was raised in a small rural town in Alberta. Her father was a Russian immigrant who worked as a labourer for a construction company. His employment was not steady nor was it secure since he often worked long hours, was laid off or was unemployed. When beth was a child her mother was diagnosed with schizophrenia which was usually controlled by medication. Beth's mother worked at a small truck stop lunch counter, and was often the object of harassment and ridicule in the community due to her eccentric dress and behaviour.

When Beth was 3 years of age, her mother abandoned the family and went to live with another man. Her father was left to raise Beth alone, and did so with very little patience or support.

Beth believed her father resented her for being small, helpless and dependant upon him. He frequently flew into violent rage against her where he would strike her, kick her, punch her and tell her repeatedly that she was of no use to him, and that he hated her. She recalled having no source of gentle nurturing while growing up. Birthdays, Christmas and all other significant holidays were never acknowledged, and Beth does not recall ever receiving a gift from anyone.

Beth and her father lived in a small, run down house, without running water. There was only one bed in the house, which Beth and her father shared. Beth remembered being severely beaten by her father because she accidentally kicked him in the groin during her sleep. She nearly passed out from this beating. No child protection agencies were ever alerted, and Beth remembered living most of her life in abject fear of her father and his relentless, predictable, yet unreasonable rage.

In school Beth was treated as a outcast. Peers teased her about her mother and about her obvious signs of extreme poverty. She experienced difficulty understanding basic skills in school, and her teachers were not

compassionate or supportive. Beth was labelled as slow, lazy and unwilling to try.

Beth sometimes spent weekends with her mother and stepfather (her mother's boyfriend), although she did not indicate whether or not these visits were court ordered or requested by her mother or father. On several occasions, her stepfather sexually abused her. Beth believed that the abuse began when she was between 6 and 7 years old, and involved physical beatings and emotional abuse as well.

The sexual abuse involved her performance of fellatio on him, penile penetration of her vagina, and being forced to watch and participate in sexual activities between her mother and her stepfather. Beth also explained that her mother was often present while she was being abused, but did not appear to care or to want to stop it.

Beth attempted to tell her father what her stepfather was doing to her, but her father either chastised her for lying or blamed her for causing it. Beth was forced to continue weekend visits with her mother because her father wanted a break from taking care of her.

Beth's mother had another daughter with her boyfriend as father. Her name was Candy and she was five years younger than Beth. Beth believed that her mother loved Candy more than Beth and this reinforced in her mind the idea that she was unimportant and unloved by everyone. In spite of her mother's favouritism for Candy, Beth was very concerned for her sister and played a protective role over her. She believed Candy was physically and sexually abused on a regular basis by her father.

When Candy reached 10 years of age, she was sent away to a home for mentally disturbed children. Beth remembered feeling both relief and horror when her sister was taken away because she understood that Candy needed protection from her own father, but she also knew from experience that young children can be traumatized by separation from the mother.

In high school Beth continued to struggle with learning, peer relationships and negative labels (such ugly, stupid and flea-bag) that followed her year after year. However, she also remembered a girl that befriended her in Grade 8, who sometimes helped Beth overcome loneliness and isolation. She became her one "best friend".

An adult male high school student also took an interest in Beth when she was in Grade 10. He was seven years older than Beth, and became her first boyfriend. Beth began to use marijuana and skip school with her boyfriend, and before the school year was finished, Beth ran away with him. They were married when Beth was 18 years old.

During this marriage Beth's husband (Lester) was often emotionally abusive to her and on a few occasions, he physically assaulted her as well. No charges were filed against Lester and Beth remained with him for ten years. When she was 28 years of age, Beth left Lester and moved back to live with her father.

Beth and her father relocated to Winnipeg when she was 29 years of age. At this time she began to date her present common-law partner, Tom.

Tom and Beth lived in an inner-city apartment. They both struggled with substance addictions, and unemployment. Beth described this relationship as having serious problems since Tom continued to abuse her emotionally and to have affairs with other women. Beth believed that she should get out of this

relationship, but she was afraid that if she left him she would be destined to live in a "rat infested dump".

In their four year relationship, Beth and Tom increased their frequency of smoking marijuana. Beth claimed that even though smoking "pot" increased her anxiety, she used it several times each day.

In 1991 Beth participated in an anxiety group facilitated by the Addictions Foundation of Manitoba. Although Beth said this experience was positive and useful to her, it did not eliminate her anxiety, or help manage her addiction.

Presenting Concerns

During the assessment interview, Beth appeared to feel very uncomfortable. As she sat in her chair, she utilized the very least amount of physical space and avoided eye contact whenever possible. She spoke in a very soft timid voice, and used very brief sentences to answer questions.

Beth explained during the assessment interview that she felt "complete terror" prior to and during the appointment. Her use of words to describe her fear and anxiety were sensationally strong. I used a rating scale to assess her anxiety, and she rated herself closest to the most extreme tip of the scale ("9" on a scale from 1-10, where "10" represents extreme anxiety).

I was very concerned about Beth's anxiety during the session, and yet I was also baffled by the apparent incongruity between her description of it and her physical presentation. She sat tall in her chair with both feet planted directly below her, with her hands, lightly folded, resting on her lap. Her breathing seemed to be deep and regularly paced.

In the second interview Beth stated that she was feeling "hysterical", and yet nothing in her body language suggested anything to me about hysteria. I described to Beth my observation of her as calm and poised, and she responded with a description of herself as struggling with tremendous fear while desperately trying to hold herself together. She said, "I might fall to pieces...I feel very fragmented".

I concluded that the incongruence I observed was a symptom of dissociation. Reflecting on her abuse history, I understood the usefulness of dissociation as a coping mechanism.

In order to further assess Beth's anxiety, I asked if she smoked "pot" before coming to the centre (since marijuana magnified her fears and anxieties). Beth stated that she did not use any drugs before coming to the session. If she had, she would not be able to have any eye contact with me at all and she would be showing me on the outside that she needed to hold herself together to keep from falling apart.

I inquired if Beth had seen a medical doctor to describe her symptoms of anxiety and panic and she explained that she saw a doctor who suggested she use anti-depressant medication. She refused his prescription with the explanation that she did not value prescription drugs and chemicals. Beth stated that she could manage her anxiety without the use of them.

At this time I noted that Beth had more strength and control over her symptoms than she thought, even though she sometimes felt overwhelmed and immobilized by them. However, I was very concerned that living each hour of

every day under extreme emotional duress and sleep deprivation might having damaging consequences for her physical and emotional health.

I was also concerned about the degree of abuse Beth experienced throughout her history, but particularly during her formative years. Persons who are severely abused and neglected often require a significant amount of time to build safety and trust in therapeutic relationships. I was concerned that my six month term in the agency would not be sufficient, and Beth might feel abandoned by me when I was ready to leave.

I discussed this concern with my supervisor, and we agreed that Beth needed to make an informed decision about this matter. If she wanted to begin her work with me, and possibly transfer at the end of the six months, I would proceed. If however, she did not want to risk establishing trust with me because she might have to build trust with a new therapist after six months, she could be assigned to the next available full-time therapist.

I presented Beth with these options and asked her to consider each of them carefully. When she was ready she could let me know her preference. A week later, Beth stated that she felt most comfortable beginning with me.

Description of the Client/Therapist Contract

In the third session Beth and I agreed that we would meet once each week for approximately six months. During this time Beth wanted to focus on:

1 quitting her use of marijuana;
2 building confidence and self esteem;
3 integrating memories of childhood trauma and connecting with feelings related to this; and
4 accessing more control over dissociation, depression and anxiety.

Beth also agreed not to attend any sessions when under the influence of alcohol or drugs. I explained to Beth that marijuana would likely interfere with our ability to build trust and it would likely intensify any fears and anxieties developed in sessions. This in turn might interfere with her ability to cope during treatment.

Description of the Intervention

Throughout the beginning phase of therapy with Beth, I continuously monitored her level of anxiety and depression. In many ways this was difficult because Beth was quite dissociated from the feelings she developed and I was not able to observe from her external presentation the level of emotion she was

experiencing on the inside. Beth assured me that she would keep me informed if she became overwhelmed by the process.

Beth informed me of the fact that she felt calm and relieved for two days following our sessions, but by the third day, she usually returned to a state of terror. She described spiralling down toward a "black hole" that swallowed her up in a feeling of despair. I asked her if she would still be in the black hole when she arrived for counselling, or if she found her way out prior to the session. Beth's response was that she would still be in the hole.

At this time I began to explore with my client what this black hole was like and what options existed for her to escape it if she chose to. Beth explained that her black hole represented her complete despair and hopelessness concerning her ability to overcome her problems. She added that she did not know what would be involved with escaping her despair, and she did not feel sure that escape was in fact possible. This process led us to some understanding of the role of marijuana in Beth's life. It did not help her to escape her fear and anxiety, but it certainly magnified her experience of these emotions...which seemed to be more harmful than helpful to her in feeling

better and stronger. Beth announced quite strongly that she really hated herself for becoming addicted to "pot" and she really wanted to quit.

I suggested to Beth that after this session she may want to consider what her life would be like if she was not using marijuana. I also suggested that she try to notice what she was doing and thinking prior to smoking a joint, and whether or not she could identify any feelings at that time. Beth agreed to try and track this and share it with me next session.

When Beth arrived for the next session, I was struck by a change in her presentation. She appeared to walk with more confidence. She took her jacket off and put it in the next chair and her feet were crossed and slightly extended in front of her. Usually, during our sessions, Beth occupied the very least amount of physical space. Her walk was usually slow and hesitant, and she never removed her jacket unless I invited her to do so. If she took her jacket off she always kept it behind her in the chair. Her legs and feet were never extended in front of her; they were always planted directly in front.

Beth explained that she benefited from the last session because she become more aware of her feelings. By realizing how disconnected she was

from her emotions, Beth realized that a part of her was missing. She said "I feel as though parts of myself are buried or disowned... I want to remember my feelings so that I will feel more whole.... If I remember my past feelings, I will have more personal integrity and I will be more mature on the inside."

I complimented Beth for having arrived at the conclusions she shared, and expressed my interest in what Beth would notice about herself and her behaviours if she felt more mature on the inside. I asked her if she could describe herself from this "inside perspective", so that I might have more clarity on what she was feeling. Beth explained that she just felt that she was weak, shy and very afraid most of the time, and she wished that she could feel stronger and more confident in herself.

I suggested to Beth that perhaps she was reconnecting with feelings from her childhood. Beth nodded in agreement, sharing the fact that she had some knowledge of the concept "inner child" in context with surviving child abuse because she enjoyed reading and found some books written on the subject of abuse to be interesting and informative. She added that she did not feel very connected to her "inner child", although she wished she was. She stated that she would like to provide her inner self with some "healing messages".

Once again I complimented Beth for having initiated her own learning about these matters... and assured her that working with her inner child could be part of our process, but we needed to pace our work and not go too deeply too quickly.

I asked Beth what she would like to discuss for the remainder of the session. Beth was obviously feeling more confident than her first few sessions, because she took the initiative to suggest a topic for discussion without any coaching.

She stated that she wanted to talk about her relationship with Tom. She told a story of how Tom would leer at other women when they were together in public, and she "felt" hurt and embarrassed. She attempted to confront Tom with her observation, but he denied it and told her she was imagining things due to her own insecurities. Beth agreed that she harboured many insecurities and she became quite confused by self doubt. While telling me this story, Beth rose above her self doubts and said, "But I saw it right before my own eyes...Does he think I am stupid?!!"

My response to Beth at this time was to highlight moments in her life she previously shared, when people told her that she was stupid. I explained that it would not surprise me if after all these years she came to believe the statement. I asked her if she thought she was stupid. She thought for a while and then said "no!" in a self-assured tone.

I asked if Tom would benefit by convincing her that she was stupid and insecure. Her response indicated that Tom was able to redirect the blame for his actions by suggesting to her that she was imagining things and insecure. I asked Beth what she stood to gain by taking responsibility for Tom's actions. Beth stated that she did not benefit from owning responsibility for Tom's behaviour.

I suggested to Beth that sometimes one partner will take the blame for her partner's abusive behaviour because she believes that claiming responsibility might enable her to change or control the pattern. Unfortunately, this is a myth. I added that when the partner committing the abuse adopts this myth, he is relieved of his responsibility to change or eliminate his abusive patterns.

Beth appeared to be intrigued by this idea, and she seemed to contemplate it carefully. Before ending the session, Beth and I explored her options regarding her relationship with Tom. Beth's perceived options were:

- stay in the relationship until she feels safe and strong enough to leave;
- leave the relationship right away or as soon as possible;
- stay in the relationship forever.

Beth explained that she would prefer to choose the second option, but felt very certain that if she were to leave him without a plan for security, she would be forced to live in a "rat infested dump". She concluded that the most logical choice would be to stay in the relationship until such time as she could establish independence. I validated her choice, and added that I also thought it wise to establish plans before making big changes.

When Beth arrived for the next session, I noticed that she had reverted back to her earlier presentation. Once again she seemed to be timid and self conscious and would avert her eyes from mine. She shrugged her shoulders to

casual questions and refused my invitation to remove her jacket and place it on the chair next to her.

I asked her what she would like to discuss in session and she took several moments to provide an answer. She stated that she had a strong desire to reconnect with her feelings, but she did not think she was making progress with this and felt very discouraged. I took a few minutes to validate Beth's concern and highlighted that she appeared to be in touch with feelings of discouragement and perhaps frustration too. I asked Beth if she realized that these were feelings but she just shrugged her shoulders.

I explained to my client that she needs to be patient with the process of becoming aware of feelings...after all, she trained herself very well to block out feelings when she was abused, in order to survive.

Beth described an incident as a child, where her father was bathing her in a large wash tub. Beth got soap in her eyes and began to cry, and her father punched her in the face. He told not to cry after the punch or he would beat her so bad she would really have reason to cry. Beth used this story as an example of how she forced herself not to show her feelings.

Although Beth showed no emotion while telling this story, I told her that I was deeply moved. I asked her if she could visualize herself as a small child sitting in a wash tub, forcing herself not to cry. Beth said that although she thought she might have visualized herself in this way, she did not feel any compassion or love toward her child self. She added, however, that she sincerely wished she could provide "love and nurturance" for this image of herself.

Toward the end of this session, I asked Beth if she would be able to perform some small task for herself that would be a loving gesture of self care. I suggested that the task might include a favourite food or activity she enjoyed as a child, or it could be something more current.

Beth thought for a long time without responding. I thought that I might have to help her with the notion of self care by assigning a task, but suddenly, she offered the idea that she could take some time to brush her hair. I complimented Beth for arriving at this beautiful suggestion, and added that she had very pretty long hair. I also asked that as she brushed her hair, perhaps she might visualize herself as a little girl, having her long hair brushed gently and lovingly. Beth agreed to try.

In the next session Beth appeared to be a little more tense than usual. She sat down in her usual position and took her jacket off when I asked her if she would like to.

Beth explained that she felt a little overwhelmed because over the past two weeks, she read the book "The Courage to Heal" from cover to cover. I expressed my astonishment at this task, and inquired why she would want to read so much heavy material in such a short period of time. She explained that prior to our sessions, she had not really thought about her sexual abuse as an important part of her pain. She felt very disturbed and preoccupied with thoughts of her father and his extreme cruelty to her. After reading the book, Beth felt more aware of disturbing thoughts and memories of sexual abuse from her stepfather.

I offered Beth the opportunity to share whatever she thought might help me to understand what happened. Beth took some time to tell me several stories about frightening experiences and she identified several feelings, such as fear, confusion, shame and disgust in reference to her experiences as a child. I validated Beth's feelings and complimented her courage and determination. I cautioned her as well not to go in the opposite extreme of minimizing her

sexual abuse by inundating herself with information on the subject and forcing herself to remember too much at one time.

At this time I inquired about her task from the previous session. Beth reported that she had brushed her hair for ten minutes and during this time she actually felt a little compassion for her inner child.

I invited Beth to explore an exercise from John Bradshaw's "Homecoming", where she would write a letter to her child self in her dominant hand...and then write a letter to her adult self from her child self using her non-dominant hand. Beth agreed to do this, and when these brief letters were complete, we read them together. Beth said she thought this exercise was interesting.

At this time she told me another story from her childhood where she was sent down the road to stay with a school teacher and her family. It was Christmas morning and all of the children were opening elaborate gifts while Beth sat motionless and empty handed. The mother told one of her children to give Beth one of her old dolls so that she too would have something. The following morning, the doll Beth was given had black marker scribbled all over

its face. Beth once again described feelings of bewilderment, fear, hurt and shame in connection to this experience.

Toward the last half of this session, Beth announced to me that she had not used "pot" in four days. She added that even though she was present while others were smoking, she refrained.

Beth added that abstinence from marijuana enabled Beth to experience more of her feelings, such as depression and despair. She went outside of her apartment on two occasions in the past two weeks. I congratulated Beth for her accomplishment, and shared my observation that she did not seem to be as pleased with herself as I thought she would be. Beth said that she did not feel proud of her abstinence.

In the next session I asked Beth if she would like to consult with her unconscious mind to gain some insight as to the purpose of marijuana in her life at this time. I detailed a process of relaxation, where Beth would ask her inner parts inaudible questions and then listen to her thoughts to discern her reactions to the questions.

I suggested to Beth that she be careful with her use of language during her questioning. She might want to avoid using words that might put her inner parts on the defensive. I asked if she would refer to the part that smokes "pot" as the "creative part" rather than the "addicted part". Beth smiled at this suggestion and stated that she liked the idea.

Once Beth achieved a relaxed state through deep breathing exercises in combination with my verbal suggestions to relax, she identified her right finger twitch as an ideomotoric signal that her inner part that desired to use "pot" was willing to consider an alternative for accomplishing its purpose. She asked her inner part objecting to the use of marijuana to identify the alternatives, and she said a very faint response suggested that she needed to be with other people.

In summary of this exercise, I questioned Beth if she thought it was a good idea to get involved with more people instead of staying in her apartment and smoking. She said that she would really like to branch out and meet new people and establish new friends. She remembered what it was like to feel connected with people during the anxiety group she attended. She stated that

this was a positive experience, and she wondered if she would ever see any of those people again.

At this time I gave Beth a suggestion that she may want to try a narcotics anonymous self help group and meet new people in this way.

Before ending the session, I asked Beth if she was comfortable with therapy thus far, or if there was anything else she wanted to explore more fully. She explained that she wanted very much to continue working on reconnecting to her feeling states. I asked Beth if she would like to try another mode of expression, other than verbal, to express herself. We agreed that in the next session, my client would use paints to express her feelings.

In the next session, I brought in some paper, some oil pastels and some water colors for Beth to use. However, before we explored the use of them Beth detailed some thoughts and some highlights from the previous week.

Beth announced that she has continued her abstinence from "pot" and became more aware of tense sensations in her stomach while others smoked around her. She added that the part that craved smoke entered into conflict

with the abstaining part... but she quickly explained "My abstinent part over rode the situation and claimed that there was no room for an argument".

Beth also explained that she went to the doctor and discovered that she had a bladder infection. The doctor believed that the infection was related to having sex. On the other hand, Beth believed that her infection was in some way connected to her history of sexual abuse. She thought that her body was rejecting sexual activity as a response to memories of past abuse. I suggested to Beth that her belief in the connection between mind and body was commendable, however I cautioned her about viewing everything as having some link with sexual abuse.

Beth shared another story from her childhood, where she was forced to perform oral sex on her step father. We discussed the confusion and horror we expected a child to feel in relation to this act, and validated several other possible feelings as well. Beth described other incidents where she was forced to share a bed with her mother and step dad, while they were having sex. Beth said she tried to move away as far as possible, but would then be forced to participate. Once again, Beth identified several feelings she "likely" experienced

at that time; however, she reported that she did not feel connected to these feelings during or after her description of the incident.

Beth used a soft timid voice while sharing her stories with me and unlike some of our earliest sessions, her facial expressions appeared somewhat pained and distressed (she frowned as she spoke, and her lips seemed to be tightly pursed).

I asked Beth if she might like to use the art supplies to describe the feelings she had. Beth took a paint brush and with much hesitation, she dipped the bristles in red paint. At this time she faintheartedly painted a red shape as we continued to talk.

Beth seemed to confuse the task with an expectation to produce a significant piece of artwork. I explained however, that the purpose was not to demonstrate talent, but to use creativity to express oneself. She could do absolutely anything she wanted with the paints and pastels, regardless of what it looked like in the end.

Beth used brown paint to paint a square, with another black square enclosed in the top right hand corner. Next she painted another smaller square in a mixture of colours, such as blue green and yellow. Mixing these colours resulted in the creation of a somewhat gloomy colour.

When I invited Beth to share her interpretation of her painting, she explained that at first she chose red paint to symbolize her bleeding on the inside. Next she pondered the square shapes and said, "I feel `blocked'....I feel as though there is a brick wall before me".

At this time I gave Beth a clean sheet of paper and asked her to draw a line in the centre to depict this brick wall. Beth took a black pastel and coloured a thick solid black line. Next, I asked Beth to use colours to depict what she thought existed on the opposite side of the brick wall from where she saw herself. Beth chose vibrant colours (two shades of green, yellow and orange) and drew squiggly lines in a circular fashion.

I asked Beth if the bright colours represented anything. Beth explained that this represented the life she wanted to be living. She could not articulate for me however, what this life would be like.

Next, I asked Beth to draw for me what lay on the same side of the brick wall where she saw herself to be. Beth sat for a long time without drawing anything. I asked her if she could visualize what it was like on this side of the wall, but she shrugged her shoulders. At this time I said various words or sentences she used in previous sessions to state or describe her feelings. Beth did not respond. I took a few colours and wrote down some of her statements ("I don't deserve to live...fear of pain...pain), and drew question marks overlapping these words. Beth nodded.

At this time I used this diagram to ask Beth what stopped her from breaking through that brick wall and living in her colourful world. After a long pause, Beth shared her insight that the part of her that keeps her blocked is the part of her that remains loyal to her dad. She explained that the world she lives in now is full of confusion, despair, worthlessness and fear of pain. "This is my father's world...and my loyalty to my father prevents me from leaving him alone in it...even though this world is empty and without value or meaning".

I told Beth that I was very moved by her insight and I was struck by what appeared to me to be a significant sacrifice. Beth added that she did not

want to sacrifice any longer and she wanted to escape that world but did not know how.

I explained to Beth that I thought she should leave that world too so that she might discover the world on the opposite side of the brick wall. I added that I thought she needed to remember her wisdom in considering her options of staying with or leaving Tom. I cautioned her to make change slowly....start small and plan ahead for the really big adjustments.

I explained to Beth that an appropriate place to start in planning her escape involved noticing her self talk. I asked her to notice when she said something to herself that reminded her of cruel things her father used to say and to record it. I also asked that she challenge that negative self talk with something more realistic and useful to her (cognitive restructuring).

In the next session, Beth reported that she did not have a good week. She had several arguments with Tom and his friend, and she felt very frustrated and put down by them. She explained however, that she did not record negative self talk.

We used this session to discuss the contents of her conflict with Tom, and to track any connections between Tom's statements about her and messages she heard from her father. Beth noted that similarities existed in the expectations both Tom and her father had of her that she should be a "good housekeeper". Both shamed her verbally for any mistakes she made or any imperfections she revealed in her household tasks.

In the next three sessions, Beth and I explored the use of relaxation and guided imagery. I used some nature sounds and instrumental music to facilitate relaxation, and verbally guided Beth to tune into her inner self and listen to her thoughts and feelings.

During these exercises Beth commented that she preferred my verbal directions in helping her to relax, as opposed to remaining quiet while she listened to music only. While verbally directing the exercise, I was very careful not to contaminate or impose any particular thought patterns on Beth. I always used language that invited her to think about her thoughts and pay attention to her feelings, rather than tell her what her thoughts and feelings were.

These exercises proved to be helpful in helping Beth to connect with feelings of being abused and neglected. She described flashes of memories of being bottle fed by a younger version of her father and being afraid of her mother.

Beth also gained insight into feelings of anxiety and panic when Tom would return home significantly later than he promised her. She connected these feelings with memories of being left to cry in her crib for hours because her father refused to acknowledge her or her needs for nurturance. She described painful sensations in her throat and stomach from crying very hard before she eventually fell asleep.

Beth also described feelings of shame and vulnerability in connection with things her father said to her. She remembered being very careful not to make anyone angry, sometimes she had to pretend that she wasn't there so that no one would notice her. She remembered feeling ashamed of herself for being small and clumsy.

Relaxation exercises also helped Beth to draw a connection between her craving for drugs and her craving for love and protection from her father. Feelings experienced during "cravings" involved extreme anxiety and despair.

When Beth identified painful feelings or disclosed some form of insight during these exercises, I praised her for her awareness and usually assigned her some form of task to do at home that would either flush out more understanding of her insight, or provide her with self care and self nurturance. For example, I assigned Beth a letter writing exercise (a letter that Beth would not mail) to express her feelings to her father for leaving her to cry for hours or for shaming and beating her. When Beth wrote this letter she connected with feelings of anger and hostility toward her father and these feelings assisted her in her escape from "his world".

When Beth connected with feelings of pain in her throat or stomach from crying or from being kicked, I asked that she pay special attention to this particular part of her body when she was at home. I suggested that she soothe this part with something pleasant, such as a soft fabric or a lotion. Beth claimed that she was not only getting better at identifying her feelings but she

was showing some improvement in her ability to respond to and care for her feelings too.

The last few sessions of working with Beth involved the use of Dolan's (1991) solution focused questions. I asked Beth to consider what her life would be like if she no longer needed to come for counselling when thinking about her past abuse. Beth explained that she would feel more confident and competent in general. She claimed that she would be able to do things that, at present she was too afraid to try, such as find a job or establish friendships. Beth stated that she would feel less negative and would worry less about things.

I asked questions directed at clarifying Beth's healing signs, such as "what would you be doing differently from now if you were feeling more confident and competent"; or "what would you be able to do if you were less negative or worried less about things"? Beth's answers to my questions revealed an effort to break her day into intervals where she would use more structure to keep self motivated and focused.

I used "scaling questions" to assess Beth's confidence and readiness to implement change in her daily functioning. For example, using a scale from 1-

10, where "10" represented extreme confidence, Beth claimed that she was at a "4". So, I asked her what would increase her level of confidence up to a "4 1/2" or a "5"? Beth answered that she would be at a "5" if she got up at 10:00 am. each morning. When I asked what would move her a little closer to a "10" she responded with more indications of a structured routine. Beth anticipated that her confidence would actually reach "8" if she followed a regular routine, but then it fell short when she reached the door of her apartment, feeling well dressed and organized but without somewhere to go.

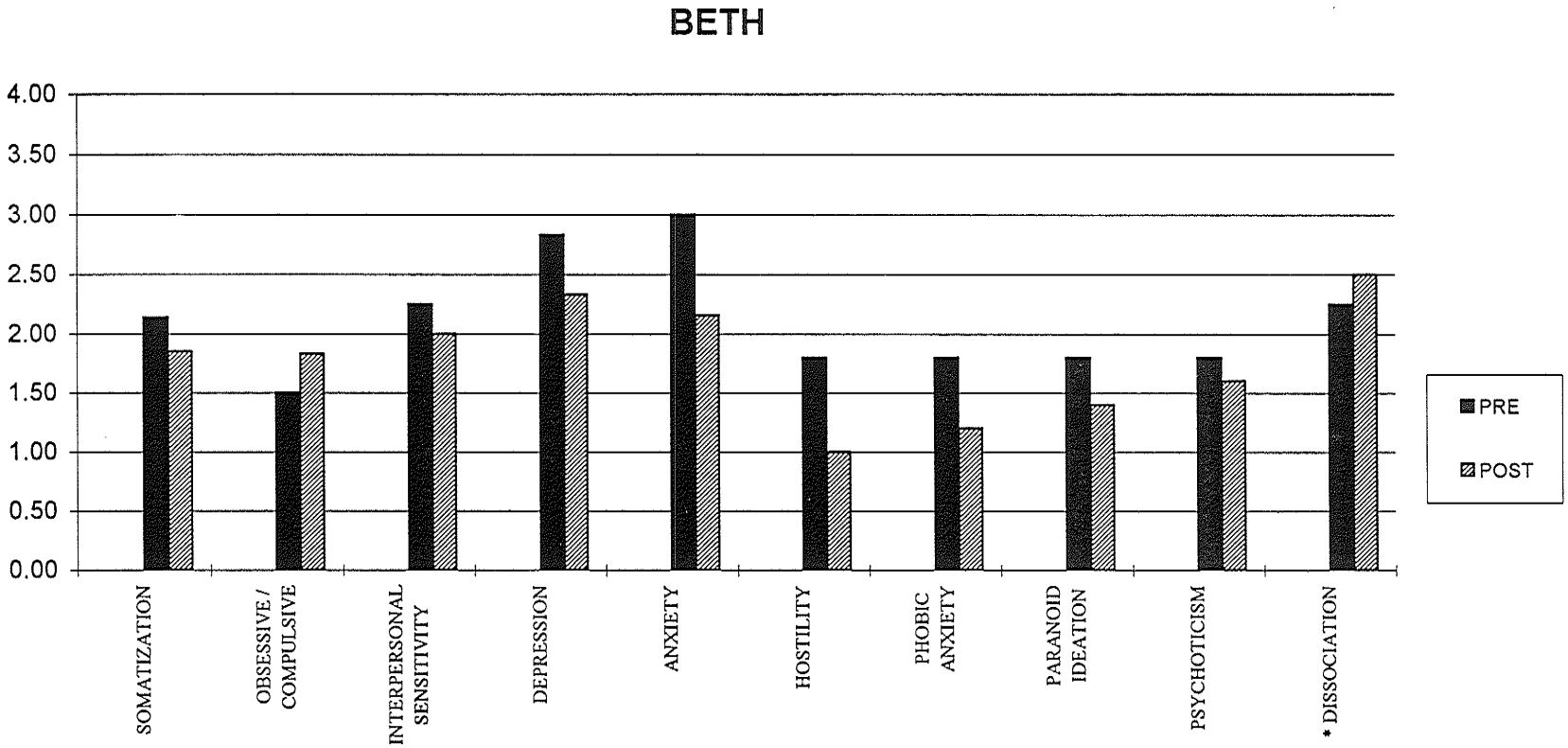
Beth and I explored options of returning to school in preparation for a career, offering time to the Winnipeg Centre for Volunteers, and joining a self help group.

Toward the second week of March, after sixteen sessions, Beth and I discussed termination of therapy. Beth indicated that she had been on the waiting list for service at the Women's Post Treatment Centre and had recently received a call from a therapist, indicating that she could be seen there.

I shared with Beth my belief that she had made good progress since our first meeting together and she might benefit by beginning something new. Beth

agreed, and expressed that she made many positive changes inside as a result of things she learned from our work.

Figure 6. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores (Figure 6.)

When Beth began therapy, she indicated that overall, she was moderately distressed. Her general severity index pretest score was at least one standard deviation unit higher then the normative outpatient data score.

Anxiety, depression, interpersonal sensitivity, low self esteem and dissociation were symptoms I recognized consistently with Beth. She described herself as feeling so anxious and terrified that she thought she might fall apart, and yet dissociative qualities prevented an outward display of this emotion.

Beth's depression was evident in her despair that she might not escape from her "father's world", or the "black hole" she sometimes fell into while using marijuana. The depressive states were also evident in Beth's feeling that she did not know how to go on with her life; that she was "stuck" either living with a man who was insensitive to her needs and feelings, or living in a "rat infested dump".

Beth's feelings of interpersonal sensitivity seemed linked to her struggle with low self esteem. She wanted more involvement with others, but felt

inadequate and sometimes terrified when talking to people she did not know well. People who were currently involved with Beth (her father, her boyfriend and his friends) seemed to take Beth for granted, criticize her and make her feel unwanted or unwelcome.

Low self esteem seemed to interfere with Beth's willingness to go back to school or join a volunteer centre. Mental stimulation and a more structured daily routine seemed to be the solution to her escape from what she referred to as a meaningless life. However, she recognized a need for more confidence before she could make her goals a reality.

Post-test scores from the BSI showed improvement in all eight of the nine symptom categories. The most pronounced changes were in depression, anxiety, and hostility.

Perhaps the reduction in Beth's hostility could be explained by the compassion and empathy Beth developed for her father, through the letter writing and artwork exercises. Beth seemed to avoid blaming her father for keeping her in his world, and recognized instead, that it was her own feelings

of loyalty to him that kept her from discovering the other side of the "brick wall".

There was an increase in Beth's symptoms of obsessive/compulsive and dissociative tendencies. Perhaps the increase in the former symptom was linked to Beth's insight that she owned responsibility for her present circumstances, and that positive change required more effort and determination from her. Perhaps she longed for changes on a cognitive level, but the emotions that would accompany change could not develop as easily. For example, Beth's determination to quit the use of marijuana seemed to override the part of her that "craved." The part of Beth that "craved" drugs indicated that developing social contacts would achieve the purpose that marijuana served. Beth stopped the use of pot, before she established the social support system she needed... I believe this may have produced a gap in her life, thus creating an obsessive or compulsive need to do or find something to fill it.

An increase in dissociation may also be tied to the "gap" Beth developed during abstinence from drugs. Increased dissociation could be understood in terms of a replacement in the "numbing" effect of narcotics. Even though Beth

claimed that drugs intensified her terror and panic, she also explained that in some instances, they may have numbed or altered her sense of reality.

Increased dissociation may also be understood in terms of reconnecting with, or reclaiming painful details of past abuse, neglect and cruelty. This was certainly part of the process Beth and I began and which may require years to complete.

Beth reported improvement in her self-esteem during post-testing. This improvement was consistant with some of the cognitive changes Beth developed, concerning her internalization of the abuse and neglect. She seemed to feel better about herself when she worked towards acceting and nurturing her inner child.

The post-test score from the ISE was still well above the clinical cutting score, which indicated that further clinical intervention was necessary in this area.

A Reflection of the Client's Evaluation

Beth offered a verbal expression of changes she perceived in herself and in her situation when therapy ended. Her first comment referred to her continued success with abstinence from narcotics, Beth had not smoked "pot" for six weeks. Although Beth explained that she did not feel as good about herself for quitting marijuana as she expected, she was glad to be free of it.

Beth also explained that she did not feel as anxious on the inside as she used to. She said that she felt more comfortable with counselling, and no longer felt as though she might fall apart.

She explained that she understood that her healing and recovery was not yet complete, but she felt very good about the beginning steps she and I made toward this end. She believed she would be able to begin treatment at the Women's Post Treatment Centre without overwhelming anxiety and fear.

Reflection of the Therapist's Learning

One of the most profound aspects of my learning from this case involves the issue of countertransference. There were moments in some of my sessions with Beth where I felt a traumatic response to her feelings of despair, loneliness and terror, I felt my own heart pounding and my limbs trembleing when Beth detailed some of her abuse. Herman (1992) refers to this as "traumatic countertransference", and explains that "in the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient".

My experience of countertransference may and may not have been connected to my own experiences as a child, but perhaps they help to explain my overwhelming desire on some occasions, to take Beth under my wing. I wanted to take her to my home and surround her with comfort and warmth. I wanted to buy her a Christmas present, and share other aspects of my life that she identified as missing from hers.

Herman (1992) cautions us that when therapists identify too closely with a client's feelings, he/she may become trapped by feelings of helplessness,

which "may lead the therapist to underestimate the value of her own knowledge and skill, or lose sight of the patient's strengths and resources" (p. 141).

At one point, I became very aware of my perception of Beth as a fragile flower who might actually fall apart if I breathed too hard, or if I said the wrong thing at the wrong time. Then I suddenly remembered that this woman was incredibly strong, and had survived a traumatic past without support. She managed to create a life and a home that was entirely different from what she once knew. It was very clear to me that she had learned to do this through her own capable internal resources. She really did not need me to take her home.

Case Example 7 - Client G - "Sandy"

Sandy, age 41, was referred to the Family Centre of Winnipeg by her medical doctor for counselling on issues related to child sexual abuse. Sandy informed her physician that she was struggling with flashbacks of abuse, frequent panic attacks, and depression. The doctor prescribed antidepressant medication for her patient, and recommended that Sandy find professional support.

Sandy contacted the intake department at Family Centre requesting individual counselling. She indicated that she had seen a psychiatrist for medication, but did not receive counselling from him.

Description of the Problem

Sandy was diagnosed with acute depression by a psychiatrist one year prior to contact with Family Centre of Winnipeg. According to my client, the psychiatrist did not seem to believe or respond to Sandy's disclosure of sexual abuse, and her understanding of his diagnosis was that

the hallucinations she experienced were manifestations of her depression. He prescribed antidepressant medication for Sandy.

Sandy was dissatisfied with this assessment and went to see a family doctor on the recommendation of a friend. While this doctor believed Sandy's claim of child sexual abuse, she also agreed that Sandy should use antidepressant medication. As Sandy talked to her doctor, more memories surfaced.

Sandy told her doctor that she was having flashbacks of her abuse, problems in her marriage, difficulty falling asleep, and she was drinking too much alcohol. For these reasons, the doctor referred Sandy to Family Centre for counselling.

Sandy explained that she suspected that she was sexually abused, but did not remember her experiences. She described flashbacks of sexual assaults, but she could not see the face of her assailant.

Sandy reported feeling anxious, distressed and confused by these intrusive flashbacks. She added that at times she felt as though she became

someone else, someone much younger than herself. During these episodes she was unable to control her behaviour or things she said. She worried about going crazy.

Sandy explained that she "became this little person" when she attempted to have sex with her husband. During sex, Sandy would hallucinate someone else's face instead of Tony's, and she would begin to cry, stop the intimacy, and hide in the closet.

Sandy claimed to have difficulty concentrating whole at work. She believed her employer placed her on evening shifts to compensate for a decrease in her work performance.

Sandy struggled with mood swings and bouts of depression at home. She realized that her erratic behaviours were an increasing strain on her marriage, and were causing her to feel more despair. She recognized that her children seemed fearful and confused and guessed this could be attributed to the existing tension between Tony and herself.

Client Biography

Sandy was raised by her parents in a coal mining town on the eastern coast of Canada. Her father, Peter, was a coal miner until he fell in a shaft and broke his back. Sandy's mother, Eva, did not work outside of the home. There were eleven children in Sandy's family; she was the seventh child born. After Peter's back injury he began to drink alcohol very heavily. He became irritable, angry and frustrated when he was unable to function as he used to, and when financial problems escalated.

In time, Peter began to physically abuse his wife and children during fits of rage; and since child protection workers were not alerted, the abuse continued for several years. Peter also sexually abused his sons and daughters.

There were several incidents of physical and sexual abuse inflicted on Sandy's oldest brother Adam, and when he reached 18 years of age he left home to join the army. He returned home for a visit, and following a severely violent fight with his father, Adam committed suicide.

After Adam's death, Sandy's parents grew more depressed and withdrawn. Eva lost interest in caring for the family and Peter became more seriously alcoholic and abusive.

A few years later, the entire family moved to Winnipeg, where problems with poverty and abuse continued. Teachers from schools the children attended failed to recognize or respond to visible indications that the children were abused at home, so once again Child and Family Services was not alerted.

Sandy was threatened both verbally and physically by her father not to tell anyone about his abusive behaviour, so she did not risk disclosure. For example, when Sandy arrived late for kindergarten class because of sexual assaults from her father, her teacher rebuked her for being disorganized and tardy. Sandy accepted the blame without defence.

In Sandy's high school years, she became sexually active with peers, and began to drink alcohol and use drugs frequently. When she graduated from Grade 12, she married her boyfriend, Tony.

Tony and Sandy, were married for 22 years and had three children: Susan, age 17; Daryl, age 14, and Kevin, age 11. Tony was self-employed as a building subcontractor. Sandy worked in an office, performing clerical duties.

Presenting Concerns

During the assessment interview, I was immediately aware of Sandy's anxiety. She described feeling nervous about coming for counselling and feeling afraid to talk about her childhood. As Sandy spoke she began to display nervous habits, such as wringing her hands and staring down at the floor. The more she talked, the more nervous she became. Her voice began to tremble and her hands began to shake. In a few moments, Sandy's entire body was shaking so severely, she was almost to the point of convulsion.

I was very concerned with this behaviour, and yet when I inquired if my client was okay, she did not seem to be aware of the fact that she was trembling from head to toe.

At this point I recalled my experience of discomfort when the affect of my previous client, Beth, did not reflect the fear and anxiety she was

experiencing on the inside. Beth's situation had presented a disquieting incongruence. However, my emotional reaction to Sandy's trembling, which was quite congruent with her affect, was in no way less pronounced. Therefore, I concluded that a counsellor will not necessarily feel "better" if there is congruence within a client's description of emotion and her external presentation.

At one point in my interview, Sandy seemed to enter a trance-like state (she closed her eyes and allowed her head to droop). Occasionally, her upper body would jerk and contort, while her eyes twitched. In trance Sandy displayed other behaviours that seemed out of character for a forty year old woman. For example, she sat in her chair in such a way as to prevent her feet from reaching the floor as she swung them to and fro. She also twirled several strands of hair around her right index finger as she spoke, or pulled her hair in front of her face, until her face was no longer visible.

At this time I began to suspect that my client was depicting the behaviour of a person much younger than her chronological age. I suspected from the manner of her speech as well as her own reports of

feeling as though she became someone else from time to time, that Sandy struggled with a fragmented personality.

My concern with proceeding further with Sandy involved two factors:

1 Was I skilled enough as a therapist to provide useful treatment to a client with complex symptoms of personality fragmentation; and

2 Was there enough time in my six-month placement to establish the safety and trust necessary to engage this client?

I consulted with my supervisors, on separate occasions to request their advice.

My agency supervisor agreed to view my second session with Sandy from behind a one-way mirror so that she might help me assess the possible diagnosis of multiple personality or severe dissociation and splitting. Sandy granted her permission that my supervisor would view our session from behind a one-way mirror. During this session Sandy demonstrated a brief trance like state, then began to display behaviours of a child while speaking to me and answering my questions.

At the conclusion of this interview, my supervisor offered her agreement with my assessment that Sandy exhibited personality fragmentation and may in fact have behaviour consistent with multiple personality disorder. She also advised me that while Family Centre does not refuse counselling service to multiple personality clients, treatment provided by this agency does not involve the psychological regression of clients as part of the therapy process. In other words, therapists at Family Centre do not deliberately attempt to separate the various personalities within individuals as a way of facilitating healing or resolution of abuse. Instead, therapists work with clients as whole persons, recognizing that some parts of clients are more or less connected to feelings and memories from the past.

My supervisor recommended that:

1 I continue to work with Sandy, (if she was indeed willing to proceed);
2 I keep my supervisor informed through regular consultation;
3 I keep therapy at a suitable pace for my client; and
4 I monitor my client for signs of suicidality.

When I explained the nature of my concerns with proceeding further with this client to one of my other supervisors, she challenged me to view these clients as very creative individuals rather than as persons with a personality "disorder" or "defect." She suggested to me that clients who demonstrate on the outside what they are feeling on the inside have tremendous abilities to be creative in therapy. This "creativity" can be a powerful resource in treatment and healing. She reminded me that I must keep myself grounded in the present, because my client's ability to feel safe in session would be directly influenced by my ability to stay calm and confident.

Description of the Client/Therapist Contract

Sandy and I agreed to meet once each week for a period of at least six months, unless Sandy believed she required less time in therapy.

Sandy expressed a desire to discern and accept truth concerning abuse in her childhood, however, she felt confused by her memories and feelings and suspected that she may have fantasized her flashbacks.

My client also expressed a desire to remember details of her abuse so that she could accept it. She thought that accepting the truth might depend on her ability to know her abuser and recognize his face during flashbacks.

I suggested to Sandy that she might not discover the truth concerning the identity of her abuser in therapy. In fact she might not recover any memories other than those she already had access to. I assured her however, that it was possible that she might access more memories, since this has happened to her already while talking to her doctor. I added that I hoped Sandy would gain increased control over flashbacks and understand their purpose as well as their content.

My client wanted to improve her relationship with her husband, and hoped that she would stop attacking him for no apparent reason. She also wanted to engage in sexual activity with Tony, without panic and hysteria.

Sandy also expressed a desire to be a better mom and restore her children's confidence in her. This meant that she wanted to spend less time alone, less time in bed, and she wanted to have more active involvement in recreational activities.

I also suggested that therapy might assist Sandy in accepting the fact that she was not responsible for her abuse. I explained that finding acceptance for what really happened, and discovering that she was powerless to stop it, might improve her self esteem. Improvements in self esteem might help to restore self confidence, which might have positive impact on relationships at home and in the work place.

Although it was clear in my mind that I would avoid the deliberate use of regression techniques designed to address individual personality fragments and issues related to them, I did not explain this to my client. At this point in our contracting, I did not know the extent of Sandy's awareness of her own dissociative tendencies, and I did not want to complicate the situation by describing symptoms of multiple personality fragmentation. I decided to wait until Sandy and I were more familiar with each other before I would address this topic with her.

Description of the Intervention

The first few sessions following the initial assessment interviews were used to establish rapport between myself and my client. Sandy continued to show anxiety while highlighting information regarding her family and its

history. During this phase, I used a very calm and gentle tone of voice to validate feelings Sandy identified, and nodded my head to signify my understanding and support for her.

Throughout most of these sessions Sandy avoided eye contact. She regularly initiated her own trance and depicted behaviours of a childlike character. In trance, Sandy demonstrated a range of emotions, such as fear, shyness, anger and confusion. Many of these emotions surfaced as Sandy described memories of abuse. For example, when one childlike part disclosed, another part would angrily interject, cussing and accusing the previous speaker of telling lies and making all of this up.

Sometimes Sandy invited herself out of the trance and spoke to me in what I believed was her core self. This part seemed to feel confused and concerned, and did not know what to believe concerning abuse in her childhood. When Sandy made this comment, I asked her to consider how the small, childlike part of her felt when she heard her say that she did not know whether to believe the memories, and suspected she made it up.

Sandy's response to this comment was slow and contemplative. She said she believed that her child-self felt hurt, angry and wanted to hide when she heard herself say that she did not believe.

Each time Sandy identified a feeling state, I praised her and validated the feeling. These assuring comments began to assist my client to feel safe with me and less anxious about coming to the office. By the fourth session, Sandy had significantly reduced the trembling of her body, and once in a while (although somewhat rarely), Sandy looked at me and quickly looked away.

Before the end of each session, I tried to assure that Sandy was as connected to the present as possible. This task included asking Sandy to describe the furnishings of the room, and describe her plans after leaving the session. Sometimes Sandy took the initiative to walk around the room or fiddle with the contents in her purse, while I asked present-focused questions. It appeared to me that Sandy was feeling or touching items in her purse almost ceremoniously before leaving, and I complimented her for knowing how to make herself ready to leave the room.

Sandy seemed shy and somewhat resistant to receiving praise and compliments, therefore I was careful not to overwhelm her with these comments. I attempted to use body language and a tone of voice that gave out a consistent message of genuine interest and patience. When I could congratulate and compliment Sandy, I always backed my comment up with reasons why I thought she was strong, courageous and wise. These additional statements also served the purpose of providing information about child abuse and the common effects experienced by children and adults who were abused as children. For example, I said, "Good for you for having the courage to tell me what happened that day. Many people have tremendous difficulty giving words to frightening experiences like that, because they are afraid something might happen to them or someone else they love, as a result. I am really encouraged by the fact that you shared this with me, because I think that a big part of you knows that it really wasn't your fault, and that you have a right for safety and protection."

The childlike part of Sandy's personality seemed very ready to share with me feelings and memories she held from the past. The core self of my client also expressed trust and comfort with our sessions. The other part, that accused Sandy of lying and making up stories, openly expressed

hostility toward me, and refused to answer questions designed to engage her further and to learn what she felt besides anger.

When Sandy refused to answer my questions, I validated her choice and assured her that she could control what she said or did not say in session. I congratulated her for knowing when to speak and when to remain quiet. Eventually, either the "hostile" part of Sandy's personality would say something harsh or cruel about the "victim" self, or her "core" self would resurface.

The first five sessions, including the two assessment interviews were the beginning phase of my therapy with Sandy. In the beginning phase we established trust and familiarity with each other, we negotiated goals and rules for the process, and we established safety for my client.

Some of the feelings Sandy identified during this phase were:

- confusion concerning what really happened, and who perpetrated the abuse;
- doubt, anger and disbelief regarding memories;
- guilt for not finding a sufficient hiding place or stopping the abuse;
- rage and fantasies of stabbing her abuser (sometimes fantasized during sex with husband);
- distraught and concerned over the damage or effect her condition had on Sandy's children and her relationship with spouse.

Toward the end of the beginning phase, Sandy suspected that her abuser was in fact her father, however she was not able to accept this completely.

During the middle or treatment phase of therapy with Sandy, I continued to gauge the content of sessions and the pace of therapy according to issues Sandy brought with her and her readiness to explore her thoughts, memories and feelings.

Sandy usually spent the first few minutes of each session in what I continued to believe was her core self. At these times, Sandy's facial expressions included frowns, down cast eyes, and nuances of smiles and sometimes laughter.

As I responded to Sandy's report or description of periods following our sessions, Sandy seemed to use my voice as a cue. The cue seemed to initiate a change in Sandy's behaviour which would set the tone for a change of pace for the session. This behaviour involved a shift in her chair or a few deep sighs. On a few occasions she stiffened or stretched her arms. She explained to me that the sound of my voice triggered a trance, and moments thereafter, she presented an image of her younger self.

My deliberate reaction to Sandy's splitting during sessions was not to react at all. I continued to speak in a consistent tone of voice and asked questions relevant to her current statements or in connection with

statements made during a previous session. Again whenever it was appropriate, I complimented or assured Sandy for retrieving a memory, understanding a theme or identifying a feeling.

Very soon after beginning this phase of the work, Sandy's childlike part began to surface more frequently and disclose more readily. During these disclosures, Sandy clearly implicated her father as perpetrator, and described clearly and confidently, his words and behaviour toward her. She explained that her father told her that he needed to teach her many things, including right from wrong, and also needed to show her in many ways that he loved her. Following these explanations, and sometimes during them, Sandy's father pinned her down and had intercourse with her.

Sandy disclosed the events of abuse using childlike language, thus revealing her confusion and panic. For example, she said "He got on top of me . . . he pushed down hard . . . that thing was in me . . . in and out, in and out . . . it was hard to breathe." Sometimes Sandy disclosed in the past tense and then shifted part way through, to a present tense, indicating to me that she was actually reliving the event. For example, following one disclosure of abuse, Sandy began to talk to herself. She said, "Don't cry . . . big girls don't cry . . . Don't tell your mom, she doesn't love you . . . She

told me to come up here and do this to you . . . I'll lock you in the parlour, in the dark, and you won't get out."

Using Dolan's guidelines for dealing with a client who has entered into crisis in session and is reliving a traumatic event, I reassured Sandy that she was not experiencing abuse at the present time. I comforted her with the fact that at present she was safe, and asked her what she needed but did not get, back when the abuse was occurring. Sandy responded favourably to my assurance that at present she was safe, although her face continued to reveal suffering, and tears continued to fall on her cheeks.

Reconnecting Sandy to the here and now allowed her core self to resurface. She stated that she needed her mom to come and save her and protect her from her dad. She added that in real life, her mom told her she was a liar, and accused her of having done something to deserve this.

While Sandy's victim self disclosed, her angry part often surfaced, uttering threats and name-calling. For example, she said, "I hate you . . . you are nothing but a stupid trouble maker . . . all you do is lie all of the time . . . I hate you . . . I hate you . . . You stupid disgusting little thing!"

While Sandy expressed her anger and repulsion toward her victim self, I thought of ways to restore empathy for her small victim self. I assured her verbally that it was not her fault that her father abused her. I reminded her that no one taught her that it was okay to say "No" to her dad. I taught her that parents do not need to have sex with their children in order to teach them right from wrong. I used Sandy's youngest child, Kevin, as an example, allowing her to explain to me that when he has done something wrong, he is sent to his room. When he has settled down, Sandy lets him out of his room and gives him a hug.

Sandy's core self had very little difficulty establishing empathy and compassion for her victim self. She also appeared to accept the disclosures as truth. However, in several of the sessions during the middle phase of therapy, the angry part of Sandy's character, seemed to personify her father's behaviour and attitude.

Several details of ongoing abuse resurfaced as Sandy and I continued to meet each week. Sandy implicated her brother as involved in the perpetration of sexual abuse against her. She added that her brother's abuse of her was forced by their father, since he would beat her brother if he did not do what he was told.

Sandy also described memories of her father whipping her dog with a skipping rope, almost to the point of death. She described her feeling of pain relating to this as more intense and stronger than if she were to stab her self in the chest with a knife. She wept as she told this story, and rocked herself back and forth in her chair.

When Sandy disclosed the details of her abuse, I insisted on keeping myself grounded in the present, and somewhat distant from the pain. I restricted myself from showing the painful emotions I was experiencing, so that Sandy would not feel the need to take care of or protect me. I assumed the role of witness to her pain, and made every attempt to soothe her with words of support and reassurance without violating her space and privacy.

At the same time, I did not want to keep myself too distant from her emotion and pain, because I did not want to give her the message that I did not care about her or was not moved by her story. This was an important balance to keep, and I usually needed to find some form of relief or support for myself at the end of difficult sessions. Self care for myself as therapist usually involved a debriefing with my supervisor, or taking a time out from my desk.

By the 14th session I noted that Sandy was spending more time in her core self each session before she split into another representation of herself. In this session Sandy remained in her core self for 25 minutes before she split off. Time spent in another representation of self was brief, usually four or five minutes.

In her core representation, she expressed concern for her husband. Sandy was afraid that Tony blamed himself for problems they were having, and she worried about what he thought about her when she displayed unusual and frightening behaviour. For example, she described situations where Tony would come home from work to find Sandy cowering in their bedroom closet.

I validated Sandy's concern and asked her if she thought it would be okay if I met with Tony, and helped him not to feel confused or responsible. Sandy agreed that I should meet with Tony, but she specified that she did not want to be present during this session. I suggested that she ask Tony to call me if he wanted to have an appointment. She agreed.

When Tony arrived for his appointment, I was struck by his mild manner and his genuine concern for his wife. Although he expressed a

strong commitment to their marriage, he was quite concerned and confused by her symptoms. I spent this session, validating Tony's concerns, and providing information to him about sexual abuse and the long-term effects on adults abused as children.

Tony was very receptive to this information, and expressed a strong desire to support his wife every way possible, so I provided him with some suggestions of how he might do this. For example, he could let Sandy have complete control regarding sex. This included whether to have sex, to select the style or techniques used, and to identify what conditions were to be met prior to, during, and after sex. I also suggested to Tony that he remain calm and composed when witnessing strange and unusual behaviour in Sandy. I instructed him how to respond in life threatening situations, securing safety first, and not to react with judgement or ridicule if he found Sandy hiding in the closet. He agreed.

Two weeks following this session with Tony, Sandy reported that her husband was helping her to feel more safe and supported at home. She told a story of him finding her in their bedroom closet one afternoon, and instead of sitting on the bed and trying to talk her out, he asked if he could

join her. Tony sat in the closet, holding his wife for at least five minutes before they withdrew.

Sandy often brought computer printouts of creative writing she did at home to session. Some of this writing was in the form of poems, where Sandy expressed her despair or told stories of things that happened. Other pieces were letters addressed specifically to me, telling me things she was either too frightened to tell me in person, or thoughts that came to her at night that she was afraid she would not remember in session. I expressed my appreciation for Sandy's written efforts and complimented her for her unique and creative style.

At this time, since Sandy was both used to and proficient at writing her thoughts and feelings on paper, I suggested that she try some writing techniques to express her feelings toward her parents. I described to Sandy the "healing Letters" as they are described by Bass and Davis (1988) and Dolan (in Winnipeg 1993).

In our first attempt, Sandy agreed to write a letter to her mother where she disclosed the abuse she experienced from her father to her mother. I suggested that Sandy might want to express in this letter what

she needed from her mother at that time and how she felt when her mother either refused to believe her or blamed her for what happened. I reminded Sandy that this letter was not to be sent to her mother, even if she thought she might like to send it. Sandy agreed that we would discuss the idea of actually confronting her mother before she would actually do it.

Sandy wrote a letter, and the tone of it revealed a soft gentleness of spirit, even though she expressed some disappointment that her mother did not actively protect her from abuse or believe her when she disclosed. She also expressed love for her mom, and apologized to her for feeling afraid of her in the past.

Sandy also wrote letters to herself, as though they were from her mother: 1) where her mother responded in the way Sandy feared most; and 2) where Sandy's mom responded in the way Sandy wanted and needed.

Sandy reported feeling a desire to reconnect with her mom (who presently resides in Ontario) after writing these letters, not to disclose abuse or confront her mom, but just to reestablish contact.

In one session, Sandy also wrote a letter to her dad; in this letter she allowed her victim self to emerge, and she expressed her fear of him and her anger toward him.

It was interesting to note that in this letter, Sandy began to write from her core self. She used a mature handwriting and sentence structure. However, as her letter progressed, there was a noticeable change in her penmanship that reflected a gradual splitting. Her handwriting changed . . . letters became bigger and less controlled. Her sentence structure also changed and she made spelling errors. In the second page she referred to herself as "us" and "we". She printed words rather than writing them, and her words reflected a more childlike manner of speech.

Even after Sandy completed the letter exercise to her father, she continued to use pen and paper to express herself. She drew scary pictures of herself and her father, and included words to describe the drawings. She also drew herself as an adult, holding herself as a baby. She drew a heart shape to enclose these images.

In her core self, Sandy expressed that she had an image of herself as existing in a bubble, where various personalities lived. She described this

"shared space" as chaotic, and her answer to the "miracle question" was that she and her child self would escape the bubble and live together. In this way, Sandy would support and protect the child self, and she would not "act out" any more.

When I asked Sandy to explain what she needed to break free from the chaos, she explained that her child self needed to feel trust for her adult self. She added that trust would follow, if she knew that the adult self believed her story. Sandy stated that she already believed the story, but she needed to be sure that it was not her child self's fault.

I used scaling questions to assess how close Sandy was to recognizing that she was not to blame for the abuse. Using a scale from 1 to 10, where "1" represented the belief that Sandy was completely responsible for the abuse, and "10" represented the belief that she was not responsible at all, Sandy described herself as being at a "2". Using the solution focused model, I asked Sandy what might help her to move along the scale toward the "10" and she explained that visualizing herself as a small child brought her to a "2.5". With a little more encouragement, Sandy added that she was able to move to a "3" when she considered the fact that no one taught her that she could say "no" to her father.

At this point Sandy began to blame herself for being so available to her father at night . . . she thought she should have found a better place to hide other than under her blankets. I suggested that Sandy consider the bedtime ritual in her present home. I asked her if she thought her youngest boy was being a good boy when he listened to his parents and went to bed at night. Of course Sandy indicated that she liked it when Kevin went to bed without a fuss or argument. I suggested to Sandy that it was reasonable for her to want to please her parents and be a good girl by obeying them at bedtime. With some encouragement Sandy shifted to a "3.5" by remembering that she was trying to please her parents with obedience. However, she continued to refer to herself as stupid for being in bed when she heard her father coming up the stairs, even though she explained that she could not leave her bed and hide because there was no heat in the house and she needed to keep warm.

I suggested to Sandy that she think about her son Kevin once again. I asked if he thought about whether or not it was safe to be in bed. Sandy quickly explained that Kevin did not have to worry about sexual abuse when he went to bed, so of course it did not occur to him to think about "safety in bed". I asked Sandy why Kevin did not have to worry about abuse

when he went to bed. Sandy explained that she and Tony would never abuse their children, and would always work toward keeping them safe. I congratulated Sandy for recognizing her responsibility as a parent to keep her children safe from abuse, and added that it was unfortunate for her as a child that she did not experience the same level of protection from her own parents, as she and Tony were able to provide. At this point Sandy arrived at a "5" on the scale, and I praised her for this accomplishment. At this time I put the scaling questions aside, feeling convinced that the move from a "2" to a "5" was a remarkable distance for my client to travel in one session.

At this time an "angry" part of my client surfaced and began calling herself names, accusing herself of telling lies and telling her childlike self to go away. I responded by acknowledging the angry emotion and reassuring my client that it was not necessary to banish parts of the self. She might feel relief if she understood her internal parts better. I asked Sandy if there was something her angry part needed from her victimized, childlike part in order to understand, and perhaps accept this part more easily. Sandy said, "I want her to understand that Dad did nice things for me, played with me, spent time with me. I need her to talk about some of the nice things Dad did."

I complimented Sandy for stating clearly what her needs were, and commented that each of her parts held important memories of her father that could be shared within herself. Sharing memories with interacting parts would enable Sandy to access a more accurate and more complete image of her father, so that she will no longer view him as totally blameless or totally harmful.

In concluding this very difficult session, I asked Sandy to tune inward and ask herself if the part of her that remembered the abuse could also remember some of the nice things her father did for her. Sandy explained that she could not remember anything pleasant at that time, but she would continue to try after she left.

During the middle phase of therapy, Sandy sometimes entered into a state of emotional crisis where she began to actually relive her trauma both during and after sessions. It was difficult to keep the pace of disclosure and memory retrieval at a minimum, especially when Sandy became depressed.

On two occasions that I know of, Sandy actually stopped taking her antidepressant medication, and her suicide ideation became more advanced. She began to plan for death. She shared thoughts with me of purposefully

crashing her car during high speed driving. On another occasion, she locked herself in a bathroom while holding a sharp butcher knife.

During suicidal crises, I focused our work on keeping my client alive, as opposed to continuing on with the exploration of memories and feelings associated with abuse. I asked Sandy to think about her family and things she liked to do with them. I reminded Sandy of items she identified earlier as "associational cues for comfort and security" (Dolan, 1992). I also explained to my client that if she continued to refuse the use of medication, I would be forced to negotiate various ways of keeping her safe with her husband. For example, we might need to explore the option of hospitalization and the termination of therapy, until such time as she was ready to proceed without harm to herself.

Sandy responded favourably to limits I established during emergency crises, even though I felt uncomfortable with setting them. For example, Sandy started to relive her trauma during the session one day. She dropped to her knees and began to moan and crawl and beg her father to stop. At this time, I gently reminded Sandy that she was not experiencing abuse at the present, and that she needed to focus her thoughts on her "video cassette" (symbol associated with comfort and security) and proceeded to

remind her of the pleasant memories she stored on the video. Sandy began to reconnect with the present, and we discussed what she needed during the trauma she had revisited that she did not have access to at the time in which the trauma occurred. We also discussed the importance of keeping balance between memories from the past and present, and between recollection of pleasant and painful feelings.

When Sandy's depression became life-threatening, it became crucial to use whatever was necessary and available to keep her from taking her own life. Sometimes this involved consequences that seemed to threaten my client. For example, she feared hospitalization, and she also hated it when I met with Tony because she thought that he was telling me horrible things about her. Perhaps Sandy's fear of hospitalization and her worry about Tony telling me stories about her kept her from following suicide plans through. Perhaps she did not want to leave or hurt her family, or my client simply wanted to live. Any combination of the above factors may have contributed to Sandy's decision to live. I learned from this experience that:

1 for some clients, the use of medication is vital,

2 the pain and trauma experienced by some clients may become life-threatening and in these instances,

3 therapists have very little power, and must be creative in finding ways to keep clients safe.

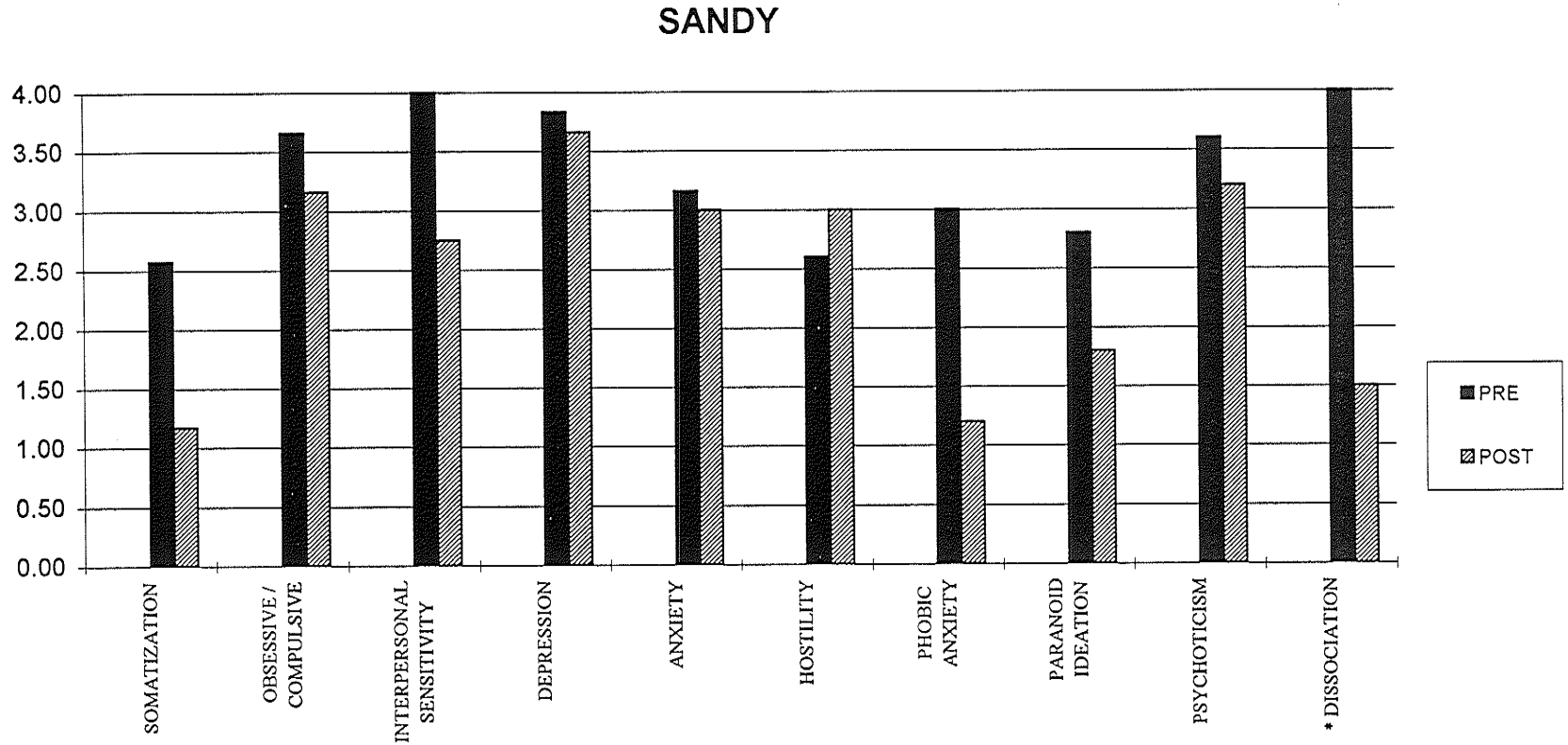
During the treatment phase of therapy I also used Dolan's (1992) concept of a "symbol for the present" to assist my client to stay present during sexual intercourse with her husband. Sandy's learned behaviour to dissociate was so powerfully strong that she frequently split off from her adult self during sex. She explained to me in session, and to her husband at home, that if she were to focus on her wedding rings (a symbol associated with her adult self) during sex, and have Tony call her name as well as state his own, she might be able to avoid hallucinations, and stay present without panic. Sandy had some success using this technique, however, she was not always able to "dissociate from her memories" and have sex without trauma.

When the end of March drew near, Sandy and I discussed the options of continuing therapy or taking a break. Since I established a short-term employment contract with Family Centre, I was able to offer Sandy a

continuation of sessions without transfer to another therapist. Sandy expressed relief at not having to end therapy even though my Practicum project was complete.

The ending session with this client involved post-testing and a verbal evaluation from Sandy concerning what she found useful during our six months of work together. Sandy and I met for 2 1/2 months following the closure of this project. When we terminated therapy, Sandy was registered to attend an intensive short-term group therapy project offered through the St. Boniface Hospital for individuals experiencing acute and chronic anxiety.

Figure 7. BRIEF SYMPTOM INVENTORY (BSI)



* Dissociation is not part of the BSI Symptom Construct. It is included here as information pertinent to client population.

Pre and Post-Test Scores (Figure 7)

When Sandy began therapy, her general severity index score was at least two standard deviation units higher that the normative scores of an inpatient sample. She struggled most with interpersonal sensitivity, depression, obsessive/compulsive tendencies and psychoticism. Her difficulties in relationships with others were hampered by a belief that something was seriously wrong with her. She believed that people would be able to discern from her outside presentation, that she was sexually abused, and emotionally disturbed. Consequently, she was not unlikely to engage in casual conversations at work, or in any other situation where she came in contact with others.

Sandy's scores in depression and anxiety were consistent with her previous diagnoses from psychiatrists and doctors, who treated Sandy with antidepressant medication. Her depression became life threatening at times and, more often than not, depression kept Sandy fixed in a state of hopelessness and despair concerning her marriage, family, career and physical appearance.

Sandy scored extremely high in dissociation, which was consistent with her lapses in memory and in her splitting off into various personality fragments.

Her pretest scores from the ISE were indicative of low self esteem, which seemed consistent with her difficulties accepting herself and understanding why she behaved in ways that seemed so "crazy" to her. The low self esteem would logically follow beliefs that something was inherently wrong with her and supported her belief that she was a terrible wife and mother.

Sandy's post-test scores showed the most dramatic improvement in the areas of dissociation, somatization, interpersonal sensitivity and phobic anxiety. Some of these changes were evident in feelings and behaviours Sandy reported or demonstrated. For example, Sandy remained in what I believed was her "core self" for longer periods of time, before she split off. This demonstrated some of the renewed control she gained over her symptom of dissociation.

Sandy reported going to the circus with her family, to a hockey game with her son, and to a gathering prepared for extended members of her

husband's family. Perhaps Sandy and her family enjoyed these activities because Sandy's symptoms were diminishing. Sandy was not ill, or in bed with a headache, "mom" did not suddenly panic in a crowd, nor did she seem far off in her mind.

One aspect of Sandy's post-test scores that I had difficulty understanding had to do with self esteem. Sandy's post-test showed very little change in her problems with self esteem, even though there seemed to be signs or indications to the contrary. For example she smiled more often in therapy, she laughed while sharing some stories, and she attended a few sessions wearing more vibrant colours than her usual choices of black, dark green, or grey.

Sometimes clients experience shame for having connected to or reclaimed memories and experiences from the past. Increased shame and guilt may have held negative impact on Sandy's self esteem, in spite of my efforts to mitigate these feelings in therapy. Unraveling the internalization of abuse and cruelty sometimes takes longer than the amount of time Sandy and I had to work with.

A Reflection of the Client's Evaluation

Sandy provided me with a verbal and a written description of her recognition of change and her evaluation of the usefulness of therapy. She admitted that she accepted and believed that she was sexually abused by members of her family, and that she could feel progressively better without reliving or remembering every detail.

Sandy recalled that before therapy, she could not use her father's name in a sentence about sexual abuse. She did not have the courage to name her abuser or to believe that the abuse was real. During and after therapy, Sandy was able to mention her father's name aloud in connection with abuse, and she explained that in her mind, this was a very big step.

She explained that she did not hear voices inside of her head as often as she used to. When she did hear voices, she felt more able to control them.

Sandy reported having days, sometimes several days in a row, when she did not think about her abuse at all. Usually, or prior to this counselling

experience, thoughts and feelings associated with her abuse were on her mind all of the time.

She also reported that sometimes her feelings of depression had nothing to do with her sexual abuse. "Sometimes my depression is related to life in general. This makes me feel more normal."

Sandy mentioned that she was able to see a light at the end of her tunnel. In other words, she felt more aware of hope for the future. She also described her ability to trust me as a vital sign that she was able to trust again.

A Reflection of the Therapists Learning

This case was difficult and challenging for many reasons. Sandy was a sensitive woman who struggled with complicating, frustrating and frightening symptoms. I, on the other hand, was inexperienced in work with clients who showed clear indications of personality fragmentation. I wondered how I could manage my limitations in the face of her disturbing symptoms without making the symptoms worse.

One of the most crucial factors contributing to the success of this intervention was my avoidance of medical or psychiatric depictions of "illness", usually associated with severely fragmented or multiple personalities. When I perceived and related to Sandy as a creative person who was capable of showing me the feelings and memories she stored, I was then ready to relate to her as a person, rather than an oddity.

I also learned that my use of language was very important in this case, particularly because it was so easy to "name" Sandy's internal parts and speak to them as though they were separate persons. Sometimes I clumsily used names such as the "nine year old" or the "angry part" which may have encouraged and reinforced my client's ability to keep her parts separated rather than integrated. I found it cumbersome but possible, especially toward the latter months of working with Sandy, to talk to "Sandy" as a whole person with various internal parts that held memories and felt emotions relating to Sandy's past, present and future.

CHAPTER 5

CONCLUSIONS

This project was successful in meeting all of the goals and objectives that I established prior to its implementation. I developed a rapport with a wide range of individuals, all of whom were sexually abused during childhood, but were at different stages of disclosure and recovery. The range of long-term effects associated with sexual abuse varied from one individual to another; some clients had more issues and problems to resolve than others (see table 1). When I reflect upon them as a group, their symptoms provide a clear representation of most, if not all of the common effects associated with childhood sexual abuse.

Individuals participating in this project were at different ages and therefore, different stages in their life cycle. Some participants were single, some were heavily involved in relationships and careers, others were married with children, while others had adult children and grandchildren. The stage of each client in terms of their life cycle likely held some impact or influence in the reasons for seeking therapy and the goals that were formed when therapy began.

Each participant had a different family background, with different values and belief systems, which may have contributed to useful and destructive methods of coping with childhood trauma and other difficult obstacles. For example, Debbie and Liz described their mothers as alcoholics who used to drink in order to escape or numb themselves from problems, stress and pain. Debbie and Liz also referred to themselves as alcoholics and they both attended Alcoholics Anonymous meetings regularly.

Janice, Sandy and Beth described themselves as having a parent with a mental illness. Janice and Beth had mothers who were diagnosed and treated for schizophrenia, and Sandy recalled her mother's reference to her father as having a multiple personality disorder. All three of these clients demonstrated mild to acute forms of dissociation or personality fragmentation.

Fredrickson (in Winnipeg, 1993) explained her belief that genetics play a role in the range of effects or problems individuals experience in relation to their trauma. She explained that people have a predisposition to the development of mental illness such as multiple personalities or borderline personalities, and she also stated that it is possible that people have a genetic predisposition to alcoholism and drug addiction. She referred to this predisposition as a "genetic fault line". Fredrickson (in Winnipeg, 1993)

explained that most individuals have some form of latent weakness that is passed down through the genes, that will likely manifest itself, in response to trauma.

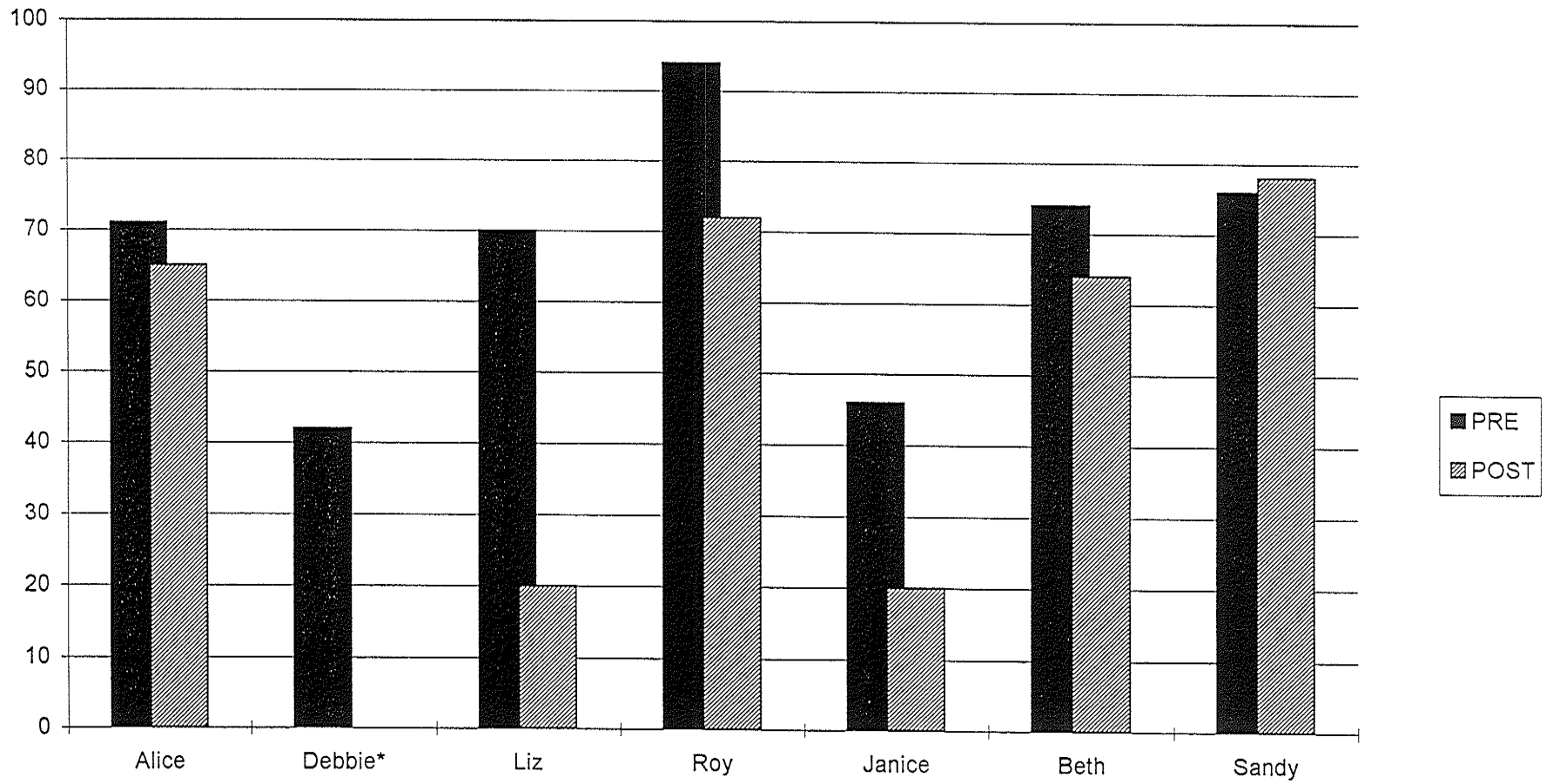
In reference to some of the individuals involved in this project, symptoms of alcoholism, drug addiction, dissociative disorders and personality fragmentations seem to be passed down from one generation to the next. On the surface, this may appear to support Fredrickson's ideas concerning the "genetic fault line." However, I am inclined to view this pattern as learned behaviour, based on my belief that social and familial forces are powerful influences that shape individual responses to pain and trauma.

Another powerful statement concerning the outcome of this project involves the concept of resiliency. Participants shared their perception of themselves during childhood, as having limited resources for support and nurturance. In some instances, clients had one parent who inflicted abuse, and another parent that seemed indifferent to the cruelty and refused to intervene. Others reported being physically abandoned by one parent and mistreated by the parent left behind. These individuals were not raised by their parents in a manner that fostered healthy self worth and self esteem. Each person perceived the power to effect positive change in their lives as existing outside of

themselves, and this belief hindered their ability to reclaim control over their situation and their problems.

All of the clients involved in this project reported feelings of low self esteem. Some clients, however, seemed to have more difficulty than others. Those that struggled less with self esteem also seemed to have more hope for their future. For example, Debbie and Janice seemed to have the least amount of difficulty recognizing their strengths and building their confidence, and this, of course, was reflected in scores taken from the ISE. Valentine and Feinhauer (1993) would likely attribute the supportive relationships these clients have or had, as factors that minimized the damage to their self esteem.

Figure 8. HUDSON INDEX OF SELF ESTEEM



For example, positive influence and support was provided by a grandfather in Debbie's life, and a grandmother in Janice's. Debbie also felt significantly influenced and supported during her stay with a particular foster family, while Janice received meaningful help and support from a therapist during her hospitalization in a children's psychiatric ward. During therapy, both Debbie and Janice enjoyed sharing memories of love and support they received during childhood.

The symptoms of depression and interpersonal sensitivity, which were measured by the BSI, were shared by all participants with some indication of severe difficulty. Derogatis (1982) states that "the interpersonal sensitivity dimension centres on feelings of personal inadequacy and inferiority, particularly in comparison with others. Self-deprecation, feelings of uneasiness, and marked discomfort during interpersonal interactions are characteristic manifestations of this syndrome" (p. 12).

Derogatis (1982) adds that "the symptoms of the depression dimension reflect a representative range of the indications of clinical depression. Symptoms of dysphoric mood and affect are represented as are signs of withdrawal from life interest and lack of motivation. In addition, feelings of

hopelessness, suicidal ideation and, other cognitive and somatic correlates of depression are included " (p.13).

While not all of these clients struggled with alcoholism, drug addiction, dissociation, sexual disinterest or promiscuity, all of them seemed to struggle to some extent, with symptoms of depression and interpersonal sensitivity. These findings seem to support the previous findings that most survivors of sexual abuse encounter difficulties with low self esteem and depression (Briere & Runtz, 1988; Jehu & Gazan, 1983).

I conclude from these findings that individuals with a history of sexual abuse may internalize their abuse as some defect in their person and their self worth. This belief will impact their relationships especially when individuals accept the idea that they are inferior to others and struggle with feelings that others dislike them. One might recognize a path or link between this belief system and depression. Self-deprecation and inferiority may easily give way to a withdrawal from life, a lack of motivation and feelings of hopelessness.

Although I did not succeed in the use of both models, with each client, I learned valuable information concerning the usefulness of knowing how and when to apply principles of various models. It has never been part of my value system as a therapist to follow any model with rigidity and inflexibility. Although an eclectic approach complicated the task of developing and reporting my Practicum project, I believe it was the most responsible method of providing service to clients which, of course, was my primary concern.

The purpose of the project involved my effort to match client needs with the most useful method of treatment. This goal depended upon my ability to listen carefully to clients, and my ability to integrate knowledge and skill in the use of treatment techniques. Unfortunately, my understanding of some of the Dolan's (1991) techniques was insufficient until half way through my Practicum. For example I believe that my work with Alice was not as successful as it could have been had I integrated my knowledge and practice of Dolan's (1991) solution focused techniques more fully.

I have reached the conclusion that therapists will always have room for more knowledge and more skill development. The idea, however, is not to abandon one model for a new one, as one might trade an old car for a newer model. In my opinion, therapists work toward their highest efficiency when they develop an understanding, appreciation and ability to apply the principles and ideas of numerous models. Borrowing useful ideas from one model may build or strengthen the usefulness of another.

In conclusion, I will not support the idea that treatment for survivors ought to focus primarily on past memories and abreactive techniques, just as I will not express a view that solution focused models are the most appropriate method for approaching recovery. I maintain that an eclectic approach to therapy, by virtue of its inherent flexibility, is more likely to match the unique and individual needs of clients and their particular stages of disclosure and recovery.

TIMING, AND THE USE OF THERAPY MODELS IN TREATMENT FOR SURVIVORS

Dolan (1991) explains that during the first session, clients should be given as much time as they choose to describe their abuse and talk about the problem. However, she also states that the beginning interview should include a balance in focus between what is distressing for clients and what is going well. For example, she highlights the First Session Formula Task (p. 35-36) as an exercise where the client is asked to list and highlight aspects of his/her life that the client would like to continue. Therapists can frame the items on this list as signs that his/her recovery has already begun, and that the client's life involves experiences and feelings outside of the pain and trauma associated with abuse.

In theory, I support Dolan's idea of preserving some time during the first session for highlighting pleasant memories and feelings. In most instances, however, I have not found it useful to do this in the first session. For example, my first session with Sandy was very difficult. She did not have a basis for trusting me, or for trusting herself, especially in context with her flashbacks of abuse. She felt nervous and vulnerable and trembled from head to toe. Consequently it did not make any sense to me to flip our focus from the

distressing to the pleasant and begin to ask questions about what was going well in her life. I was afraid that if I had used the first session formula task in the first session, Sandy may have thought that I was out of touch with her or worse, colluding with her or others in maintaining denial.

In most of my first sessions I gave clients a brief message that I believed that there were positive aspects involved in their past and present lives, and as we got to know each other better, I would ask for more information regarding this. In the beginning, however, I hoped to establish some trust with my clients, and ensure them that I understood and validated their purposes for therapy.

I found that with most clients, I used solution-focused techniques toward the middle or ending phases of therapy. Toward the ending phase, Herman (1992) says that, "having come to terms with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self" (p.196). In my opinion, this is the stage of therapy when it makes the most clinical and logical sense to ask questions the client, concerning aspects of life that he or she currently enjoys and would like to have continue.

In the final phase of therapy, Sgroi (1988) says, "what remains in the recovery process is to move beyond: to see oneself in a multidimensional perspective . . . Relinquishing a survivor identity also means the person is ready to take responsibility for his or her own present and future happiness . . ." (P. 128-129). I believe that it is in this context of therapy that therapists have an appropriate opportunity to explore with the client, "what he or she would be doing differently when sexual abuse has less of an impact." I also think this is a useful time to reflect on what significant others would indicate that their past abuse was having less impact. This is a good time to ask "constructive systematic and individual questions" as Dolan (in Winnipeg, 1993) described them.

I recognize that many solution focused questions assist clients to demystify the therapy process, and highlight the client's expertise in authoring goals and purpose for therapy. For this reason, I think it would make "theoretical" sense to incorporate these questions earlier than the middle or ending phase of therapy. However, once again I am not convinced that this is always wise, from a "practical" stance.

For example, when I was working with Beth, I did not ask questions early in our work, concerning what she would do differently if she broke

through the "brick wall"; or what her life would be like if she managed to "escape her father's world." It would be difficult to ask these questions without Beth's insight into the existence of the "brick wall" and her understanding that she felt stuck in her "father's meaningless world." Beth developed this insight toward the middle and ending stages of therapy. Would Beth have a basis for establishing goals for more stability and structure, if she had not increased her understanding of her current lack of it?

In some instances, I believe it would have been useful to employ solution focused ideas sooner than I did. For example, my effort to introduce some of Dolan's questions to Janice toward the ending stages of therapy, was fruitless. At this time, Janice was less motivated to continue the "work" involved with creating change in her life. She seemed annoyed with my questions, and wanted to return to a more casual and friendly form of discussing events. Perhaps what was lacking in this intervention was a clear structure or format for our sessions. A lack of structure may have contributed to the difficulties we encountered with keeping clear boundaries between client and therapist. An earlier introduction to the solution focused questions may have kept Janice focused on what she wanted to achieve through therapy, which may have guided her toward more accomplishments.

As I reflect on my sessions with Janice and Debbie, I am struck by the fact that although solution focused questions were not used with success, we did not really follow the abreactive models of recounting painful memories either. Much of our work seemed to involve tracking old patterns in current situations to see if something could be learned or improved with insight. I maintain my belief that if my clients had been willing to continue exploring these patterns, solution focused questions could have facilitated positive change based on the insight each client achieved.

IMPROVEMENTS FOR FUTURE INTERVENTIONS

I have learned from this experience, that it is possible to integrate some aspects of different therapeutic models even when the basic principles from each of the models seem to be in conflict. I also believe that the more experience therapists have using and integrating ideas, the more success he/she will have assisting clients.

One of the aspects of this project that I recognize as lacking, is clarity about the identification of the conditions that make the selection of one model's principles and techniques more suitable than those of another model. I do not believe one can devise a "treatment map" that can indicate when and

why a given technique is more or less useful for a particular situation, unless one intends to follow a specific model. de Shazer (1988) developed a "central map" that is used by therapists to guide the thinking and actions involved in the process of developing goals and solutions with clients. I do not believe however, that a map could capture the uniqueness and individuality of each case. In other words, it may be advantageous, to blend an insight oriented approach with solution focused therapy with one client, but that rule cannot be applied universally. I do not think we can create an overview of when and why to add to one model or abandon the next technique because each client situation is different. Each session, with the same client is different.

In closing, I would like to reflect on a pearl of wisdom shared with me by my primary supervisor. She said "Philosophically there is a difference between being true to a treatment model and being true to a client's uniqueness. The capacity to integrate both streams of intervention does grow with experience, but it can also rigidify in one direction or another, over time."

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July 7, 1995

Ms. Darlene Archer

Winnipeg, Manitoba

Dear Ms. Archer:

We understand that you purchased the Brief Symptom Inventory™ (BSI®) instrument from Multi-Health Systems, Inc. for use in your Practicum entitled, "Short-term Therapy for Adult Survivors of Childhood Sexual Abuse." We appreciate your use of this instrument. NCS is pleased to hereby grant to you permission to reproduce up to three (3) items from the BSI test to be used as examples in any publication you author in connection with the above-referenced research project.

Best wishes in your Practicum.

Sincerely,

Patricia A. Elias
Sr. Contracts Specialist

cc: Virginia Smith
Elisa Ship, Multi-Health Systems, Inc.

APPENDIX 1

Bloom and Fischer (1982), state the following:

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