Co-creating Treatment for Women Survivors of Child Sexual Abuse: A Time Limited Approach

A Practicum report

presented to the Faculty of Graduate Studies

The University of Manitoba.

In Partial Fulfilment of the

Requirements for the Degree of

Master of Social Work.

by

Margaret Tamara Dicks

Department of Social Work

University of Manitoba

Winnipeg, Manitoba

1997

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

CO-CREATING TREATMENT FOR WOMEN SURVIVORS OF CHILD SEXUAL ABUSE: A TIME LIMITED APPROACH

BY

MARGARET TAMARA DICKS

A Thesis/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

TABLE OF CONTENTS

ABSTRACT iii

ACKNOWLEDGEMENTS iv

LIST OF FIGURES v

CHAPTER 1
INTRODUCTION

Overview 1
Purpose of the Practicum 2
Learning goals of the Student 2

CHAPTER 2
LITERATURE REVIEW

Definition of Sexual Abuse 4
Prevalence of Child Sexual Abuse 9
Causes of Sexual Abuse 13
Long Term Effects of Child Sexual Abuse 18
Post Traumatic Stress Disorder 34
Overview of Treatment Models 39
Retrospective or memory based abreactive models 40
Solution Focused Brief Therapy 50
The Dynamic Co-Creative Healing Model 59

CHAPTER 3
PRACTICUM PROJECT

Clinical Setting 78
Participant Selection 78
Duration of the Practicum 79
Committee Members 80

Methodology 80

Initial Telephone Contact 82

In-Person Screening Interview....84
Second In-Person Interview....87
Evaluation Instruments....87

CHAPTER 4
CLIENT CONTACT....94

CLIENT A-Anna....94

Client biography....94
Description of the Difficulty....96
Presenting Issues/Concerns....97
Goals....98
Treatment Process and Intervention Strategies....100
Pre-Test and Post-Test Scores....113

CLIENT B-Lucy....115

Client biography....116
Description of the Difficulty....118
Presenting Issues/Concerns....119
Goals....120
Treatment Process and Intervention Strategies....121
Pre-Test and Post-Test Scores....132

CLIENT C-Betty....135

Client biography....135
Description of the Difficulty....137
Presenting Issues/Concerns....137
Goals....138
Treatment Process and Intervention Strategies....139
Pre-Test and Post-Test Scores....143

CLIENT D-Tory....145

Client biography....145
Description of the Difficulty....147
Presenting Issues/Concerns....147
Goals....148
Treatment Process and Intervention Strategies....149
Pre-Test and Post-Test Scores....161

CLIENT E-Jill....163
Client biography....163
Description of the Difficulty....165
Presenting Issues/Concerns....166
Goals....166
Treatment Process and Intervention Strategies....167
Pre-Test and Post-Test Scores....177

Client F- Sabrina....180
Client biography....180
Description of the Difficulty....181
Presenting Issues/Concerns....181
Goals....182
Treatment Process and Intervention Strategies....182
Pre-Test and Post-Test Scores....185

CHAPTER 5

CONCLUSION
Learning of Student Clinician....188
Effectiveness of the Dynamic Co-Creative Healing Model....199
Time Limited Therapy....201
Reflections of Practicum Project....203

REFERENCES....206

APPENDIX A....215
APPENDIX B....216
APPENDIX C....217
APPENDIX D....218
APPENDIX E....219
APPENDIX F....220
APPENDIX G....221

ABSTRACT

The title of this practicum report is "Co-Creating Treatment for Women Survivors of Child Sexual Abuse: A Time Limited Approach". The purpose of the practicum was to develop skills as a therapist in working with women survivors of childhood sexual abuse. The participants experienced a variety of symptomatology and were at different stages of their healing processes. All but one of the six women volunteered to participate in the practicum.

I chose the "Dynamic Co-Creative Healing Model (DCCHM) (Bell-Gadsby and Siegenberg, 1996) as the framework from which to develop my skills as a therapist. The DCCHM takes an Ericksonian solution-focused approach in working with survivors of childhood sexual abuse. The practicum was time limited and I utilized techniques from other sources (Dolan, 1991) in order to effectively meet the needs of each client.

The Beck Depression Inventory, the Beliefs Associated with Childhood Sexual Abuse, the Trauma Sequelae and the non-standardized Solution-Focused Recovery Scale for Survivors of sexual abuse, were used to evaluate the women's progress at pre- and post-testing. In addition each woman was invited to discuss her progress at various intervals within the practicum process.

ACKNOWLEDGEMENTS

I would like to extend appreciation to all of my committee members in assisting and supporting me through the trials and tribulations of this practicum project. It has been fruitful and has stretched me both professionally and personally. I would like to personally thank my advisor Shirley Grosser who graciously and generously offered her time and expertise to assist in my development. Many thanks to my second committee member Linda Perry for offering her time and expertise when my advisor was not available and to all my committee members, Kim Clare, Linda Perry and Shirley Grosser for reviewing and offering feedback on my report at various intervals of this project. The feedback was invaluable.

I would like to acknowledge my parents, Margaret and George Dicks. My parents have stood quietly but firmly in their support for me over the years and I am grateful to have them as my parents. I want to express gratitude to my husband Brett Deitzer who was immensely supportive of me during this entire project. Without his love and support this experience would have been much more difficult.

I would like to extend my appreciation to the Peguis Indian Band for their financial support, and for the support offered by my educational counsellors, Rhonda Olson and Bev Cochrane.

Lastly, I want to express my sincere appreciation and gratitude to the women who participated in this practicum project. Each one showing immense courage and strength despite their past experiences. I am honoured to have had the privilege of being a part of their lives, if only for a brief time.

Again, thank-you to all who made this dream possible.

THIS PRACTICUM IS

DEDICATED TO WOMEN EVERYWHERE

WHO HAVE SURVIVED CHILDHOOD SEXUAL ABUSE.

MAY THE GREAT SPIRIT GUIDE YOU ON YOUR HEALING JOURNEY.

List of Figures

Figure 1- Anna's (client A) Loneliness Scale.....103

CHAPTER 1

INTRODUCTION

Overview

The format of this report will begin with a brief explanation of why I chose to study child sexual abuse with adult survivors, and will follow with a brief description of the purpose of the practicum. I will then present my review of the literature as it pertains to defining child sexual abuse, its prevalence in Canada and the United States and possible causes identified from both feminist and child protection positions. In addition the review will highlight a range of theoretical positions regarding the long term effects of childhood sexual abuse, followed by a discussion of post traumatic stress disorder as a possible outcome of childhood sexual abuse. Finally an overview of treatment models utilized with adult survivors of child sexual abuse and a detailed review of solution-oriented models will be presented.

Following the literature review I will discuss the components of my practicum in more detail. This will include a brief introduction of my committee members and what their roles were during this project, the clinical setting, the criteria for selecting participants for the practicum, the duration of treatment, and the evaluation measurements utilized during the practicum. I will then present case studies of the participant's progress and conclude the report with a summary of what

the student clinician learned from the practicum.

Purpose of the Practicum

I believe sexual abuse is a common phenomenon in our world and as clinicians we will continue to come into contact with people who are living with the aftermath of sexual abuse, regardless of whether we choose to work specifically with this population or not. Therefore I believe we have a responsibility as "healers" to educate and prepare ourselves to meet this challenge.

I have chosen the "Dynamic Co-Creative Healing Model" (Bell-Gadsby & Siegenberg, 1996) as a framework within which to develop my clinical skills and increase my knowledge in providing treatment services to adult survivors of child sexual abuse. The treatment services were provided on a one on one basis to women who were sexually abused as children, and who requested service.

Learning Goals

The main goal I had established for myself during this practicum was to develop a deeper understanding of the complexities involved in assisting those who were sexually abused as children. Several goals, which addressed my main goal in greater detail, emerged. First, I wanted to develop knowledge concerning the long term impact of

childhood sexual abuse on adult women, and of the treatment approaches used in addressing the aftermath of childhood sexual abuse. Childhood sexual abuse can be traumatic (Herman, 1992) and therefore I wanted to develop an awareness of Post Traumatic Stress Disorder (PTSD) and its relation to childhood sexual abuse. In addition, I wanted to develop the ability to identify PTSD and respond appropriately to PTSD manifestations. In working with survivors, learning and utilizing a variety of techniques which were relevant specifically to the treatment of women sexually abused as children was also important. In addition I wanted to increase my knowledge and skills in evaluating the outcome of individual treatment for women survivors of child sexual abuse. Finally, I wanted to develop a deeper understanding of the therapist/client relationship through gaining a better understanding of the notion of "co-creation". By achieving these goals I hoped to evolve into a more effective clinician in working with women survivors of child sexual abuse.

CHAPTER 2

LITERATURE REVIEW

The literature review is divided into two main sections. The first section includes a definition of childhood sexual abuse, the prevalence rates of childhood sexual abuse in Canada and the United States, possible causes of childhood sexual abuse and the long term effects of childhood sexual abuse on adult women. The second section includes a discussion of therapeutic approaches, both abreactive and solution focused, utilized in working with adult survivors of childhood sexual abuse.

Definition of Sexual Abuse

Within the literature the definitions of child sexual abuse vary in what authors constitute as a sexually abusive act, the age difference between the abused and the abuser and at what age the victim is considered to be a child. Definitions range from a broader to more narrow perspective of child sexual abuse. Here are several definitions offered by various clinicians/authors that work in the area of child sexual abuse.

Hartman and Burgess (1989) utilized the United States 1981 National Centre on Child Abuse and Neglect's definition of child sexual abuse:

> Child sexual abuse is defined as: Contact and

> interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another (p.96).

In this definition the abusive behavior is defined in terms of the offender's intent as well as actual "contact", and it stipulates that there is an "interaction" that occurs between the child and perpetrator. This definition also states that children/adolescents can be sexually abusive towards others if there is a significant age difference or power difference between the victim and perpetrator.

Dolan (1991) defined sexual abuse as:

> any form of coerced sexual interaction between an individual and a person in a position of power over that individual (p.1).

She refers to child incestuous sexual abuse as:

> any sexual involvement between a child or adolescent and an individual who is in a position of power over her and from whom the child would traditionally expect protection and affection (Dolan, 1991, p.2).

Similar to the previous definition, Dolan (1991) included the issue of power in her definition of sexual abuse. In addition she defined sexual abuse as a "coerced sexual interaction", suggesting that the perpetrator forces the child into a sexual interaction. Unlike the

previous definition of Hartman & Burgess (1989). Dolan does not include actual "contact" in her definition, suggesting that there does not have to be physical contact for the interaction to be abusive. In defining incest she added a description of an unequal relationship between the victim and perpetrator.

Grammer and Shannon (1992) cited Dr. Suzanne Sgroi's definition of child sexual abuse as:

> a sexual act that is imposed on a child who lacks emotional, maturational, and cognitive development. It is the ability to lure a child into a sexual relationship based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position. Authority and power enable the perpetrator to coerce the child into sexual compliance (P.20).

In this definition the child's level of immaturity is mentioned along with the perpetrator's status in relation to the child. Similarly to the two previous definitions, Sgroi (1982) highlighted the issue of power and authority in her definition. In addition, Sgroi (1982) did not add the term "contact" in her definition of sexual abuse, which again suggests that a sexually abusive act may involve either or both physical and non-physical interactions.

A much narrower view of child sexual abuse can be found in the

criminal code of Canada. Canada's code specifies sixteen sexual offences used to define child sexual abuse. These offences include: sexual interference, invitation to sexual touching, sexual exploitation of a young person, anal intercourse, bestiality, a parent or guardian procuring sexual activity of a child, a householder permitting sexual activity, exposing genitals to a child, vagrancy, offences in relation to juvenile prostitution, incest, corrupting children, indecent acts, sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm, and aggravated sexual assault (Wells, 1990, p.14). Wells (1990) continued by stating that:

> under the criminal code, children under 12 are unable to give consent to participation in a sexual act and therefore are protected under the law against such allegations. Children between the age of 12 and 14 are only able to consent if the person they are sexually involved with is no more then 2 years older but under the age of 16. The person they are involved with may not be in a position of trust or authority over the other. The consent of adolescents between the age of 14 and 18 is nullified if the person they are involved with is in a position of authority or in a position of trust (p.15).

Furthermore "sexual activity without consent is always a crime regardless of the age of the individuals" (Wells, 1990, p.15).

The common thread between each of the above definitions is the issue of power and authority that the perpetrator holds in relation to

the child. With the exception of Hartman and Burgess (1989), all the definitions suggest that sexual abuse may involve either both physical contact and/or no contact. Additionally, Sgroi's (1982) definition suggests that a child may be "lured" into a sexual act. I believe that it is important to recognize that a child is not always forced into a sexual act, but may also be tricked or somehow enticed into compliance due to the perpetrator's manipulative skills, the authority held by the perpetrator in the eyes of the child, and the child's immaturity and naivete.

In defining childhood sexual abuse for this practicum project, I have chosen to utilize Archer's (1995) definition of childhood sexual abuse. Incest and rape along with other physical and non-physical acts which "are imposed on a child that serve no other purpose other then to provide for the curiosity or sexual gratification of the abuser" (p.13). In addition, the sexual abuse may have been a one time incident or may have occurred over an extended period of time. It may have involved a stranger or someone the child knew. The sexual abuse can involve violence or no violence and the victim may be "coerced" or "lured" by the perpetrator.

In my practicum I will refer to anyone under the age of 18 years of age as a child. It has been suggested that when there is an age disparity the abuse may be more damaging to the child (Courtois, 1988) and

in some definitions the perpetrator is defined as someone who is at least 5 years older than the victim (Hajes, 1990). In my opinion, sexual abuse can occur between the child and perpetrator regardless of age difference. Power, authority and the gratification of the perpetrator are the most significant defining elements.

Prevalence of Child Sexual Abuse

Most researchers who have completed studies on the prevalence of child sexual abuse agree that child sexual abuse remains largely under reported (Renvoize, 1993; Jehu, 1988; Wynkoop & Capps & Priest, 1995; Hartman & Burgess, 1989; Archer, 1995). Offenders who are detained for one or two sexual offenses often have committed several additional sexual offenses which remain unreported (Renvoize, 1993). Renvoize (1993) cites an American study which showed:

> that 567 abusers, promised freedom from imprisonment under legal amnesty, admitted to having had almost incredible numbers of victims, far higher than had been expected: on average each non-incest offender against girls averaged twenty victims, while each non-incest offender against boys averaged 150 (p.69).

Jehu (1988) cited an American study with a random sample of 1, 374 females of which 27% of the sample disclosed some form of sexual abuse during their childhood. In another large scale American study,

Russel (1983) found that out of 930 women, with a response rate of 50%, 38% of this population had been sexually abused at least once by the time they were 18 (Renvoize, 1993, pp. 66). Archer (1995) cited a survey conducted by Finkelhor et al. (1990) which involved 2, 626 adult respondents. The results of the survey found that 27% of the women and 16% of the men disclosed being sexually abused (p.14). One of the most significant studies completed on child sexual abuse in Canada was the Badgly report (1984). Some of the findings of the committee included the following:

1) At some time during their lives about one in two females and one in three males have been victims of one or more unwanted sexual acts.

2) About four in five of these unwanted sexual acts had been first committed against these persons when they were children or youths.

3) Four in 100 young females had been raped.

4) Three in five abused children had been threatened or physically coerced by their assailants. Young victims are as likely to be threatened or forced to engage in sexual acts by persons relatively close in age as by older persons.

5) About one in four assailants is a family member or a person in a position of trust.

6) Virtually all assailants are male.

7) A majority of victims or their families do not seek assistance from public services" (Schlesinger, 1986, p.85).

Wynkoop et al. (1995) cited various studies and stated that prevalency rates for victims "have ranged from a low of 5.3 % for females and 3 % for males to a high of 62 % for females and 30 % for males" (p. 56). Wynkoop et al. (1995) continued:

> in Canada, prevalence rates also vary, ranging from a low of 22 % (Bagley & Ramsay, 1986) to a high of 34 % (Badgly et al., 1984) for females, with 13 % for men (Badgly et al., 1984) (p. 56).

The difference in prevalency rates between studies may be influenced by a variety of factors, such as the acquisition of the sample, the diverse methods by which information was gathered, the types of questions asked, the response rates, how each researcher defined sexual abuse, and regional differences.

Haugaard and Emery, (1989) state:

> in general, the highest prevalence rates have come from samples of women from urban households; intermediate rates have come from nationally based surveys; and lower rates have come from surveys of colleges (p.89).

Although this would suggest that prevalency rates are influenced by choice of sample, the different methods used to gather the data cloud our ability to conclude that the differences are attributed to sample

type (Haugaard and Emery, 1989, p.90).

The diverse methods by which information was gathered may include face to face interview, mail-out questionnaires, and telephone contact. Due to the sensitive nature of the topic, some respondents may feel less threatened by a random mail out survey than a face to face interview with a researcher. Other respondents may appreciate the face-to-face interview and therefore disclose more information than they would have on a mail out questionnaire. In fact, Wynkoop et al. (1995) cited a study which concluded that face to face interviews resulted in higher reporting rates for prevalence (p.56).

In addition, the differences in prevalency rates may be explained in part by the lack of a standard set of questions utilized by researchers in the various studies. "Additionally, many researchers either did not utilize an operational definition of child sexual abuse or failed to report how it was operationalized" (Rowan et al. 1994, p. 52).

Some American studies have highlighted differences in prevalency rates by region (Wynkoop et al., 1995). For example, there appears to be a higher level of sexual abuse in the Western region of the United States than other regions (Wynkoop et al., 1995). Therefore this "research supports the notion that regional differences could introduce systemic bias into the data that cannot be accounted for by survey format" (p. 56).

Again, although no researcher can agree on the exact percentage of people sexually abused as children most can agree that sexual abuse remains under reported (Jehu, 1988, Renvoize, 1993). It is worth noting that although there is a higher rate of girls sexually abused as children (Finkelhor, 1984; Stuart and Greer, 1984; Dominelli, 1989, Walker, 1994; Geffner, 1992) boys are also sexually abused. In fact a previously cited American study highlighted that each non-incest offender victimized more boys than girls on average (Renvoize, 1993).

Two Views on Causes of Child Sexual Abuse: Feminism and the Child Protection Movement

The sexual abuse of children became public knowledge through the Feminist and Child Protection movements (Finkelhor, 1984). Some would argue that it was actually feminism that took the leading role in uncovering the sexual abuse of children:

> Linda Gordon, Professor of History at the University of Wisconsin, points out that in America there have been three waves of public awareness of child sexual abuse- in the 1870's and 1880's, again from 1910 to 1920 and since the 1970's-all of them allied to peaks of feminism: this awareness of child abuse was/is a result of women's movements being concerned with the welfare of children as with women. When feminism ebbs, she suggests, problems such as child sexual abuse are pushed back under the carpet (Renvoize, 1993, p.70).

I will briefly discuss points from both of these movements beginning with the feminist perspective. "The feminist perspective of child sexual abuse looks within and beyond the family unit and takes a victim advocacy approach based on the model of rape crisis counselling and victim witness programs" (Finkelhor, 1984, p.4). The influence of, patriarchy, defined as a political system which maintains male power and privilege through the subordination of women and children, is believed by feminists to be at the root of child sexual abuse (Rush, 1980; Dominelli, 1989; Kane, 1994). Fathers who molest their own children most often do not feel they have done anything wrong because they view their children as their property, to do with as they please (Rush, 1980). Walker (1995) affirmed this by emphasizing that the inequality which exists between men and women in our society "is a breeding ground for male expectations of entitlement" (p. 214). Rush (1980) continued, "this right is reinforced by the media in films, advertising and pornography, which constantly eroticize children, and by professionals who endorse father-daughter incest and adult child-sex" (p. 14).

Most offenders who sexually abuse children are male. Finkelhor (1984) offered several points in explaining why he believes men are more likely to sexually abuse children. His points include:

1) Women learn earlier and much more completely to

> distinguish between sexual and non-sexual forms of affection.
>
> 2) Men grow up seeing heterosexual success as much more important to their gender identities than women (men are more likely to look for sexual contact in order to make themselves feel adequate).
>
> 3) Men are socialized to be able to focus their sexual interest around sexual acts isolated from the context of a relationship whereas women are socialized to focus on relationships.
>
> 4) Men are socialized to see as their appropriate sexual partners, persons who are younger and smaller than themselves, while women are socialized to see as their appropriate sexual partners persons older and larger (Finkelhor, 1984, p.13).

Many feminists believe that male socialization and the issue of power are directly related to child sexual abuse, and in order to deal effectively with the problem of child sexual abuse they believe that:

> eroticization of powerlessness must be addressed. As well as those forces which encourage many men to believe that they have the right, by virtue of being male, to sexual gratification with or without consent (Health and Welfare, 1990, p.43).

The child protection movement views childhood sexual abuse

somewhat differently than those concerned with childhood sexual abuse in the feminist movement. The child protection movement views sexual abuse in the context of other forms of child abuse, e.g. physical abuse and neglect (Finkelhor, 1984). This view concentrates on the family unit and is more concerned with the parents and caretakers of children (intrafamilial abuse). Incest is viewed as a "product of family pathology in which all members contribute" (Finkelhor, 1984, p.4). This view takes the sole responsibility of the incest away from the perpetrator and places it on the entire family unit. "The child abuse movement argues for whole family treatment programs with an emphasis on reconciling and reconstituting the family" (Finkelhor, 1984, p.4).

Therefore, the child protection movement views the incest factor in child sexual abuse as a problem that is caused not by one person but by a dysfunctional family system, whereas the feminist perspective views all child sexual abuse as a social issue and stresses that the responsibility for the sexual abuse remains with the individual who committed the offense. The two views also differ in what should be done when someone sexually abuses a child. The child protection movement does not agree with putting all offenders in jail. One reason is due to possible repercussions towards the victim/family once the offender is released from jail. The feminist perspective supports jail

terms because it feels that this stance will emphasize that this type of behavior is shunned by society and will not go unpunished, and therefore will deter individuals from committing such offenses (Finkelhor, 1984).

A feminist perspective reflects my own beliefs about the causes of sexual abuse, what should be done with perpetrators, and what guiding principles I should adhere to in treating adult survivors of child sexual abuse. I believe we live in a patriarchal society which promotes the devaluation of women and children. This devaluation process makes it easier for individual men to exploit and violate women and children without negative sanctions to the perpetrators. I also agree with Finkelhor (1984) in that men and women are socialized differently and that this socialization process sustains the patriarchal system.

Three feminist treatment principles which I feel are relevant to my work with survivors include, "the personal is political, mutual goal setting and a nonpathology-nondeficit model" (Lenore Walker, 1995, p.293). The statement "the personal is political" reflects a view beyond the individual. The violence and exploitation that occurs in the lives of women and children are a reflection of the political climate. In order to address these issues in treatment the therapist must understand how gender issues, the socialization of women, and the political climate of the day impacts the lives of their clients. One way of addressing this

statement in treating survivors is by educating clients on ways in which men and women are socialized and discussing with them how this effects them personally. Mutual goal setting rather than telling clients what they need may assist them in feeling that they have control over their lives. Due to the experience of powerlessness within the lives of survivors mutual goal setting is an important step in empowering clients.

Finally, utilizing a nonpathology-nondeficit model in reference to child sexual abuse, commits the practitioner to avoid viewing the client as being sick, mentally unstable, or abnormal. The sexual abuse is viewed as the problem and the client's symptoms are considered a "normal" response to such abuse.

Long Term Effects of Sexual Abuse

The long term effects of child sexual abuse are the result of the individual experiencing some form of sexual victimization during their childhood. Early research suggests that the long term effects differ from "initial or short term effects" in that initial effects are those reactions which occur within 2 years of the individuals last sexual abuse experience (Browne and Finkelhor, 1986).

Early researchers in the field have disagreed over the long term effects of sexual abuse on individuals. In fact some researchers have

claimed that sexual abuse has no long term effects or that these effects are overemphasized (Conte, 1985). Conte and Schuerman (1988) cited a clinical report conducted by Bender and Gruett in 1952, in which the researchers stated that "there are no long term negative effects.... and that most had good adjustment some years after the abuse" (p. 158). Conte and Schuerman (1988) continued by stating:

> however in actually reading the fifteen brief case reports, it appears that only two of the cases reflected good adjustment. The remainder experience a range of problems, including a successful suicide, repeated hospitalisations, and drug and alcohol abuse (p.158).

In the review of a study which supported the non aversive effects of sexual abuse, Brown and Finkelhor (1986) were unable to isolate sexual abuse within the research and therefore did not include this Bender and Gruett's study in their review of long term effects of sexual abuse (p.2).

In sharp contrast, the last decade has produced a number of studies which support the claim that there are long term effects of sexual abuse and in fact describe these long term effects (Courtois, 1988; Dolan, 1991, Herman, 1992; Jehu,1989; Beitchman et al., 1992; Rowan et al., 1994; Briere, 1996; Peters, 1988; Russel & Schurman & Trocki, 1988). Browne and Finkelhor (1986) stated "eight non-clinical studies of adults, including three random sample community surveys,

found that child sexual abuse victims in the normal population had identifiable degrees of impairment when compared with nonvictims" (p.13).

One such study, conducted by Peters (1988) on a community sample of adult women, found that:

> women with a history of contact abuse were more likely to experience problems with depression and substance abuse and reported a greater number of depressive episodes, as compared to women with a history of no abuse or only no contact abuse (p. 112).

Jehu (1988) found that 92 % of the 51 women in his study had at least one form of mood disturbance which resulted from their childhood sexual abuse experiences (p. 164). Anderson, Yasenik & Ross (1993) found a "very high prevalence of dissociation experiences and disorders" in their community-based sample of 51 sexual abuse survivors (p. 682). In addition the researchers found that 54.9 % of the women in their study met the criteria for multiple personality disorder (Anderson et al., 1993, p. 683).

The difficulties which arise from some of these studies include the way in which samples were selected. Anderson et al. (1993) utilized volunteers from specific community agencies, such as other treatment focused agencies, which make it difficult to generalize the study to other survivors or to the general population. Only one of the twenty-

five studies reviewed by Conte (1985) utilized a random community sample, the rest of the studies utilized special populations which resulted in biases (Conte, 1985).

Another area of difficulty is in the methods used in measuring outcome. Beitchman et al. (1992) stated that "comparing findings across studies when outcome measures vary in their degree of specificity is difficult" (p.110). Beitchman et al. (1992) concludes in their review of the literature that "although very few studies reviewed here were able to achieve the controls required, recurring themes are sufficiently evident to permit conclusions about the long term effects of CSA" (p.115). These conclusions support the long term negative effects of child sexual abuse.

In determining the long term effects of sexual abuse a variety of factors are believed to influence the severity of the aftereffects. These include such factors as whether the perpetrator used violence or threats against the victim, the extent of the abuse, the frequency of the abuse, the duration of the abuse, the identity of the perpetrator or perpetrators (e.g., family member versus stranger), the kind of support the survivor had before and following the sexual abuse, family functioning before and following the sexual abuse, and the child's personality and health (Grammer & Shannon, 1992; Finkelhor, 1984; Beitchman et al. 1992; Briere, 1996, Courtois, 1988).

The most commonly reported long term effects of child sexual abuse may include, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency towards revictimization, depression and self-destructive behavior, substance abuse, and sexual maladjustment (Browne and Finkelhor, 1986, p.1). Oversexualization, idealization, and an impaired ability to discern who is not trustworthy are factors in explaining the revictimization of sexual abuse victims (Beitchman et al. 1992). Beitchman et al. (1992) continued:

> childhood sexual abuse may also have a corrosive effect on self-esteem, therefore making these women conspicuous targets for sexually exploitative men (p. 108).

In reviewing the literature and utilizing the experience from my clinical work, I found cognitive distortions (e.g., self-blame, guilt) depression, anxiety, self destructive behaviours, damaged self-concept, sexual maladjustment and post traumatic stress disorder as common long term effects of child sexual abuse (Finkelhor and Browne, 1986; Briere, 1996; Rowan et al. 1994). Each of these long term effects are discussed in more detail throughout the following pages.

Cognitive Distortions

Cognitive distortions are common among sexual abuse survivors (Jehu, 1988; Briere, 1996). Cognitive distortions are distorted beliefs

related to the victim's sexual abuse experiences which are believed to "lead to distressing feelings and inappropriate actions" (Jehu, 1989, p.169). For instance, one of my clients (Jill) often experienced cognitive distortions while her partner had baths in the evenings. She believed he masturbated during his bath because he preferred to masturbate than to have sex with her. This distortion lead her to feeling unwanted which resulted in an inappropriate action, charging into the bathroom, and accusing her partner of masturbating. This cognitive distortion was directly related to her abuse. Her father sexually abused her in the evenings and often abused her in the bath tub.

A study conducted by Jehu (1988) which highlighted various cognitive distortions in sexual abuse survivors, found that "78% of the sample endorsed the statement I am worthless and bad; and 90% endorsed the statement I am inferior to other people because I did not have normal experiences" (pp. 77-79). When the perpetrator is someone the child knows, such as a parent or other trusted adult, it is very difficult for that child to understand why the perpetrator would violate them and therefore survivors often blame themselves for the abuse. The self-blame experienced by many survivors is often reinforced by the perpetrator, the victim's family and society. This process may also be referred to as stigmatization. Stigmatization as defined by Finkelhor:

> includes negative connotations--for example, badness, shame and guilt--that are

> communicated to the child about the (abuse) experiences and then become incorporated into the child's self image...They can come directly from the abuser, who may blame the victim for the activity, denigrate the victim, or, simply through his furtiveness, convey a sense of shame about the behavior" (Briere, 1996, p.16).

Again, this attribution of blame onto the survivor may result in irrational feelings of guilt and shame which may lead to self hatred. Self hatred may be expressed in self-destructive behaviours. Dolan (1991) recognized that survivors are more likely to commit suicide then those not sexually abused. Beitchman et al. (1992) confirmed this idea by citing a study in which 56 % of women with a history of child sexual abuse compared with 23 % of non-abused women had a history of previous suicide attempts (p. 107).

Some researchers suggest that a survivor's self-blame gives the survivor a sense of control, albeit a false one, and saves them from having to deal with additional anxieties such as being abandoned by the perpetrating parent and or non-perpetrating parent, or from having to deal with the reality that the world is not always "just" (Briere, 1996).

Depression

Several authors have identified depression as a common long term effect of sexual abuse (Briere, 1996: Courtois, 1988; Jehu, 1988; Koverola, Pound, Heger & Lytle, 1993). Koverola et al. (1993) stated,

"research on women who were sexually abused as children have documented that there is a significant and positive relationship between severity of abuse and the degree of depression" (p. 393). Jehu (1988) found that "on the Beck Depression Inventory 29 (56%) of 51 victims scored 21 or more which is indicative of clinically significant depression" (p.47). Briere (1996) cited a study by Bagley and Ramsay (1986) which supports the findings of the Jehu (1988) and Koverola et al.'s (1993) studies.

> In a community sample of 387 women, those with a history of childhood sexual abuse were approximately twice as likely to be clinically depressed as were women with no history of sexual abuse (p. 20).

Other researchers may not support these findings as readily. Courtois (1988) stated that there does not seem to be a significant difference in the level of depression between those sexually abused in contrast to the general population. Her work supports Dolan's (1991) later observations regarding self-destructive and suicidal behaviours when it notes that "significant differences have been found repeatedly between the two groups in terms of suicide attempts and behavior and self-destructive wishes" (Courtois, 1988, p.105). Beitchman et al. (1992) indicate that "of eight studies reviewed, six found an association between CSA (sic) and adult depressive symptoms, while two found no such association" (p.107).

Anxiety

Beitchman et al. (1992) stated that "three of seven studies showed a positive relation between CSA (sic) and adult anxiety symptoms (sic) also reported that the use of force or threat had been common among CSA (sic) victims (p.106). Therefore it is not clear whether the sexual abuse was directly related to the outcome of anxiety or whether it was the force or threat at the time of the abuse which caused the anxiety (Beitchman, 1992).

Not all survivors of child sexual abuse are forced or threatened by their abusers. For instance, Jill's father (perpetrator) was less verbally abusive towards Jill and he did not use physical force when he sexually abused her but Jill continued to suffer from high levels of anxiety which appeared to be related to her sexual abuse experiences.

In one study the researchers found that "feelings of fear and anxiety are strongly related to experiences of intrusive thoughts and emotions pertaining to the incestuous experience" (Edwards and Donaldson, 1989, p.107). During dates with men, Anna one of my clients, would often experience intrusive thoughts related to her rape which left her feeling extremely anxious and fearful. In addition, her level of anxiety and fear often interfered with her self-assertion abilities.

Self destructive behaviours

Self-destructive behaviours or what Briere (1996) refers to as "acting- out behaviours" as it relates to sexual abuse victimization, include behaviours such as, alcohol and drug abuse, self mutilation, suicide or attempted suicide, and promiscuity (Dolan, 1991; Briere, 1996, Courtois, 1988). Briere (1996) makes an interesting point in stating that although these behaviours are labelled "self destructive" they are in his opinion, "survival activities" (p.29). He continues by stating "the very notion of a self-destructive survivor, in fact, is an oxymoron" (p. 29). These behaviours are often utilized by survivors as ways of coping with their victimization. Dolan (1991) emphasizes that self-mutilation has been used by survivors as "ways to reorient from flashbacks, end dissociative experiences, reconnect to a feeling of being real and express how bad it (the memories of the sexual abuse) really hurt me" (p.17). Although some of these behaviours may have been effective for short periods of time during or following the abuse, in the long run they prove to be ineffective coping strategies (Briere, 1996). The old coping strategies may lock survivors into rigid patterns of relating to themselves and others which may not be helpful in their post abuse environment.

Self Concept

The notions of "boundary" and "boundary violation" are important concepts in explaining the importance of the development of self concept and threats to the integrity of self. McEvoy (1990) stated:

> we need boundaries because they tell us who we are and what our rights and responsibilities as person's are. They tell us we are unique individuals, entitled to needs and to having those needs met (p.64).

Visac (1988) stated "the 'I have boundaries' experience is essential for an 'I am me' (self-concept) to develop" (p.27). When children are sexually abused their boundaries are violated and when their boundaries are continually violated they lose touch with their sense of who they are as individuals. They begin to believe they have no rights and that their needs are secondary to the needs of others. Briere (1996) stated "an absence of boundaries when confronted with a stressor can reduce the individual's ability to negotiate interpersonal interactions, leading to, for example, difficulties in self-other discrimination, effective help seeking, and self-assertion in the face of victimization" (p. 66).

For instance, one potential client I met during an intake session disclosed that she had been sexually abused by her father, who had recently died. Her father left her as the executor of his will. This woman's ability to negotiate interpersonal interactions was damaged by her abuse. She was not able to assert herself and get someone else in

the family to be responsible for the funeral and the will, even though she did not want the responsibility of being the executor.

Sexual maladjustment

The literature provides several examples which suggest that the sexuality of a survivor may be affected in various ways by the experience of sexual abuse (Courtois, 1988; Maltz and Holman, 1987; Browne and Finkelhor, 1986; Briere, 1996; Jehu, 1988; Beitchman et al., 1992). Maltz and Holman (1987) suggest that one of two patterns of experiencing sexuality may emerge for the survivor, she may feel repulsed by sex and distance herself from sexual experiences, or secondly, the survivor may use sex as a way to get her needs met and "sexually act out". Browne and Finkelhor (1986) cited Herman's 1981 study which supports the notion that survivors may sexually act out in order to get their needs met. Her findings included that "35% of the incest victims in her sample reported promiscuity and observed that some victims seemed to have a repertoire of sexually stylized behavior that they used as a way of getting affection and attention (Browne and Finkelhor, 1986, p.11).

In another study Sandberg, Lynn and Green (1994) indicated that child sexual abuse victims are over represented among prostitutes and exotic dancers. Sandberg et al. (1994) cited a study which found that

11 of 20 prostitutes, and 13 of 20 exotic dancers reported a history of sexual abuse (p. 246). Some possible reasons for "promiscuity" in survivors is their need to regain control over their past abuse. They may try and relive their abuse experience in order to try, unconsciously, to alter the experience. The survivor may sexualize her relationships with others because she was sexualized as a child and has difficulty relating in other ways, or she may believe that sex is the only thing she is "good for" and therefore have difficulty in establishing sexual boundaries.

Another area of concern for some survivors is the issue of sexual orientation following abuse. In one study quoted by Beitchman et al. (1992) "7 out of 23 women abused by their fathers were lesbian or had significant conflicts about homosexual feelings, whereas homosexual behavior was rare in the control group" (p.105).

In still another study reviewed by Beitchman et al. (1992) Herman (1981) found that five out of 40 incest victims "appeared to be involved in homosexual activities," although Beitchman et al. (1992) stated that the researcher failed to include how many women in the control group had similar experiences (p.105). Browne and Finkelhor (1986) cited two studies:

> although one study of lesbians found molestation in their back grounds (Gundlach, 1977), Bell and Weinberg (1981), in a large scale, sophisticated study of the origin of sexual

preference, found no such association (p.12).

There appears to be "little empirical confirmation" that there is an association between sexual abuse and a change in sexual orientation following victimization (Browne and Finkelhor, 1986, p. 11). Maltz and Holman (1987) suggested that some heterosexual survivors may choose to have sexual relations with other women for the following reasons:

> Female partners may be less pressuring than males for sexual contact, and more understanding and supportive of the survivor's anxieties about sex, some survivors feel more comfortable with females because their bodies lack many of the reminders of the abuse, such as penis, semen, and body hair and because their voices do not remind them of the low voice of the offender (p.73)

As the women heals she may begin to realize her heterosexual tendencies more clearly and choose to reunite with a male partner. With women who are lesbian from childhood the sexual abuse by the male offender may have "blocked their awareness of their preference for female partners" (Maltz and Holman, 1987, p.74). Again, as a woman starts to heal from the abuse she may choose to reunite with a female partner.

Many survivors utilize "numbing out" strategies, for example dissociation, and or utilizing drugs/ alcohol in order to cope with their childhood sexual abuse. Utilizing numbing out strategies may further alienate the survivor's relationship to her body and sexuality. When

these "numbing out" strategies are carried to adulthood, the person's ability to sense or receive messages from her body are deeply affected. The survivor learns not to pay attention to her body when her body is tired, hungry, or tense. If the survivor continues to ignore her body she may manifest physical ailments such as urinary infections, back pain, *etcetera*. Not only is the survivor out of touch with her body but she is also out of touch with her intuition or "gut level" feelings. When she is disconnected from her "gut feelings" she is at a higher risk of further abuse. In addition the survivor may not have a clear understanding of how her body functions and what gives her pleasure or she may fear her body and her body's response to pleasure. If the survivor physically responded to her abuse she may feel betrayed by her body which may affect future sexual relationships. Through sexual pleasure she may be reminded of her abuse.

In reviewing the potential long term effects that sexual abuse has on a survivor's sexuality it is important to consider other factors as well. Factors such as religious background, family values, societal values and cultural values will all have an impact on how the survivor perceives her sexuality (Courtois, 1988). The "Hite Report" (Shere Hite, 1981) completed in the 70's on female sexuality received just over 3000 replies from the one hundred thousand questionnaires sent out to women across the United States. Out of those three thousand women,

95% of the women grew up with the idea that "sex was bad or at the very least is was never mentioned, - implying that it was bad" (p.39). If we assume that most women feel this way whether they were abused are not, this alerts us to the fact that women who were, in fact, sexually abused are dealing with a double blow to their sexual self-esteem.

When considering the effects of sexual abuse Archer (1995) emphasized the importance of "clinicians striving toward the development of a balanced perception, being mindful of minimisation, but keeping one's mind open to the possibility that for some, sexual abuse has little or perhaps no long term effects" (p.20). Although I agree with Archer that clinicians should not create symptoms where there are none, I am also cautious about accepting the idea that some sexual abuse survivors experience no long term effects without any prior intervention. Herman (1992) stated:

> As intrusive symptoms diminish, numbing or constrictive symptoms come to predominate. With the passage of time, as these negative symptoms become the most prominent feature of the post-traumatic disorder, the diagnosis becomes increasingly easy to overlook (p.49).

Another area of concern is what has been identified by Beitchman et al. (1992) as "sleeper effects" (such as, sexual dysfunction) which are effects of sexual abuse which do not surface until the abused child becomes an adult. Young adults may also experience a similar process

to the sleeper effect. For example, a single 18 year old survivor may not develop any significant sexual difficulties until she is older and involved in a serious relationship (Browne and Finkelhor, 1986). Because the effects of early sexual abuse may be experienced in a variety of individual and unique ways by each survivor, it is best that as clinicians, each person be approached as unique and be treated accordingly.

Symptomatology of Childhood Sexual Abuse: Post Traumatic Stress Disorder (PTSD)

Although Rowan et al., (1994) cited Lipovsky & Kilpatrick, in press, indicating that there have been studies that have found relationships between child sexual abuse and psychiatric disorders, like depression, Rowan et al. counter this assertion by stating that "none of these disorders encompass the full range of symptoms frequently reported by sexual abuse survivors" (p. 52). Rowan et al. (1994) believed that Post Traumatic Stress Disorder (PTSD) was a more accurate diagnosis for those sexually abused as children than other disorders which have been found to be related to child sexual abuse (such as depression). Dolan (1991) supported this view and indicated that:

> A PTSD diagnosis is helpful for survivors of sexual abuse because the definition not only has a normalising effect for clients but also is clinically accurate (p.5).

Dolan (1991) continued by defining Post traumatic stress disorder as "the psychological reactions that typically occur as a result of a disaster or other extreme psychological stressor" (p.4). "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" (Archer, 1995, p. 35).

Briere (1996) outlined the criteria for diagnosing Post Traumatic Stress Disorder according to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) with the following points:

> 1) The existence of an event that involved witnessing or experiencing actual or threatened death or serious injury, or a threat to physical integrity of self or others, that produced intense fear, helplessness, or horror. Childhood sexual abuse is specifically included in this criterion, despite the fact that not all abuse confers threat of death or injury.
>
> 2) Later reexperiencing of the trauma in one's mind, for example, through recurrent dreams of the stressor, or flashbacks (intrusive sensory memories) to the original traumatic situation; or an intensification of symptoms on exposure to situations that resemble the original traumatic event.
>
> 3) Persistent avoidance of stimuli associated with the

> event and numbing of general responsiveness to the external world-for example, dissociation, withdrawal, inability to recall important aspects of the trauma, restricted affect, or loss of interest in daily events.
>
> 4) Persistent symptoms of increased arousal, not present before the trauma, such as sleep disturbance, irritability, difficulty concentrating, hypervigilance to danger in the environment, and an exaggerated startle response (p.6).

In the DSM-III-R the first criterion of Post Traumatic Stress Disorder was "the existence of a psychologically distressing event that would evoke significant disturbance in almost anyone" (Dolan, 1991, p.4). In the DSM-IV the first criterion was specified as "witnessing or experiencing actual or threatened death or serious injury" (Briere, 1996, p.6). In addition, the first criterion includes childhood sexual abuse, regardless of whether death or injury was involved. Briere (1996) highlighted that although the new criterion appears more restrictive (limiting events to physical versus psychological) it does address childhood sexual abuse which the DSM-III-R did not (p.6). Recognizing childhood sexual abuse as a traumatic event will hopefully lead to further research in this area which will assist clinicians, survivors and the public in better understanding this type of abuse.

Herman (1992) stated that symptoms of PTSD fall under three main categories. These are hyperarousal, intrusion and constriction. The

first, hyperarousal describes a person who is unable to relax and is constantly on the alert for danger. "The traumatized person startles easily, reacts irritably to small provocations, and sleeps poorly" (Herman, 1992, p.35). They seem to be constantly in the "fight or flight" mode. Eventually such hypervigilance may take an enormous toll on the individual's health and well-being.

The second category, intrusion is defined as reliving the event as if it was happening in the present. Bell-Gadsby & Siegenberg (1996) indicated that the traumatic event was so overwhelming that it could not be integrated into the individual's existing framework and instead was dissociated, only later to return intrusively as fragmented sensory or motoric experiences (p.6). These intrusions can appear in the form of "flashbacks during waking states and as traumatic nightmares during sleep" (Herman, 1992, p.37). These intrusions are not limited to a person's thoughts or dreams but also their behaviours as well (Herman, 1992). In order to overcome a traumatic experience some individuals may attempt to relive the event in an attempt to alter the experience. Gil and Johnson (1993) have often seen children acting out their victimization through their play. Adults may participate in other actions which may be healthy or unhealthy in trying to resolve their victimization. Herman (1992) shared the story of a woman who was raped in an alley and told by her perpetrators if she ever came down

the alley again they would get her. She continued to go down the same alley so her perpetrators would not "get the best of her". Her need to gain control over the abuse put her in a potentially dangerous situation each time she went down the alley in the dark (Herman, 1992, p.40).

The last category Herman (1992) mentioned was constriction. Constrictions are altered states of consciousness which are often experienced and utilized by victims of trauma. Briere (1996) defined this aspect of PTSD as "an attenuation in feeling or emotion, wherein the individual experiences reduced reactivity, detachment from others, or constricted emotionality" (p.11). Constriction or what Briere (1996) refers to as reduced responsiveness, is "at its most basic level a form of dissociation" (p.11). Other dissociated responses include "depersonalization (the feeling of not being in one's own body); derealization (the feeling that one's surrounding is not real); out of body experiences (the sensation of being disconnected from one's body, particularly during sex" (Dolan, 1991, p.11). Herman (1992) indicated that "traumatized people who cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol and narcotics" (p. 44). For some individuals this could eventually result in a drug addiction. Herman (1992) continued:

> Although dissociative alterations in consciousness, or even intoxication, may be

> adaptive at the moment of total helplessness, they become maladaptive once the danger is past. Because these altered states keep the traumatic experience walled off from ordinary consciousness, they prevent the integration necessary for healing (p. 45).

Treatment Models

An Historical Overview

Walter and Peller (1992) explained the history of various approaches to therapy as reflecting three fundamental questions. Each question represents a particular therapeutic approach and each of these questions have evolved over time. The first question which is fundamental to most of the traditional approaches, such as the psychoanalytic approach, asked the question "what is the cause of the problem"? From this perspective clinicians feel that if they can find the cause of the problem, the person can be helped and eventually experience relief from their symptoms. As new ideas emerged in therapy approaches a second question was asked, "what maintains the problem"? The question "presupposes that the problem is being maintained and that there is a relationship that can be found and described between the maintenance and the problem" (Walter & Peller, 1992, p.4). This question reflects a systemic approach to therapy. The last and most recent question to be asked is "how do we construct solutions?" (Walter & Peller, 1992). The focus is no longer on the

problem but rather on solutions to the problem. This question suggests a solution-focused therapy model (Walter and Peller,1992). In addition, each of these questions deals with a particular time frame. The first question "what is the cause of the problem?" deals with the past. The second question "what maintains the problem?" focuses on the present and the third question "what is the solution?" focuses on the present and future (Walter & Peller, 1992). A solution focused approach in working with survivors of child sexual abuse will be the focus of this report and will be discussed in greater detail under the section titled Solution Focused Therapy.

The Utilization of Abreactive Models with Survivors of Sexual Abuse

The approaches which "rely primarily on the retrieval of childhood memories, the development of insight, and cognitive reconstruction of thoughts, behaviours and perceptions" (Archer, 1995, p.50) best reflect the first question, "what is the cause of the problem". From this perspective the survivor must confront her memories of child sexual abuse in order to reduce the power the memories have within her adult life. Courtois (1988) stated "the focus of the therapy is the recollection, exploration and abreacting of the traumatic material from the adult context"(p.174). Through this process insights will be gained,

new behaviours and thoughts will be learned and the survivor's symptomatology resulting from the abuse will be diminished if not resolved. Some of the treatment models which "provide a structure for understanding the relationship between the cause and the solution of problems associated with sexual abuse" (Archer, 1995, p.51) were developed by professionals such as Gil (1988), Courtois, (1988), and Herman (1992). Archer (1995) labelled these models under the umbrella of "Memory-based Abreactive Models".

Courtois (1988) referred to her work with incest survivors as retrospective therapy.

> Retrospective incest therapy can be conceptualized as a healing or recovery process or an abreaction of the trauma, which generally involves breaking the secret, catharsis and reevaluation of the incest, its circumstances and its effects" (Courtois, 1988, p.170).

Courtois (1988) includes intake and diagnosis, building the adult relationship, working with the child within, integrating the helpless child with the nurturing adult, and disclosure to and confrontation of the family and any involved others as the process used for incest treatment (Courtois, 1988, p.170). Courtois (1988) "does not refer to treatment as involving stages but as working towards a series of survival goals" (Archer, 1995, p. 52) with the therapist as an "ally".

Herman (1992) referred to the client's recovery as occurring in stages, and the therapist as being responsible for providing appropriate treatment at each of these stages (Herman, 1992, p.156). Herman's (1992) three stage model of treatment included, safety, remembrance and mourning, and reconnection. Gil (1988) also outlined a three phase treatment model: the beginning phase which involves assessment and alliance with the client; the middle phase which she refers to as rebuilding; and a termination phase which she entitles empowerment. Bass and Davis (1988) have developed a model which may be utilized by a survivor without the assistance of a therapist. Archer (1995) referred to this model as having the "unique features of self help and survivor as therapist built in" (p. 52). Bass and Davis's (1988) three stage model included taking stock, the healing process, and changing patterns.

Although each of these experts are individuals and have different styles in addressing the problem of sexual abuse, each of their models appears to progress in a similar fashion. In the next section I will present the commonalities found in the models of Courtois (1988), Herman (1992), and Bass and Davis (1988).

Beginning Phase

Clients may not immediately disclose sexual abuse upon entering

the therapist's office and therefore it is up to the therapist to learn as much as possible about the client's presenting concerns (Courtois, 1988, Herman, 1992). Once the sexual abuse is disclosed the therapist must assess the impact of the sexual abuse, assist in establishing the clients's safety, and build a "therapeutic alliance" with their client (Courtois, 1988; Herman, 1992; Bass and Davis, 1988).

In order to assist survivors effectively, therapists must understand how the abuse has impacted the lives of their clients. During the beginning of therapy it is important for the therapist to conduct a thorough assessment of the client's symptoms. By educating the survivor during the assessment stage on the impact of sexual abuse, coping strategies used by survivors and the possibility of recovery, the client may gain a deeper understanding of how the abuse has impacted her life. Survivors often feel a sense of relief when they realize that the symptoms they are experiencing are related to the sexual abuse experience, and are in fact "normal" reactions to childhood sexual abuse. As Herman (1992) stated "knowledge is power" and in this sense having knowledge of sexual abuse and its impact may restore some of the survivor's power to her.

Providing a safe environment, assisting the client to feel "safe"and "securing a therapeutic alliance" are also important steps in the beginning phase of abreactive models (Herman, 1992, p.172). Herman

(1992) stated "no other therapeutic work should even be attempted until a reasonable degree of safety has been achieved" (p.160). Safety can then be established by "focusing on control of the body and gradually moves outward toward control of the environment" (Herman. 1992, p. 160). Once a level of safety is established within the working relationship (therapist/client) trust begins to develop and a therapeutic alliance can be formed.

Second Phase

The second phase involves the telling of the survivor's story. It is at this phase that the survivor makes the decision to tell her story and reconnect with her traumatic past and all that this reconnection entails. "This work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life story" (Herman, 1992, p. 175). Herman (1992) indicated that:

> the action of telling a story in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory. With this transformation of memory comes relief of many of the major symptoms of post-traumatic stress disorder (p.183).

As the survivor reconstructs her story she is faced with intense and often overwhelming feelings. During this phase survivors begin to reconnect with some of the same feelings they experienced during their

abusive experiences. At this stage it is important for the therapist to monitor the client's responses closely and to "assess the risk that the client may commit suicide or homicide" (Archer, 1995). Continually assessing the client's responses is particularly important due to the low level of affect tolerance in many survivors. During this stage it is not uncommon for clients to feel worse before they start to feel better (Herman, 1992).

Courtois (1988) suggested that at this stage the survivor "integrates the various aspects of the trauma experience, whether positive, negative or ambivalent, into the self and separates from family rules and patterns" (p. 174). It is also at this stage that old coping strategies are evaluated and replaced if they have proven ineffective (Courtois, 1988).

At this stage it is not uncommon for survivors to confront their abusers, either symbolically or directly (Courtois, 1988). Some techniques used in the confrontation include writing a letter to the perpetrator (with the choice of sending the letter or not), role playing the confrontation, and confronting the abuser in person or on the phone. Not everyone needs to confront their perpetrator in order to heal from their abuse and not all survivors have the strength to face their abusers directly, which should be respected.

Finally, it is at this stage that the survivor needs to accept that the

abuse occurred and grieve the losses which were the result of their traumatic experiences (Herman, 1992; Bass and Davis, 1988). The mourning of losses in the survivors life can be the hardest work of this stage (Herman, 1992; Courtois, 1988). Some survivors may attempt to resist this aspect of recovery for two reasons. First, survivors may feel once the "flood gates are open" there will be no way to "close" them again. The survivor may feel that they will "lose it" if they allow themselves to feel their own grief. Second, the survivor may resist grieving because she feels that by doing so she is giving in to the perpetrator. Herman (1992) indicated that "she may consciously refuse to grieve as a way of denying victory to the perpetrator" (p.188). It is very important for the survivor to know that in order to heal she must be able to grieve in order to move on in her healing, and that the acts of grieving take strength and courage. Herman (1992) stated, "It is important to reframe the person's mourning as an act of courage rather than humiliation" (p.188).

The Final Phase

During the final stage the survivor begins to look ahead and is no longer defined through her abuse experience. The task now is to "become the person she wants to be" (Herman, 1992, p. 202).
At this stage the survivor may be filled with apprehension and anxiety,

knowing that in order to grow she must forge ahead into the unknown. At this stage the survivor begins to realize more and more that she deserves to be treated with dignity and respect and may begin to practice this belief in her day to day interactions. Bass and Davis (1988) quoted a survivor who shared her experience at this stage in her development:

> and then I started taking care of my own life. I changed my relationships. I changed my job. I changed my home. I started taking care of business! I filed a suit against my ex-lover for assault. I got money back that I loaned out. I fought a custody battle against my ex-husband. I started getting angry. I started to cry. I really changed. I look different. I changed my life intentionally (p.174).

The key word in this citation is "intentionally". This survivor made the decision to change her life and realized that she was the only one who could make those changes.

Courtois (1988) described this final phase by stating:

> This process includes the ability to practice new ways of relating and behaving, including being able to experience with adult behaviours rather than relying on parent/child interactions, dependency and manipulation. In essence, it is gaining and unfolding a differentiated personality...she is able to behave more as an adult with the opportunity for continued individuation and independence (p.182).

At this final stage the survivor has come to terms with her abuse and no longer is self-blaming but rather has placed the blame where it belongs, on the perpetrator. All the energy the survivor required for her own healing is no longer needed and now some can be spared towards other areas in the survivor's life. At this stage the survivor begins to focus her energy outward. The survivor's energy is not exerted on contemplating revenge against the perpetrator but rather on how she can prevent similar atrocities from reoccurring. The survivor may realize that the crime that was committed against her was not only personal but was also political. She may want to get involved in various social causes like, creating better laws for survivors, getting involved in a women's group which works at improving the living conditions for women in society, and or she may want to assist other survivors in their own recovery. "The sense of participation in meaningful social action enables the survivor to engage in a legal battle with the perpetrator from the position of strength" (Herman, 1992, p. 210).

One criticism Archer (1995) made about this approach involved the second phase of treatment, the retelling of the survivor's story. Archer (1995) stressed that having the client retell her story for the sake of desensitization is unethical and does not necessarily help the client. In utilizing this approach I agree that simply reconstructing the survivor's story in and of itself is not adequate. Other techniques must be

utilized within this phase of treatment to assist a person through her healing in an effective manner. In continuing this point Herman (1992) emphasized:

> while intrusion and hyperarousal symptoms appear to improve after flooding, the constrictive symptoms of numbing and social withdrawal do not change, and marital, social and work problems do not necessarily improve. By itself, reconstructing the trauma does not address the social or relational dimension of the traumatic experience. It is a necessary part of the recovery process, but it is not sufficient (p. 183).

The second criticism Archer (1995) made of this approach was that it followed a linear progression and, according to "most therapists", therapy is not linear. "It's as though survivors begin therapy, establish safety, proceed to unravel feelings, and memories associated with abuse, resolve symptoms, and when they are ready, they can terminate therapy" (Archer, 1995, p.62). I agree with Archer (1995) in that recovery does not follow a straight line and to suggest that it does would be too simplistic. Herman (1992) also recognized that,

> no single course of recovery follows these stages through a straightforward linear sequence...however in the course of successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection (p. 155).

I also agree with Herman (1992) in that the therapist should be able to recognize changes or shifts within the survivor over the course of recovery.

The last point I would like to make regarding abreactive models, is in reference to "balance". In utilizing an abreactive approach therapists are generally focused on the past. Focusing mainly on the past fails to perceive the client holistically, that is, the client has not only been influenced by their past but also by their present circumstances and by how the client perceives her future. In order to consider the whole client there must be a more balanced approach, that is, an approach that acknowledges and incorporates the client's past, present and future. Dolan (1991) and Bell-Gadsby & Siegenberg (1996) create this balance in the work they do with survivors. This "balanced" approach will be discussed in detail under the section titled "Dynamic Co-Creative Healing Model".

Solution-Focused Therapy

The Dynamic Co-Creative Healing model is a combination of Ericksonian techniques and a solution-focused, future-oriented approach to working with survivors of childhood sexual abuse. In order to set the groundwork for discussing the model I would first like to discuss solution-focused therapy.

The solution-focused approach evolved from the work of Milton Erickson. O'Hanlon & Weiner-Davis (1989) emphasized that although Erickson was not purely solution-focused his work inspired much of solution-oriented therapy. Molnar and de Shazer (1987) stated that "solution-focused therapy seems, at this point, to represent a distinctive synthesis of Ericksonian indirection, an emphasis on functional systemic behavior, and a future orientation in therapeutic practice" (p.351). Although there has been much progress in developing solution-focused therapy over the last nine years, a combination of Erickson's ideas (not limited to indirection), systems theory and a future orientation still make up the solution focused approach (Molnar and de Shazer, 1987, p. 351).

I will briefly explain some of the concepts which solution focused therapists have adopted from the work of Erickson. According to Combs and Freedman (1990) these include utilization, indirection, multidimensionality, strategies and experience. Utilization refers to using everything the client brings to the session as a possible resource (Combs and Freedman, 1990). Therefore there is no such thing as a "resistant client". Even the so called "resistant client" gives important information to the therapist. For example, if a client is not following through with a homework assignment it does not mean they are resistant, but rather the client is attempting to tell the therapist that

the homework assignment is not useful and something else needs to be tried (Combs and Freedman, 1990).

Indirection is "any approach that moves toward a goal in something other than a straight line" (Combs and Freedman, 1990, p.20). Metaphor is an example of a indirect approach. It is a useful way to bypass objectivity and get people thinking about what is meaningful for them (Combs & Freedman, 1990).

A multidimensional perspective views the person holistically.

> Erickson enriched his understanding of the problems, resources and goals of the client system by paying attention to what they said and what they did not say, what they said in words and what they said in facial expression and body movement, when their breathing changed and when they momentarily stopped breathing (Combs & Freedman, 1990, p.4).

The strategies that Erickson uses in therapy are "aimed at co-creating a reality with clients in which they can discover the motivation and develop for themselves the confidence to use their particular range of resources, their unique whole self, in developing and pursuing appropriate goals" (Combs & Freedman, 1990, p.10). The best ways to achieve these goals are through experience.

Walter and Peller (1992) recognize the solution-focused brief therapy approach as a total model. "It encompasses a way of thinking, a way of conversing with clients, and a way of constructing solutions

interactively" (p.6). The model defined by Walter and Peller (1992) is said to be based on twelve guiding assumptions.

"Focusing on the positive, on the solution, and on the future facilitates change in the desired direction. Therefore, focus on solution-oriented talk rather than on problem-oriented talk" (Walter and Peller, 1992, p.10). Assisting the client in focusing on what she is doing that is working and what she will be doing in the future when the problem is no longer a concern is the essence of the first assumption.

"Exceptions to every problem can be created by therapist and client which can be used to build solutions" (Walter and Peller, 1992, p.12) is the second assumption. Exceptions are referred to as exceptional times in which the problem does not occur. By "working on encouraging exceptions more often the therapist helps the client develop a sense of control over what seemed an insurmountable problem" (Walter and Peller, 1992, p.14).

The third assumption is that people are always changing and it is the therapist's job to assist the client in recognizing this fact (Walter and Peller, 1992). The fourth assumption is that "small changes lead to larger changes" (Walter and Peller, 1992, p.18). If a client has been successful at making a small change in her life then she has the ability to make more difficult changes in her life (Walter and Peller, 1992).

The fifth assumption is that "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" (Walter and Peller, 1992, p.21). The sixth assumption is that "people have all the resources they need to solve their problems (Walter and Peller, 1992, p.23). In other words clients are "capable of doing what they need to do to get what they want" (P.24).

The seventh assumption is that:

> 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 (Walter and Peller, 1992, p.24).

For instance, in the therapist's office it is the therapist and client who construct meaning from their experience and the experience in turn constructs meaning for the therapist and client.

The eighth assumption is that "actions and descriptions are circular" (Walter and Peller, 1992, p.26). Descriptions are followed by actions, which are followed by descriptions, which are followed by future actions, and so on.

The ninth assumption is "the meaning of the message is the response you receive" (Walter and Peller, 1992, p.26). Therefore from this perspective if a client misinterpreted a message received from her

therapist, it is up to the therapist to say something different. The responsibility of conveying a message rests with the messenger.

The tenth assumption is that "therapy is a goal or solution-focused endeavour, with the client as expert" (Walter and Peller, 1992, p.28). "Any change in how clients describe a goal and or what they share reflects future interactions with all others involved" (Walter and Peller, 1992, p.30) is the eleventh assumption. The final assumption Walter and Peller (1992) highlighted is that "members in a treatment group are also those who share a goal and state their desire to do something to make it happen" (p.31).

These assumptions can be very useful in working with survivors of child sexual abuse. During the initial stages of treatment it is not uncommon for the survivor to feel a sense of hopelessness. From a solution focused approach the survivor is given the message that change is possible and that change continues to happen even when they are not aware of it. In addition, the client is seen as the expert of her life and her healing. When an individual has been disempowered by forces outside her control, how power is distributed within the therapeutic relationship is key to effective treatment. Adhering to the concept of "client as expert", and assisting the survivor to realize she has the resources to heal from her abuse, are empowering messages for the client. If the client feels she has resources and is the "expert" in

her healing she would unlikely become dependent on the therapist.

In addition to the strengths of the solution focused approach there are several limitations. One criticism of this approach, particularly with survivors, is that the approach is ahistoric, *ie.*, the person's history/roots are seldom taken into account and or does not form a significant factor for assessment. Due to the secrecy surrounding sexual abuse in our society many survivors often live in despair and shame because they are unable to share their sexual abuse experiences. Dolan (1991) indicated that:

> 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).

Therefore it is important that the therapist not play into the secrecy. I also believe that focusing on exceptions too early and too frequently in therapy, may leave the client feeling misunderstood by the therapist, particularly if they have not had an opportunity to tell their story. The survivor must have the opportunity to share her experience during therapy.

A second area of concern with this approach is the "shift away from the client's emotions onto the observable behaviours that accompany them" (Kiser, Piercy and Lipchik, 1993, p.234). Bell-Gadsby & Siegenberg

(1996) stated that:

> Forgotten traumatic memory is not repressed, that is, pushed down and out, but rather dissociated, that is, contained in an alternate stream of consciousness where the narrative form of the memory becomes inaccessible and instead, is often expressed on a visceral and emotional level (p.4).

Therefore if the traumatic memory is expressed on an emotional level, shifting away from the emotions may result in further constriction and may negate the survivor's opportunity to heal from her abuse.

Kiser, Piercy and Lipchik, (1993) stated that:

> The role of emotion in solution-focused therapy has been neglected and that theory and practice of solution-focused therapy can be enhanced by both examining and extending the place of emotions in this model (p. 234).

Thirdly, it is not uncommon for severely traumatized individuals to experience as sense of "futurelessness" (Terr, 1995), or an inability to see themselves in a future context. Terr (1995) stated:

> The limitation of future perspective is particularly striking in traumatized children because ordinary youngsters exhibit almost limitless ideas about the future (p.307).

Adults who have experienced childhood sexual abuse may exhibit remarkably similar characteristics to those identified by Terr (1995) as she spoke of children's feelings of a foreshortened future. Kiser, Piercy

and Lipchik (1993) offer a possible explanation:

> At times, client's reluctance to imagine a future time when the problem is partially or completely resolved may be an effort on their part to protect themselves from consequences of change or from getting their hopes up when they believe disappointment will follow (p.235).

Therefore in working with traumatized individuals a solution focused approach may not always be effective, particularly in the beginning stages of treatment. It would be important to address the person's belief systems before attempting to have her consider her life in the future.

Other limitations involve the therapist's lack of experience in the utilization of the brief solution-focused approach. Lipchik (1994) stated that novice brief solution therapist's often focus too much on technique rather than the client and what the client is trying to tell them. This can have negative consequences for survivors who have just disclosed and are only beginning to reach out to others for help. Under these circumstances the client would be unlikely to return for future appointments, and may possibly feel disillusioned by their experience.

Another problem Lipchik (1994) emphasized relates to goal setting. "Unfortunately, novice therapists often feel such pressure to set concrete goals that they sometimes begin building therapy on entirely incorrect premises" (p. 38). Novice therapists get so caught up in trying

to establish goals they immediately accept the first goal the client tells them and "assume that clients are ready to move ahead simply because they have defined a goal" (Lipchik, 1994, p. 39). Making a goal and working to achieve it can sometimes be scary for clients, the unknown is sometimes more threatening, so naturally they may appear ambivalent (Lipchik, 1994).

As mentioned earlier, utilizing a balanced therapeutic approach with survivors is essential. One dimension of exercising a balanced approach means taking into account the client's significant life experiences and learnings of the past, seeking to understand what they wish for themselves in the present and assisting clients in shaping their futures, should they wish to do so. The "Dynamic Co-Creative Healing Model" reflects this approach and was utilized as part of my own work with survivors. In the next section I will discuss this approach in more detail.

The Dynamic Co-Creative Healing Model

The Dynamic Co-Creative Healing Model (Appendix A) was developed by Bell-Gadsby & Siegenberg (1996) out of their work with female survivors of sexual abuse. I have utilized this model in my work in combination with ideas taken from Dolan (1991), and Comb & Freedman, (1990). The Dynamic Co-Creative Healing Model was chosen

because although the approach has a future orientation it is not "ahistoric", that is, it does not omit the client's abuse history. Both Bell-Gadsby (1996) and Dolan (1991) are sensitive to the needs of survivors and realize the importance of integrating and respecting the emotional and past experiences (related to the abuse) of each survivor.

In addition, I found the notion of "co-creating" (Appendix B) with your client an exciting prospect. In describing the therapist-client relationship Bell- Gadsby and Siegenberg (1995) stated:

> This is a continual process that involves the expression and assessment of needs and goals, the co-creation of a treatment plan that is individually tailored to meet the needs and developmental level of each client (employing specific metaphors, exercises and rituals where appropriate) (p. 22).

This process invites both the therapist and client to be creative in order to co-create the therapeutic process. In developing a treatment plan the authors suggest the utilization of "creative measures" in working with clients. In my opinion this signifies a creative step beyond some of the more traditional methods of therapy and may be more beneficial for those clients who have difficulty verbalizing their experiences.

In addition, co-creating with one's client may instil a sense of hope and relief within both the therapist and client. Hope that "yes" the client

does have the resources to heal, and relief that the responsibility is not entirely on the therapist to solve the client's problems. Dolan (1991) stated:

> Shifting from the present not only to the past but also to a hopeful future makes dealing with the trauma less overwhelming for the client and makes the treatment process more manageable for the therapist (p.30).

In addition to practising from a Ericksonian solution-focused perspective Bell-Gadsby and Siegenberg (1996) also emphasized their feminist leanings with which I also identify. The author's included material and information that reflected and focused upon abuse issues within a societal, political viewpoint as well as on individual experience (Bell-Gadsby and Siegenberg, 1996, p. 9). The authors view their clients in the context of their environment, they make a connection between the personal and political in the lives of the women they work with. The authors continued by stating:

> We each come into the room with our own experience defined in our own unique way and we are continually aware of how our biases concerning gender, politics, race, culture, and so on affect how we relate with each client. It is important to be as honest as possible about how these issues and beliefs affect the way we work and also be aware of their moral and ethical implications for the therapeutic relationships (Bell-Gadsby and Siegenberg, 1996, p. 10).

In addition to offering information to the client which reflects abuse issues within and beyond the survivor's individual experience, the authors suggest that it is important for the therapist to evaluate their own beliefs and biases which, if they go undetected, may negatively impact the client/therapist relationship. I feel that the therapist's own self evaluation is very important in developing counselling skills. I also believe that every therapist has her blind spots, that is, beliefs or biases of which she is unaware. In order to be more effective therapeutically I feel every therapist should go through her own counselling experience. It not only gives the therapist the opportunity to understand better what her clients experience during the course of therapy but again, also helps her in evaluating her own biases.

Bell-Gadsby and Siegenberg (1996) referred to their model as the "Dynamic Co-Creative Healing Model which they divide into four main stages:

> 1) Breaking the Silence/Unmasking the Secret
> 2) Becoming Visible
> 3) The Reclaiming and Reintegration of Self
> 4) and Empowerment and Evolution of the Sexual Self (p.28).

Each of the stages mentioned also have substages which will be highlighted in the description of the model which follows. I will now give an overview of each phase of treatment and describe some of the techniques utilized by the authors in their work with survivors. I will

begin with stage one of the "Dynamic Co-creative Healing Model".

Stage One

The first stage is called "Breaking the silence/Unmasking the secret" and is divided into five substages. The substages are:

1) Prevalent psychological and physiological symptoms
2) Isolation
3) Denial/ambivalence/fear
4) The power of the secret
5) Blaming self/ magical thinking
6) Reclaiming my voice and herstory.

At this early stage of the survivor's healing she is "cut off from her inner resources and abilities. She is powerless to alter her present dysfunctional behavior in anyway" (Bell-Gadsby & Siegenberg, 1996, p.50). Yet it is recognized by the survivor that the current coping mechanisms do not serve her well and coming to therapy may be the first step the survivor makes in breaking her isolation from her inner resources. At this stage many survivors experience a "self-imposed" isolation because they feel they are "different" from other people. This self-imposed isolation may prevent them from seeking help because they do not feel deserving of assistance. At this stage it is the therapist's job to help the client realize that she is deserving of help and prior to her contact with the therapist, other survivors have also

sought help for their own abuse (Bell-Gadsby & Siegenberg, p. 57). The therapist attempts to convey to the client that she is not alone.

It is not uncommon for the survivor to experience "uncertainty over whether or not she should disclose the secret" (Bell-Gadsby and Siegenberg, 1996, p. 52). This uncertainty can take the form of denial, fear and ambivalence regarding the abuse (Bell-Gadsby and Siegenberg, 1996). Survivors may alternate between experiencing feelings and thoughts that support the notion that they were abused, to experiencing feelings and thoughts that totally deny their abuse. In many cases survivors only experience fragments of the memory of abuse which often leave them feeling unsure that the abuse actually took place. "It is the therapist's role at this point to assist the survivor in gradually reintegrating the splintered fragments so that she can reclaim the lost parts of herself" (Bell-Gadsby & Siegenberg, 1996, p.53).

It is also common for the survivor to feel fear and panic at this stage as fragments of the traumatic memory begin to break through her unconscious into consciousness. Bell-Gadsby & Siegenberg (1996) stated that:

> The key is to assist the survivor in initially creating enough distance between herself and the abuse until she is personally ready to begin to initiate the steps toward reintegrating those parts of herself that were lost as a result of the trauma, going at her own pace, that each reintegrated piece of memory can ultimately assume a healthy permanency (p.56).

Dolan (1991) provides recommendations on techniques to help clients move through this stage, specifically the "symbol for the present". The "symbol for the present" is a technique which reminds the client where she is, that is, in the "present", rather than lost in the past abuse (Dolan, 1991). For example, when my client Lucy was face to face with one of her perpetrators, she utilized her wedding ring as a way to remind herself that he could not longer hurt her because she was no longer a child. It reminded her of who she was in the present, a working adult who was married with two of her own children and an adult who was capable of looking after herself. This symbolic reminder gave Lucy the strength she needed in order to face her step-father (perpetrator) again. "This 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" (Dolan, 1991, p.28). In Lucy's example it reduced the emotional impact of being in the presence of the perpetrator after 16 years.

It is important for the therapist to have some knowledge of child development to understand the self-blame that many clients experience. When children are abused they do not yet have the capacity to understand what is being done to them. The self-blame may be a way to try and gain control over a situation that is out of control. Self-blame may also be a result of what the offender has told

the child, "it's for your own good", or "if you were a good child I wouldn't have to do this". Often adult survivors will see themselves much in the same way as they did when they were children because of the developmental disruption they have experienced.

As the client works through stage one it is important to provide opportunities for hope, hope that what she is experiencing at this stage will begin to wane and she has the resources to heal from the abuse. Bell-Gadsby & Siegenberg (1996) recommended an Ericksonian technique called the "early learning set" which gives the client hope that she is capable of learning new ways to be in the world. An example of this technique would be to have the client recall a time in her childhood in which she learned and achieved a task such as taking her first step or learning to count to ten. Realizing that she has achieved these tasks reminds her that she is capable of learning new ways to cope or be in the world.

As the survivor moves through this final substage the client may begin to feel more "alive". An exercise to help survivors develop a "stronger sense of self" is the "self portrait" activity of how the survivor perceived themselves in the past, how they perceive themselves in the present and how they perceive themselves in the future (Bell-Gadsby & Siegenberg,1996, p. 59).

Stage Two

The next phase in the healing model is called "Becoming Visible". At this stage the secret of the abuse is out and the survivor "must face the often disquieting experience of becoming visible" (Bell-Gadsby & Siegenberg,1996, p.74). The substages that make up this phase include:

1) Prevalent Psychological and Physiological Symptoms.
2) The Healing Is In the Telling: Joining a Survivor's Group.
3) Minimizing the Abuse Experience.
4) Realizing That It Is Okay to Feel: Some Common Coping Skills
5) Vocalizing the Experience (p.74).

At this stage the therapist continues to assist the survivor in dealing with their abuse-specific symptoms. The therapist "normalizes such coping mechanisms as dissociation, flashbacks, nightmares, anxiety attacks, hypervigilance, numbing and self-mutilation by making it clear that these mechanisms are and were necessary methods of dealing with the abuse and which allowed them to survive (Bell-Gadsby and Siegenberg, 1996, p.83). It is at this stage that the survivor begins to connect their traumatic reactions, their current coping behaviours, to their abuse (Bell-Gadsby and Siegenberg, 1996, p.75).

At this stage Bell-Gadsby and Siegenberg (1996) believed that a group experience can be helpful for survivors. It breaks down their feelings of isolation, helps them realize they are not the only ones who have been abused and it gives them an opportunity to learn social

skills. The group experience is recognized as a "positive ritual". Bell-Gadsby & Siegenberg (1996) continued by stating:

> We view group therapy as a positive ritualistic event that can reframe or alter the identity of the survivor once again..therefore the group experience can become an initiation back into mainstream society (p.77).

Minimizing the abuse is not uncommon during the first three stages of recovery. Minimization may occur due to the messages passed from the offender to the child and the messages passed on to the child/survivor by society (she was to blame). It is important for the therapist to assist the survivor in identifying the negative self-talk and change it to self-talk that is more self-affirming. An exercise for combating negative self-talk is the "exercise for reframing critical voices" which consists of identifying the negative messages, replacing them with kinder ones and "co-creating a letter of appreciation with the survivor for the survivor" (Bell-Gadsby & Siegenberg, 1996, p.91).

"In the present the survivor faces the struggle to find effective methods of coping with feelings that are desperately trying to find some means, some outlet for expression" (Bell-Gadsby &Siegenberg, 1996, p.83). Bell-Gadsby & Siegenberg (1996) continue by stating:

> It is critical that we as therapists honour whatever coping mechanisms the client has employed in order to survive, until she is fully aware of what they are, how she has used them

> in the past and present and throughout the healing process, that is, assisting the survivor, when ready to connect with more viable alternatives (p.83).

As the survivor vocalizes her experiences she becomes more in touch with herself and her feelings. The methods used at this stage should be future focused in order to support the individual's hope so that the survivor does not get stuck in the trauma of surfacing feelings (Bell-Gadsby and Siegenberg, 1996, p.88). Dolan (1991) suggested several techniques which may be useful for this stage in the survivors healing, these include, the solution focused recovery scale, the miracle question, the scaling technique, the first session formula task, and the older wiser self activity. See Appendix C for details on these techniques.

Stage Three

The third stage of the healing model is referred to as "The Reclaiming and Reintegration of Self. At this stage the "survivor's focus is to reintegrate the true parts of the self" (Bell-Gadsby & Siegenberg, 1996, p.106). The survivor slowly comes to distinguish between parts of her true self from those parts which were formed as a result of the sexual abuse. The substages of this stage include:

> 1) Struggling to gain approval and feel loved
> 2) Recognizing one's own power to contain feelings and not be overwhelmed by them

> 3) Loving, self-developing compassion for the child
> 4) Reclaiming the positive memories as well as the more painful ones
> 5) Celebrating the child

Bell-Gadsby and Siegenberg (1996) stated:

> An additional indication that the client has shifted from stage two to stage three is her new found courage and willingness to take the risk of connecting more consciously to the abused child, which she can gradually confront directly instead of, for example, choosing to withdraw or experience her feelings as symptoms in her body (p.107).

It is at this stage the survivor begins to realize how the abuse has affected her relationships. For example, she may realize some of her past sexually acting-out behavior was the result of her need for love and acceptance.

At this stage the client continues to work through her feelings of guilt, betrayal, shame and anger and begins to realize that she does not have to maintain all of these feelings. Again it is important for the therapist to recognize these feelings as "necessary coping mechanisms" that the client utilized in order to survive her childhood abuse. Bell-Gadsby and Siegenberg (1996) stated:

> Only when she is ready and able to actually name what she can replace these feelings with is it appropriate for the therapist to assist the survivor in initiating the process of challenging and transforming these and other feelings (p.114).

This stage is hopeful in that the survivor begins to understand where some of her feelings really belong, with the perpetrator, and with those who did not protect her as a child. This is an important stage because the client is able to separate the abuse from who she is. As the client reconnects with the child, the task for the survivor is to learn how to "stay present" while discussing painful experiences and to begin replacing old coping mechanisms with newer ones. As the survivor connects with her "inner child" she learns to have more compassion towards herself. The survivor becomes more understanding of what she experienced as a child and begins to recognize the courage and strength she exercised in order to survive.

Bell-Gadsby and Siegenberg stated:

> One of the by-products of beginning to integrate and connect the feelings of the child at the time of the abuse with the survivor in the present is making connection to some of the positive memories one had as a child (p.119).

At this stage the survivor is able to reclaim the positive moments she had as a child. Playfulness becomes important and easier to access for the survivor. It is important for the survivor to acknowledge and honour their inner child as much as possible (Bell-Gadsby and Siegenberg, 1996).

Stage Four

The fourth and final stage of the Dynamic Co-Creative Healing Model is referred to as "Empowerment and Evolution of the Sexual Self". The "reintegration process", initiated in stage three, continues during the first half of stage four. At this stage the survivor "is concerned with redefining herself in relation to others" (Bell-Gadsby & Siegenberg, 1996, p.152). Later she becomes "more future-oriented... generally more proactive. She is concerned with redefining her sexuality and with the big picture, both personally and in a societal sense" (Bell-Gadsby & Siegenberg, 1996, pp.152-153). The substages at this final phase are divided into part A and part B. I will begin by discussing Part A.

" Prevalent Psychological and Physiological Symptoms" is the first of the four substages of Part A. At this stage there is a recognition of how the abuse has effected the survivors relationships. The survivor may still experience some of her old coping mechanisms but she is now able to counteract them with her new skills and recover from the episodes much quicker. These "intermittent set backs" can be reframed and viewed as "transition periods" or opportunities in which the survivor can practice new skills (Bell-Gadsby & Siegenberg, 1996 p.153).

"Understanding How the Abuse Continues to Affect the Survivor in the Present" is the second substage under Part A. At this stage the survivor is more connected with her adult self and has a deeper

understanding of how the abuse has effected her relationships. The survivor may want to deal with some family of origin issues at this stage and possibly may want to reconnect with family members she lost touch with following the disclosure of her abuse. She may also want to confront the abuser. It is important to prepare the survivor for dealing with her family if that is what she wants. Courtois (1988) offers some guidelines that help clients when they are considering confronting the perpetrator or other unsupportive family members. They are:

1) Carefully consider timing (not while other crises are occurring within the family or within the client's life).

2) Assess survivor readiness. The survivor must be strong enough to withstand any negative responses from family or others.

3) Expect family denial and do not over react to it. It may take more than one time to break through the family's denial.

4) Try to be patient with the process.

5) Do not look to the confrontation for validation of either the abuse or the survivor.

6) Expect a variety of outcomes and varying degrees of success and resolution (p.338).

Dolan (1991) suggested in preparing a client for disclosure, writing "healing letters" before the actual confrontation takes place can be very helpful. The client is asked to write a letter disclosing the abuse without sending the letter. She is then asked to respond to the letter the way she thinks the person will respond (worst scenario). The last letter she writes is also a response but is a letter of support and includes what the survivor would most like to hear from the abuser (p.63). In writing the last letter she is able to give herself the support she needs rather than trying to get it from someone else.

"Lifting the Cloak of Self-Blame and Dealing with Family and Trust Issues" is the third substage of Part A. At this stage trust becomes more important to the survivor. Self-trust is increasing within the survivor and she is learning to make distinctions between who she can and can not trust in her life.

"Creating Boundaries" is a important component of substage four. "In order to establish boundaries, one has to understand one's own value system and to understand and to define one's needs and expectations about any particular subject or situation" Bell-Gadsby and Siegenberg, 1996, p. 161). The exploration of values and beliefs is recommended as a way of defining herself and deciphering between

what she believes and what are old beliefs from the past (Bell-Gadsby & Siegenberg, 1996). The goal of the therapist at this time is to assist the survivor through this process. The ability to trust one's instincts, utilize those instincts in making distinctions between who and who is not trust-worthy and practise setting boundaries are important tasks of stage four.

"Externalizing the Expression of Grief and Loss and the Empowerment of Self" is the final substage of Part A. "As the survivor reexamines her values and beliefs we have found some common themes emerge. One of the most significant of these is the understanding of grief, loss and anger at society for not protecting its children and the commitment to self and one's children to end the cycle of abuse" (Bell-Gadsby & Siegenberg, 1996, p.163). During this stage the survivor is encouraged to grieve these losses. It is recommended that the grieving process be explained to the survivor in order to assist her in making sense of her strong emotions.

The first substage of Part B is referred to as "Acknowledging and Reintegrating the Sensual/Sexual Self: Retrieving Creativity". Connecting with one's sexuality and sensuality becomes more important at this phase. The "thriver" can begin to connect with her sensuality and sexuality in positive ways through self-nurturing activities. Dolan (1991) suggested an activity called "Hypnotic accessing of good body

feelings". Following a relaxation induction the client is asked "let's ask your unconscious to come up with a time in which you experienced wholesome, safe and very comfortable body sensations. The client is directed to

> ...let the unconscious do the work for you, you can feel free to enjoy the surprise or unexpected familiarity of a nice experience. When you have the experience take a moment to enjoy it and then come back and tell me what it was like for you (p.167).

"Rejoining Society: Creativity in the Present to Promote a Positive Future Focus" is the second substage of Part B. At this stage the "thriver" is more future focused. The survivor now has the ability to plan for the future and set goals for herself, and it is not uncommon for survivor/thriver to get involved in social causes in order to help create a safer world for other women and children.

"Transforming the Fragile Alliance: Building Stronger Healthy Partnerships" is the final substage of stage four. The main focus of the final stage involves the building of intimate relationships from a "health oriented context" within the "thrivers" adult life. It is also important to recognize that not everyone has the same definition of success. Breaking free from the grasp of their offender, become independent, and establishing a safe place for themselves in society can be a major success for many women (Bell-Gadsby and Siegenberg, 1996, p.196).

The client/survivor will have completed all phases of the Dynamic Co-Creative Healing Model when/if she is able to demonstrate a capacity for self-nurturing, and she "has emotionally worked through her sexual abuse to the point that she is successfully able to sustain a healthy, thriving lifestyle that has transcended mere existence, freeing her to ally with healthy others"(Bell-Gadsby and Siegenberg, 1996, p.186).

This concludes chapter two of the literature review. In chapter three I will discuss the practicum project in more detail, including the clinical setting, participant selection, duration of the practicum, contributions of the committee members, and methodology.

Chapter 3

Practicum Project

Clinical Setting

The practicum was carried out at the Elizabeth Hill Counselling Centre (EHCC) in Winnipeg, Manitoba. The EHCC is an inner-city branch of the Psychological Service Centre and the Faculty of Social Work, both departments within the University of Manitoba. The EHCC is used as a clinical training centre for psychology and social work students and serves people from the inner city who cannot afford to pay for treatment elsewhere.

Participant Selection

Participants were selected from the Elizabeth Hill Counselling Centre's waiting list and/or accepted from other community referral resources when they met the criteria as designated.

The criteria I established for client participation were fairly general and included women:

1) who had been sexually abused in childhood.

2) who were 19 years old or older.

3) who were prepared to be seen by a graduate student, supervised by a faculty member.

4) who were prepared to participate in the practicum project and all that the project entailed *ie.*, that the client agreed to the student

sharing segments of therapy sessions with their supervisor and other committee members for supervisory purposes. In addition, participants were appraised of the likelihood that some of the content of our sessions would be included in my final report, with attention directed at maintaining anonymity.

5) who were not involved with another therapist for childhood sexual abuse issues.

6) who signed a consent form to video-tape the sessions for supervisory purposes, and

7) who agreed to fill out measurements for pre-post testing evaluation purposes.

These criteria were reviewed with each client during the first interview. One client claimed that I had not told her that the sessions were to be video-taped. She made it clear that if she did not want to be video-taped, and if she had known this prior to the initial interview, she would not have appeared at EHCC. She did not return after our intake session.

Duration of the Practicum

Work on the practicum began in August, 1996 and ended on April 30th, 1997. The Elizabeth Hill Counselling Centre was closed for two weeks during the Christmas break and the student therapist was

absent for two weeks at the end of March, 1997. Therefore, the duration of the practicum was approximately seven months.

Committee Members

Three committee members provided clinical support throughout the project. Shirley Grosser, an Associate Professor, Faculty of Social Work, University of Manitoba was the primary advisor. Shirley and I met on a weekly basis throughout this project for supervisory purposes. Kim Clare, Associate Professor, Faculty of Social Work, and Director of the Winnipeg Education Centre was the second committee member. Linda Perry, full time therapist, Elizabeth Hill Counselling Centre was the third committee member. Linda Perry, was also available for consultation when my advisor was unavailable.

It was the responsibility of all members of the committee to review the student's proposal, evaluate the student's progress during the course of the practicum, and review and evaluate the student's final report.

Methodology

Over the course of my practicum I contacted 13 women. Ten of the women were taken from the Elizabeth Hill Counselling Centre waiting list. One woman had her social worker from Child and Family Services

call Elizabeth Hill Counselling Centre in order to request services for child sexual abuse. This call was immediately transferred to me. Two of the thirteen clients were transferred internally from another student therapist who had been employed by the Elizabeth Hill Counselling Centre over the summer and worked with the women.

All thirteen women were initially contacted by phone. (The details of this contact will be discussed under the next heading). One woman I contacted by phone had received assistance elsewhere and no longer required service from EHCC. Another woman contacted by phone decided that she was not yet ready to attend counselling. Following phone contact with all of the women, I scheduled an in-person interview with eleven of the thirteen women.

I had at least one meeting with each of the eleven women. After receiving permission from one client I conducted a collateral check with her previous therapist. The previous therapist did not feel the woman had the ego strength, at that time in her life, to deal with her childhood sexual abuse issues. In addition, the woman's presenting concerns during the intake interview were related to domestic violence and not childhood sexual abuse. It was decided that she was not appropriate for the practicum and therefore she was referred to an agency which assisted women with domestic abuse issues. Following another interview meeting, a woman did not meet the videotaping criterion of

the practicum and therefore was not accepted for the practicum, although she was assisted in finding alternative resources within the community. Another women did not return after our first meeting, although I did have phone contact with her on a two occasions after our first meeting. Her father (who was also her perpetrator) had died a few weeks before our first meeting and, although she initially wanted help, it appeared to the therapist that she did not have the ego strength at the time to begin working on her sexual abuse issues. Another woman decided after two meetings that she was not ready to work on her sexual abuse issues because she was attending school. She withdrew from the practicum.

Of the remaining seven women, one attended 4 sessions, two attended 5 sessions, two attended 19 sessions, one attended 21 sessions and one woman attended 24 sessions. For the purpose of this practicum, in chapter 4, I will discuss the therapeutic process as it unfolded with six of the seven women.

Initial Telephone Contact

The purpose of the initial phone call was to tell potential clients about the services I was providing through EHCC. The intention of the phone call was to encourage both the client and therapist to make personal contact which "can be useful in building rapport and trust

between the family member and therapist" (Karpel and Strauss, 1983, p. 100). Elizabeth Hill Counselling Centre has intake workers who take incoming calls from possible clients. There is a standard form that is used in order to collect basic data on the client. The clients are then placed on the waiting list. There is a long waiting list at EHCC and sometimes potential clients remain on the waiting list for several months before receiving services. During the initial phone call I introduced myself to the client and asked whether they were still interested in receiving counselling services from the EHCC.

If the individual expressed an interest in utilizing our services I continued with the following question; "I have been made aware that one of the issues you are seeking counselling for is in the area of childhood sexual abuse. Is this still a concern for you"? If the client continued to express an interest in receiving counselling from our agency I then asked her if she was presently receiving assistance from another agency regarding this issue. I explained that one of the criteria for participation was that the client not be involved with another therapist for sexual abuse. This was asked in order to insure there was no duplication of services being provided.

If the client met the previous criterion I would give them some background information on EHCC and inform the client that I was a graduate student specializing in sexual abuse. Following this brief

discussion the client was asked whether she was interested in attending a screening interview in order to discuss the project further. If the woman expressed an interest then I scheduled a second meeting with her. If any of the women did not want to meet I thanked them for their time and suggested they recontact Elizabeth Hill Counselling Centre in the future if the need arose (although they would not be eligible for this practicum). If any of the women requested services but did not want to participate in the practicum, they had the choice of remaining on the EHCC's waiting list.

In-Person Screening Interview

The screening interview was intended to explain the practicum project in more detail and elaborate on the initial phone call. It was important to make the client feel as comfortable as possible during this initial face-to-face contact. For some of the women this was the first time they had approached a counsellor for assistance regarding their childhood sexual abuse and so I assumed that they would naturally feel quite nervous and somewhat intimidated. In order to alleviate possible feelings of anxiety and nervousness I would often start with non-threatening types of questions, such as their place of residence and whether or not they had any children. I also explained briefly, my own personal interest in taking on this project, my interest in women's

issues, particularly in working towards ending violence against women, and my belief that women can heal from sexual abuse.

I then explained to each of the women that as a counsellor I had to report any suspicions I had of child abuse and or if I felt the woman was in danger of harming herself. More specifically I said "before we go any further, I tell all the women that I work with that if they tell me a child is being abused or that they are going to seriously hurt themselves, as a counsellor I have a legal obligation to report this to the proper authorities". Following the above explanation I continued with a discussion of the Elizabeth Hill Counselling Centre, explaining its originator's role in service to children and families, and that the centre was developed in order both to meet the needs of people living in the inner city area, and as a training centre for students in professional training programs.

I also explained the practicum in more detail, starting with an explanation of the measurements, and the importance of each client filling out the forms before treatment began and after treatment ended. The role of the supervisory committee members were discussed, and the importance of video-taping the sessions for supervision purposes was also highlighted. In addition, I emphasized confidentiality with exceptions in the case of committee members and my professional obligation to report suspected child abuse. I also explained that I

would have to complete a final report and that the client's anonymity would be maintained, although some details of the treatment sessions might be included. My respect for where each client was in her healing process was emphasized, as well as my belief that each client moved at her own individual pace. Each client was told that the practicum would last approximately seven months and finish at the end of April, 1997.

In order to assess whether the client was using alcohol/or drugs to deal with her abuse the following question was asked: "Some people, when they are faced with such a stressful situation, turn to alcohol or drugs to help them cope. Is this the case for you"? (Perry, 1994, p.180). If the answer was "yes" the client will be asked to what extent had she used this as a coping mechanism. The client was not necessarily omitted from the practicum because they had used or were using drugs or alcohol as a coping mechanism. If the client began attending sessions under the influence of alcohol or other non-prescribed drugs then the therapist would refer the client to a more suitable agency and exclude them from the practicum.

Following an explanation of the above details each woman was told that in order to participate in the project they would have to consent to participate within the parameters of the practicum. If they consented they were asked to sign a consent form (see appendix G) developed by

the student counsellor, and were asked to sign a video-tape consent form administered through the agency's intake process. A second interview was then set up with those women who met the criteria and agreed to participate in the project. Each woman was also told what to expect for our next meeting.

Second In-Person Interview

During the second interview each women was requested to fill out the pre-test measurements and other relevant data was collected, for example family history. The measurements which were utilized with the clients in this practicum project, will be discussed in the next section.

Evaluation Instruments

The practicum project used a pre and post-test design for evaluation purposes. Four measures were used in order to measure the impact of treatment. These were: Beliefs Associated with Child Sexual Abuse (Jehu, Klassen & Gazan, 1986); the Beck Depression Inventory (Beck, 1978); the Trauma Sequelae (Koverola, Proulx, Hanna, Battle, Chohan, 1991); and the Solution Focused Recovery Scale for Survivors of Sexual Abuse (Dolan, 1991).

The first measure used, the Beliefs Associated with Child Sexual Abuse (BACSA), is a 17 item instrument designed to "measure common

distorted beliefs associated with childhood sexual abuse" (Jehu, 1988, p.53). The scoring procedure for the BACSA is to add up all the scores of each item chosen. Each item utilizes a 5 point scale ranging from 0-4. The cut off score is 15, therefore anyone with a score of 15 or more is considered to have clinically significant distorted beliefs in relation to their sexual abuse experience (Jehu, 1988). The BACSA was revised and now consists of 26 items (Jehu, 1988). However, due to the lack of psychometric data available on the revised measure, the original inventory was used in this practicum.

The BACSA has high test-retest reliability (.93, $p<.001$) (Jehu, 1988). A Pearson correlation of .55, $p < .01$, between the scores of the 25 sexually abused women on both the BACSA and the Beck Depression Inventory suggest that the BACSA has acceptable concurrent validity with the Beck Depression Inventory (Jehu, 1988, p.54). The BACSA appears to measure common mood-disturbances which are reflective of someone sexually abused as a child and therefore the BACSA has good face validity (Jehu, Klassen and Gazan, 1986).

> The highest score on the original 17 item BACSA during initial assessment was a clinically significant level of 15 or more for 94% of the victims. This proportion was reduced to 13% at termination of therapy focussed on mood disturbances, and to 5% at the final follow-up (Jehu, 1988, pp. 99-100).

At termination, Jehu found that 81% of the victims no longer had clinically distorted beliefs and at follow-up 89% of the victims no longer experienced distorted beliefs. Therefore the BACSA appears to be sensitive enough to measure changes in the degree of distortion associated with child sexual abuse.

The second measure used was the Beck Depression Inventory (Beck, 1978). The Beck Depression Inventory has been used to measure depression in child sexual-abuse survivors (Jehu, 1988; Jehu, Gazan, Klassen; 1985). Jehu, Gazan and Klassen (1985) found that 18 of the 22 women in their study experienced some degree of depression resulting from their child sexual abuse experience. The inventory has been found to be sensitive enough to measure changes in the levels of depression and is a useful "indicator of particular symptoms that require therapeutic attention" (Jehu, 1988, p.54). High scores on symptoms such as suicide ideation and pessimism may require immediate therapeutic attention (Jehu, 1988).

The Beck Depression Inventory is a 21 item tool which is easily administered and measures presence and degree of depression in adolescents and adults (Stehouwer, 1985, p.83). Jehu (1988) states "this very well-established instrument was developed by Aaron Beck and it covers all the major symptoms in the depressive syndrome, including low self-esteem, guilt, and dysphoria. Thus, it is a very useful

comprehensive measure of mood disturbances in victims" (of child sexual abuse) (p.54). Stehouwer (1985) stated:

> The score is obtained by taking the highest score circled for each item and adding the total numbers of points for all items. While the authors admit there is no arbitrary score that can be used for all purposes as a cut off score and that the specific cut off point depends upon the characteristics of the patients used and the purpose for which the inventory is being given, they do give the following guidelines: 0-9 normal range; 10-15 mild depression; 16-19 mild-moderate depression; 20-29 moderate-severe depression; 30-63 severe depression (Stehouwer, 1985, pp.84-85)

In interpreting the scores the interviewer should pay attention to specific symptoms. The interviewer should be concerned if their client scores 2 or above on both pessimism and suicide ideation. A high score on both of these items may reflect someone who is contemplating suicide (Beck, 1980). Another factor to be aware of in scoring is in regard to the weight-loss question; if a client is consciously trying to lose weight, the number is not added to the total score.

In order to read the test the individual must be at a grade eight reading level. If this is not appropriate for the client, the interviewer can read the questions to the individual.

The third measure used was the Trauma Sequelae (Koverola, Proulx, Hanna, Battle, & Chohan, 1992). It is a self-report which measures Post Traumatic Stress Disorder symptomatology based on DSM-IV criteria. The questionnaire consists of 23 items and is scored utilizing the following criteria:

> A) The person must have experienced a traumatic sexual abuse experience.
>
> B) **Reexperiencing the trauma.** The person must answer yes to at least one of questions 1-10, and the duration of these symptoms must be at least one month.
>
> C) **Avoidance of stimuli associated with the trauma.** The person must answer yes to at least three of questions 11-17, and the duration of these symptoms must be at least one month.
>
> D) **Increased Arousal.** The person must answer yes to at least two of questions 18-23, and the duration of these symptoms must be at least one month.
>
> Criteria A, B, C, and D are necessary to categorize the person as PTSD positive. Partial PTSD is indicated when the person meets Criterion A plus any of B, C, or D (Perry, 1994, p.188).

This measure is still in the process of being validated, although there have been some prior studies done supporting the measure's concurrent validity.

In a study investigating the incidence of PTSD within a sample of 833 female university students, Hanna, Koverola, Proulx and Battle (1992) found that 6 % of the sample met the criteria for PTSD.

> These results were validated by administering the Structured Clinical Interview for the DSM-III-R-Nonpatient Edition (SCID-NP) to a subset of 45 subjects. Chi-square analysis of the results indicated no significant differences in the way that the Trauma Sequelae and the SCID-NP classified individuals as either PTSD positive or PTSD negative (Hanna, Koverola, Proulx and Battle, 1992, p.?).

The fourth measure used was the Solution Focused Recovery Scale (Yvonne Dolan, 1991) which was "inspired by the Solution Identification Scale developed by Ron Kral at the Milwaukee Brief Family Therapy Centre in 1988" (Dolan, 1991, p.31). Dolan (1991) indicated that:

> The Solution Focused Recovery Scale for Survivors of Sexual Abuse was developed as an external device to help the client begin to identify and talk about the ways she has already begun to heal and the signs that will convince her that she is healing in the future (p. 31).

The scale can be read aloud to the client or the client can fill out the questionnaire privately (Dolan, 1991). For this practicum I had each of the women fill out the report privately. The scale consists of 38 questions in which the client responds with; a) Not at all; b) Just a Little; c) Pretty Much; or d) Very Much. This scale was chosen because of its

solution focused approach and its emphasis on the survivor's resources and strengths. As far as the author knows there has been no validity or reliability testing completed on this measure.

In concluding this section, please see permission letters to use the various scales in Appendix D.

CHAPTER 4

Client Contacts

In this section I will include the client biography, a description of the problem, the client's presenting concerns, the goals of treatment, and the treatment process and intervention strategies utilized with each of the six women. The first client I will discuss is Anna (client A), the second client is Lucy (client B), the third client is Betty (client C), the fourth client is Tory (client D), the fifth client is Jill (client E) and the sixth client is Sabrina (client F). I will now begin this section by discussing Anna.

Case example- Client A- "Anna"

Anna, a caucasian woman in her early twenties, was self referred in order to deal with her child sexual abuse issues. She was raped at the age of fourteen and feels the trauma has continued to affect her adult life.

Client biography

Anna is the only child to Greg and Sue. Anna's mother was sixteen when she married Greg, 9 years her senior. Anna's biological parents divorced when she was four years old due to Greg's extra marital affair. Anna resided with her mother following the divorce but had frequent

visits with Greg. Eventually both parents remarried. Greg married the woman he had an affair with, and the couple had a second daughter which is Anna's half sister.

Anna's mother remarried a man, referred to as Ben, who suffered from alcoholism. The couple eventually separated and Ben died several months later due to liver problems caused by excessive drinking. Anna was in her late teens when her step-father died. Anna felt very close to her step-father and had a difficult time dealing with his death.

Anna indicated that she and her mother have a more open relationship than Anna has with her biological father. Anna considers her mother to be her "best friend". There is a history of alcoholism in Anna's mother's family of origin. In addition Anna's biological mother was also raped as a young adolescent and did not receive any assistance during that time in her life.

Greg is described by Anna as "secretive" about his family history and therefore Anna has little information about his family of origin. She also defined her biological father as "overbearing" and controlling. Anna stated that her biological father sent her to a weight-loss clinic when she was nine. She felt he was overly concerned about her weight during her childhood. Although Anna knows little about her biological father's family of origin, Anna speculates that Greg's mother may have been schizophrenic. In addition Anna has observed that alcohol

abuse seems to be an issue in her father's family of origin as well.

Anna did well in school until she was raped at the age of fourteen, by an adolescent acquaintance. Following the rape Anna's ability to concentrate and focus on schooling declined until she eventually dropped-out. Her parents did not find out about the rape until two years after the trauma. After the rape Anna's behavior became progressively more concerning for her parents and she was eventually referred to a counsellor. This gave Anna the opportunity to disclose the abuse. Although Anna disclosed the abuse to her counsellor, much of the time spent in sessions involved discussing other matters. Following the rape disclosure, the counsellor informed Anna's mother, without Ann's consent, about what had happened to her daughter. Both her mother and step-father responded supportively. Anna's biological father was not told about the rape until some time later. When her biological father was told he responded by calling Anna a "liar". He suggested that her disclosure was only a tactic used for the purpose of getting out of attending high school.

Anna is now in her early twenties, is single and is employed on a full time basis. She has no children and has never been married.

Description of Difficulty

Anna's initial difficulty, which she discussed during our first meeting,

revolved around the abuse experience she had at the age of fourteen. Anna was raped at a party by an acquaintance while she was resting in one of the bedrooms due to her over consumption of alcohol. Anna's friends walked in while the rape was in progress. The perpetrator was beaten and let go. The police were not notified. The following day Anna's friends behaved as if nothing happened. During the following school year Anna returned to school only to find the perpetrator attending the same school. Apparently he was "bragging" to other students that he "popped this chick's cherry". Due to the discomfort and retraumatization of seeing the perpetrator and his continued abusive behavior, Anna dropped out of school. In addition to the first rape Anna disclosed being raped on two more occasions while still an adolescent, the second and third rapes were perpetrated by a long-term boyfriend.

Presenting Issues/Concerns

Anna initially explained that she was suffering from intrusive symptoms such as recurring memories or what she referred to as a "movie screen in her head". Other intrusive symptoms included flashbacks and dreams. Anna also suffered from constricting symptoms such as feeling numb and cut off from others. In addition Anna presented her "promiscuous" behavior as a problem. She felt

that she was unable to say "no" to having sex with certain people due to her fear of being raped. Therefore she was not able to set boundaries and keep herself safe. During our initial sessions together Anna also expressed a high degree of guilt about "letting her parents down". She assumed that because she dropped out of high school and was not attending College her parents were unhappy with her. Anna also expressed self-blame and guilt regarding the rape. She stated that if she had not been drinking and "flirting" at the party (where the rape took place) she would not have been raped.

Goals

Following our intake session Anna and I decided to meet once a week in order to address some of her presenting concerns. Although I conveyed to each client that recovery was possible, I also reminded each individual that we would have to be realistic in regards to what goals could be achieved in the seven month duration of the practicum.

Although Anna had previously disclosed her sexual assault to another counsellor, at that time she was not emotionally or psychologically ready to discuss the assault in any great detail. Both Anna and I felt she was now ready to take on that challenge.

The first goal was to establish rapport with Anna and at the same time gather important information which would assist in the therapy

process. It was important that Anna feel safe enough to share her story, as well as have the opportunity to discuss the assault and surrounding circumstances.

It was also apparent that Anna needed to explore and develop new coping behaviours, particularly in regards to behaviours which were putting her at further risk. A particular concern for Anna was her inability to say "no" to having sex. She wanted to understand this behavior and gain control in situations in which she felt particularly vulnerable.

Another coping strategy which Anna utilized was over eating as a way, she claimed, to"stuff her feelings". Although Anna appeared to be of average weight for her height, over eating was a theme that appeared throughout our sessions together.

Anna's self-blame and guilt surrounding the assault also required further exploration in order to assist her in placing the blame where it belonged, on the perpetrator. Although in the Dynamic Co-Creative Model the survivor does not appear to "openly blame" the offender until stage four of the model, the groundwork for decreasing Anna's self-blame began through an information process of describing the common effects of sexual abuse, developing self-awareness in regards to her self-critical internal messages and reframing those messages into more positive ones.

Anna also experienced a deep "loss" as a result of the assault. She felt that following the assault her whole life had changed for the worse. She expressed a desire to become "5 years old again", a time during her life in which she felt content. In addition to the losses Anna experienced due to the assaults, she also lost her step-father whom she was close to. This "loss" also had to be addressed during the course of treatment. Therefore another goal co-created with Anna was to provide an opportunity for her to mourn these "losses".

Treatment Process and Intervention Strategies

Following our intake meeting Anna and I decided to continue with treatment. Anna returned for a second meeting in which she completed the pre-test measurements. In addition to filling out the questionnaires I asked Anna questions about her family of origin for assessment purposes.

Following our second session together I asked Anna to do the "letter from the future" activity (Dolan, 1991, p.132). The purpose was to instil a sense of hope within Anna, hope that there is life after therapy. I asked her to imagine her self in 5 years from now, and from that place write a letter to her present self describing where she is, what she is doing, and how she feels. The idea is to keep the letter as a reminder that things will get better.

When I asked Anna if she had done this the following session she replied "no". She stated that she was unable to see herself in the future and therefore the activity was dropped. From a solution focused perspective Anna's non-compliance would not be perceived as "resistance", but would be interpreted as the client attempting to tell the therapist that what they are doing is not helpful and therefore something else should be tried. It was explained to Anna that her experience of "futurelessness" is not uncommon for survivors. By meeting Anna where she was also assisted in promoting a sense of safety and strengthened the therapeutic relationship.

When Anna arrived for our fourth session she claimed that she had unsafe sex while under the influence of alcohol over the weekend. She referred to the behavior as "raping herself". She then started sharing the story of her abuse at the age of fourteen. As she talked about the circumstances surrounding the rape she expressed feeling "guilty",--- guilty because she was "flirting", and if she had not been "flirting" the rape would not have occurred. I reframed her "flirting" behavior as a normal behavior for a fourteen year-old adolescent. I explained that adolescence is a time of exploration, a time in which every young person wants to fit in, and a time when young people are beginning to notice one another in a sexual way. I stressed that "flirting" was a

"normal" behavior whereas the raping behavior as not normal. It was during this session that Anna disclosed being raped on two more occasions by a long-term boyfriend while she was intoxicated. During this session Anna continued to blame herself for the rapes and talk negatively about herself. It was important during this phase of treatment that I attempt to emphasize what ever Anna was doing in her life that was supporting her growth, and behaviours she could recognize as self-supporting. I stressed such things as her ability to find and stay with a job and support herself, her choice to leave her home town as a way to keep herself safe, and her courage and ability to seek counselling.

During our next session Anna stated that she "had been a good girl" (meaning she had not had sexual intercourse with anyone) but had been eating too much over the previous week. It was during this session that we discussed the messages she received from her family as a child about what it meant to be a "good girl" and about being a woman. We discussed the socialization of girls and the traditional stereotypical roles of women and girls in our society. At this point Anna disclosed that her father had taken her to a diet centre when she was nine and the message she received from her father was that "if you don't lose weight no one will want you". This was a constant concern for her father and he often let Anna know it. At the end of this session I

introduced the "box of sorrows" activity (see appendix A). She appeared interested in continuing with this activity in future sessions.

During the next session Anna arrived dressed in black. She expressed feeling very sad but was unable to identify why she was sad. She spent much of the session with tears rolling down her cheeks and talking about this deep sadness. During this session I utilized the box of sorrows activity again. I asked Anna if she would like to leave her sorrow in the box. I also told her she did not have to share her sorrow with me if she was not ready, but if she wanted to in the future she had the option. I emphasized that the box of sorrows was hers and I would respect her privacy if she chose not to take the box home. Anna was interested in doing the activity and continued by writing her sorrow on a piece of paper and placing it in the box. She did not want to share the sorrow with me but requested that I keep the box in my possession between sessions. Acknowledging her feelings in this way appeared to be helpful for Anna. We utilized this activity on several occasions throughout the treatment process.

Anna missed the next two sessions. When she returned, she again discussed "misbehaving" (having sex with someone) and talked about her feelings of loneliness and emptiness. At times Anna seemed "stuck" in this despairing state. During this session I utilized a solution focused scaling technique in order to assist her in developing an

awareness of what her loneliness meant (see figure 1).

Figure 1:

not lonely somewhat lonely moderate lonely lonely very lonely

* The scaling question was a modification of O'Hanlon and Weiner-Davis's (1989, P. 150) suggestion.

On that particular day Anna positioned herself as feeling "very lonely" and described this as including an "unbelievable sorrow, difficulty sleeping and waking up often during the night, an empty feeling, still continuing to work but eats like crazy". Anna then stated that she would feel better if she could move down the scale to a place between moderate and somewhat lonely. Between moderate and somewhat lonely was described as, "sleeping without waking up, eating less, sadness not sorrow, and continues to work". Just by doing the activity Anna dropped from "very lonely" down to just above "lonely". When I asked Anna how she was able to move down the scale she stated that just by recognizing her feelings it helped decrease her sense of loneliness. Recognizing and acknowledging Anna's feelings were very important during this stage of her recovery.

During the next session, Anna no longer showed an interest in doing the loneliness scale or in any other suggestions that I made. She began to discuss her loneliness again but was not willing to explore it in any great detail. At times Anna appeared to be frozen in a state of despair and during these times she often was unable to find solutions to her difficulties. During this session I decided to utilize Dolan's (1991) pattern interruption technique (see appendix C) in order to interrupt Anna's state of despair. During the session I asked Anna to switch seats with me, which she promptly did. Following the directive Anna began to cry and was unable to speak for approximately ten minutes. When she regained her voice she stated that she was upset because I was sitting by the door and she felt safer by the door because she knew she could leave.

During the following session we continued to debrief what occurred the week before. Anna again told me that she felt scared because she could not sit by the door. Although Anna had refused to participate in the activities I had suggested she was too afraid to say no when I asked her to switch seats with me. She stated the request "felt different" to her when I asked her to move during the previous session. She also disclosed that before she had arrived at the previous session she was mad, and she did not want to come for counselling but forced herself to come because she knew this was a pattern of hers. When

Anna was angry at someone it was easier for her to terminate or walk away when situations became uncomfortable for her. She stated that her plan for the previous session was to get me angry so she could get angry and then have an excuse to leave counselling. She stated that is why she did not want to do the activities I had originally suggested (e.g., loneliness scale). It was apparent that Anna was beginning to feel a sense of safety and trust in our relationship. She felt safe enough to share her fears, and her behavioral expressions of these, which I saw as a positive step in her healing.

It was during the ninth session that I began to notice a slight change in the way Anna spoke about herself. She began to sound more caring and less critical of herself. As the session continued Anna identified two sides of herself, one as the "fun" side and the other as the "lady" side. The fun side was the side which often got Anna into trouble and therefore it was the side of herself that she held in most contempt. In order to explore these aspects of herself in more detail I asked Anna to give me a list of the qualities that each of her "sides" possesses and I wrote them down on a flip chart. As we continued with the activity Anna found that there were qualities from her "fun side" that she actually liked. Some of the fun side qualities she came up with included, being witty, having a sense of humour and being friendly. Before ending

the session Anna had stated that she really got something from the session but was not able to elaborate on exactly what she gained until the following week.

Before our session ended, Anna and I had arranged that she come in for a session during the anniversary of the rape which was the following week but on a different day than we usually met. I gave her some readings to take home on the topic of mourning losses resulting from sexual abuse. The purpose was to get her thinking of ways in which she could begin to recognize and grieve the losses she experienced from the sexual abuse.

Upon her arrival during the next session Anna shared a new outlook she had regarding herself and her biological father. Her first new understanding regarding herself arose from the activity we did on the board regarding her two parts, her fun side and lady side. She articulated that before the rape, both her "fun side" and "lady side" were integrated, but after the rape she changed. She realized that although she wanted to be whole again she was also afraid to change.

The second new development Anna experienced had involved her father and his response to her disclosure of the rape. This new understanding evolved from Anna's journal writing over the course of the previous week. Anna came to the conclusion that her father's response to the disclosure had more to do with his inability to protect

her and his lack of control in the situation than it had to do with her. She explained that her father was always protective of her and believed that he could protect Anna from harm. When she disclosed the rape he realized he was unable to protect her and so it was easier for him to blame Anna than accept the fact that he was unable to protect her. Although she still felt hurt by his response, this new understanding had decreased her level of self-blame.

Anna also recalled feeling quite sad during the previous week (between sessions) and that is why she decided to write in her journal. Her journal writing resulted in a cathartic experience in which she sobbed and was able to get some of her feelings out on paper. She said she was able to get in touch with her inner child for the first time, and stated that it was a strange experience but a good one. She also stated that she went out that weekend and for the first time felt "ok" not going home with anyone. When I asked what had changed for her, she was unable to articulate the change. During the remainder of the session Anna discussed in more detail what happened prior, during and after the rape. At the end of the session she asked if she could put something in the box of sorrows. She also stated that she read the material on mourning and grieving and found it helpful. Apparently it had motivated her to do some of the writing she had completed over the weekend.

During the next few sessions Anna discussed the loss of her step-father; she continued to work through her feelings regarding her biological father's unsupportive response to her abuse and her difficulty setting boundaries with both her parents. Anna often felt responsible for her mother's unhappiness and therefore had difficulty setting boundaries with her. A key issue for Anna at this point was the guilt feelings she had when she attempted to set boundaries with her mother.

Relationship issues also became a common topic in our remaining sessions. Over the Christmas break and following our twelfth session Anna became emotionally involved with an older male currently residing in prison for murdering a woman. She met him through a female friend and then began writing letters to him while he was in prison. She eventually met him in-person. Anna stated she was attracted to this person because "he liked her before he saw her". Anna's self-esteem was quite low and she often felt judged as a person by how much she weighed. Anna's self-esteem appeared either to increase or decrease based on how she felt she was perceived by the men in her life. Eventually Anna was able to put this relationship in perspective and decided not to pursue it further.

By our fifth session Anna became involved with a second person. This man was older than Anna and had two children. Some of our time

together involved discussing this new relationship. It was during this relationship that Anna's "movie screen" became more active. The images reoccurred at various times and consisted of images of her past relationships. The images seemed to appear more frequently when she was having an enjoyable time. The "movie screen" was often followed by feelings of guilt and remorse. When I attempted to assist Anna in finding a way to decrease these images through Dolan's (1991) movie screen technique (see appendix C) she was reluctant to participate. Following this session Anna discussed her distress regarding this problem less and less. I am not sure whether she had found relief from her concern or whether she had lost hope in finding relief and therefore decided not to discuss it any further.

When Anna was intending to move in with the man with which she was having a new relationship, his ex-wife returned. Anna had already given up her cat to the Humane Society. When she requested they return the cat, the cat's life had already been terminated. Anna was very distressed and blamed herself for what happened. Anna professed that she had relinquished all for this new relationship and in the end she was the one to lose, again. Apparently Anna often felt she gave more attention to her partners/relationships then she received in return.

During the onset of the following session Anna stated she felt a deep sorrow. When asked where in her body she felt the sorrow, she

stated in her stomach. I continued to assist Anna in getting in touch with her sorrow as a way to assist Anna in grieving the previous loss of her cat and relationship. I asked her to hold on to her sorrow and suggested she ask her sorrow to teach Anna what she needed to know in order to heal. This led into a visualization exercise involving Anna as a 5 year old child. During this activity Anna claimed that she "never felt good enough and always felt like she was in the way", especially in relation to her biological father. It appeared that the loss of her cat triggered other sorrows/losses within Anna's life, e.g., never getting the acceptance she needed from her biological father.

Closing Sessions

During the remaining sessions I requested Anna fill out the post-treatment questionnaires and we continued to discuss her plans following termination. Anna made contact with another agency and was to start counselling a few weeks after our final meeting.

We discussed what had been most helpful for Anna during our sessions together, and what she would need and could ask for at the other agency. The most significant change for Anna was in relation to her "promiscuous behaviour" which she felt had decreased dramatically since the onset of treatment. Anna also claimed that she did not blame herself for the rape as much as she did prior to

treatment. Anna was pleased that counselling was abuse specific, otherwise she claimed that she might not have talked about the abuse. In addition, she stated there was a decrease in the images (movie screen) she saw in her mind, although she wanted to continue working on decreasing the images further. My hypothesis was that since guilt often followed Anna's "movie screen" the images were a part of her self-deprecation which resulted from the rape and in part from the relationship she had with her biological father. If this was so, then one could assume that as Anna continued to experience less self-blame regarding the rape and gained an increased understanding of her subsequent behavior, the movie screen would continue to "decrease" and so would her guilt.

On the last day we had a termination party. Part of that ceremony involved participating in a ceremony to burn Anna's box of sorrows. This was an action Anna initiated. Following this ceremony I awarded Anna with a diploma for her wisdom and courage and she was given a small gift. We spent the rest of the session discussing the difficulties involved in saying good-byes and shared some food. Anna was able to express her sadness at having to say good-bye, as did I. Before leaving Anna gave me a card. On the envelope she had written "different as day and night", and on the card she wrote the following:

> Dear Tamara
> I want to thank-you for so much, for being there

> for me, for being my solace and safe place, for helping me to realize the strength that I now know I do possess. I know things haven't been easy, per say, (sic) but at least they haven't been boring! Ha! Ha! I do appreciate your kindness and understanding and as far as I have come and as far as I have to go, I'm happy that you shared my journey. I will miss you and your sessions, but I know I'll be okay, even though I'm afraid. Thank you for everything and I wish you all the best!

Pre-test and Post-test Scores

The pre-test data from the Trauma Sequelae indicated that Anna was experiencing symptoms consistent with post-traumatic stress disorder. She experienced all the intrusive symptoms, four of seven of the numbing symptoms and answered positively for all six of the hyperarousal symptoms. The post-test data suggests that Anna continued to experience PTSD but there were some changes in the symptomatology. In particular, she no longer was distressed when reminded of the rape and no longer had "symbolic reminders of the experience". Prior to treatment a "red carpet" would remind Anna of the rape. Following treatment she no longer referred to the "red carpet" as a symbolic reminder of her abuse. In relation to the numbing or constricting symptoms Anna no longer deliberately avoided thoughts or feelings which reminded her of the abuse. This was congruent with Anna's statement at the end of treatment in which she highlighted her appreciation of the abuse specific nature of treatment.

The results of the BACSA (Appendix F) indicated that Anna had clinically distorted beliefs in relation to her experiences of child sexual abuse in both pre- and post-tests. In fact, her score increased from thirty three in the pre-test to forty two in the post-test. However, the score did not reflect Anna's statements at termination, particularly in relation to her level of self-blame. According to Anna's perception of blame in relation to the rape, she indicated in the pre-test that she accepted no blame. In the post-test she indicated that she accepted most of the blame. Anna clearly expressed a high level of self-blame during the course of therapy and therefore her score on this item in the pre-test was not consistent with my clinical observations. This discrepancy was discussed with Anna. Anna felt her higher post-test score was related to the break up of her last relationship (with the separated man) and the death of her cat. She also emphasized that her scores would probably vary depending on the day she was asked. In my opinion, Anna highlighted an excellent point in regards to the accuracy of some standardized measurements. It is important to recognize that scores may vary depending on the mood state of the client on a particular day, therefore it is important to utilize other ways of measuring the client's progress, such as direct observation, and discussion and questioning.

The result of the Beck Depression Inventory (Appendix E) suggest

that Anna's level of depression decreased substantially over the course of therapy. Her score decreased from thirty in the pre-test, which is reflective of someone with severe depression, to fourteen in the post-test, which is reflective of someone who is mildly depressed. The most significant changes on this scale included an improvement in Anna's scoring on the question regarding self-dislike. She continued to be disappointed in herself but she no longer hated herself. She also felt more motivated to work after treatment than prior to treatment. Although Anna's overall score decreased on the BDI, there was an increase in her level of dissatisfaction in her post-test score. The dissatisfaction could again be due to the break up of her relationship, the death of her cat and subsequent lack of recreational activities to fill her time.

The result of the Solution Focused Recovery Scale suggest that Anna had made considerable progress in several areas relating to her perception of her healing progress. The most significant areas of progress included an increase in her perception of her ability to stand up for herself and her ability to choose supportive relationships.

Case Example-Client B- "Lucy"

Lucy was self-referred for counselling at Elizabeth Hill Counselling Centre (EHCC) for issues pertaining to child sexual abuse. Lucy was a

caucasian woman in her mid thirties, married, with two children. Lucy had six sessions with another therapist before being transferred to me. Her previous counsellor was leaving EHCC and had told Lucy about my practicum project. Lucy expressed an interest in continuing in counselling and was transferred to me in order to assess whether her situation would be appropriate for my practicum. She subsequently met the criteria, and agreed to participate in the practicum.

Client biography

Lucy was one of four siblings. Her sister had died a few years ago. She has two older brothers who are still alive. Lucy's biological parents were divorced when she was quite young. After her parents separated Lucy and her sister went to live with their maternal grandparents and her brothers remained with their father. Lucy described her two eldest brother's as "mentally challenged". Following her parent's breakup Lucy's mother left the province and Lucy remained with her grandparents until she was approximately thirteen years old. Both of Lucy's parents remarried.

Lucy felt that her grandparents "were not there for her" when she was growing up and stated that they were also physically and emotionally abusive towards Lucy and her sister. During the first thirteen years of Lucy's life she saw her brothers and biological father

about once a month, even though they lived fairly close to one another.

When Lucy's mother returned to the town with her new husband, Lucy moved back in with her at the age of thirteen. Shortly after, her step-father began sexually abusing her. When she disclosed the abuse she received no support and was mistreated further by her step-father. In addition Lucy was also sexually abused during her childhood by her biological father, her older brother and by a male adult outside of the family.

As an adolescent Lucy left home and moved in with her older sister. Her sister was physically abusive towards Lucy which led to Lucy's apprehension by Child and Family Services and short-term placement in a foster home. Lucy eventually returned to her mother and step-father's house until approximately age sixteen.

At the age of sixteen Lucy married and had a child. The marriage did not work out and the husband retained custody of their child. Shortly after the break up of the marriage, Lucy recalled "prostituting" herself in order to make some money. She remarried at the age of twenty and had two children. The couple are still together although their marriage has been difficult. Prior to Lucy's attendance in therapy her adolescent son was placed in detention due to his sexual offending behavior. In recent years Lucy has utilized the Church for support and now attends services on a regular basis. She considers herself to be a

Christian.

Description of Difficulty

Lucy was sexually abused as a child by her biological father, step-father, brother and an adult male outside of her family. She recalled her first sexual abuse experience around the age of eight. Her step-father continued to sexually abuse Lucy until she left home at the age of sixteen. When Lucy was a young adolescent she disclosed to her grandmother that her step-father had sexually abused her. Lucy suspects that her grandmother told Lucy's parents about the allegations, because Lucy received a beating from her step-father shortly after the disclosure. Her mother was unsupportive and accused Lucy of being "crazy". She eventually sent Lucy to a psychiatrist who found nothing wrong with her and quickly terminated therapy. I am not sure if Lucy disclosed the abuse to her psychiatrist. From that day on Lucy kept the secret of the abuse to herself, and no one else in her family brought the topic up again.

Lucy also had memories of being abused by her biological father and older brother around the age of eight or nine. These abuses were not disclosed. In addition, Lucy was also abused by a man outside of her family. At the age of ten Lucy stated that she "went out" with a thirty year old man and initially was unable to recognize the relationship

as abusive. No one in her family questioned this relationship although they knew she was spending time with this individual.

Presenting Issues/Concerns

There were several issues Lucy presented during the onset of therapy. Her son's sexually offending behavior was a primary concern during the start of therapy. Lucy felt she was being blamed for her son's offending behavior and felt betrayed and mistreated by the professionals involved with the family prior to her son's detention.

Other concerns involved her older brother's (one of her perpetrators) continual telephone access to her. Although he lives in another province he continued to contact Lucy by phone. Lucy found this very upsetting. Each time he phoned she would experience her body tightening up and stated that she "couldn't stand hearing his voice". Lucy was not able to tell her brother not to call because of her "guilt" feelings. She felt her brother needed her support due to his mental deficiencies and alcohol addiction, even though it was unpleasant for her. Lucy had ambivalent feelings towards her brother and therefore had difficulties establishing boundaries with him.

Lucy blamed herself for the sexual abuse she endured as a child. She felt that because she "liked older men" that she was the one who was responsible for the abuse. Lucy assumed that her step-father

abused her because he felt she was already going out with older men and therefore it would not harm her. In addition to the self-blame Lucy continued to experience, she also denied and minimized her sexual abuse experiences, possibly as an attempt at self-preservation.

Goals

Following our first session, Lucy and I agreed to continue working together. It was difficult at this stage for Lucy to identify what she hoped to achieve from therapy. Again, one of Lucy's primary concerns at the onset of therapy revolved around her son's offending behavior which resulted in Lucy feeling responsible and blamed for his behavior. Due to her stated feelings of betrayal within her contacts with previous professionals, it became apparent that I would have to work hard at gaining Lucy's trust in order to convince her that I would not betray her also. Therefore the first goal was to build a therapeutic alliance with Lucy and create safety within the therapy sessions. The second goal was to co-create a safety plan with Lucy so that she could protect herself when her brother or parents called. It was important that Lucy felt safe within her home environment as well as within my office.

It was also apparent that Lucy required time during therapy to work through some of her feelings towards her son and the impact his behavior had within the family. In addition it was important that Lucy be

given the opportunity to "break the silence" and share her own story of abuse during our time together.

According to the Dynamic Co-Creative Healing Model (Bell-Gadsby and Siegenberg, 1996) Lucy's symptoms are consistent with survivors who are in the first stage of healing. Therefore the final goal was to address her minimization, denial and self-blame by educating Lucy about the effects of child sexual abuse.

Treatment Process and Intervention Strategies

Lucy explained the circumstances surrounding her son's detention during our initial session. She was visibly upset and wept while she discussed her son. In addition Lucy disclosed some of her own abuse during this first session. She stated that she had been sexually abused by her biological father, step-father and brother.

After our first visit I found it difficult to arrange another appointment with Lucy. She cancelled three times following our first meeting. I was not sure she would continue with treatment even though we both agreed that she was a suitable candidate for the practicum.

Three weeks after our first session I was able to set up a second meeting with Lucy. Lucy filled out the pre-test questionnaires and continued to discuss her son. Lucy tried desperately to understand why her son behaved as he did. She reported that the professionals

involved in her son's case stated that her son had been sexually abused as a child and suggested that as a possible reason for his behavior. They also had accused her of sexually abusing her son which she denied outright. She spent most of the session convincing me that they were incorrect in their accusations. She admitted openly to physically abusing him but was adamant that she did not sexually abuse him. The initial sessions were utilized as a way to build rapport with Lucy and support her by giving her the opportunity to discuss her feelings regarding her son. Many of our initial sessions involved listening and validating Lucy's feelings.

By the fourth session Lucy began to discuss several key issues regarding her own abuse. Lucy blamed herself for some of her childhood sexual abuse, a typical reaction of sexual abuse survivors. Self-blame is also one of the symptoms identified as commonplace in the first stage of the Dynamic Co-creative Healing Model. Lucy stated that because she "liked older men" the abuse was her fault. She continued by stating that at age ten she was "dating" a thirty year old man. It was difficult for Lucy to recognize this experience as "abusive" and that she had little power as a child over a thirty year-old man.

One strategy I utilized was an an age regression (Dolan, 1991) imagery exercise in which I asked Lucy if she knew any ten year-old children. Once she was able to think of a child I asked her to describe

in as much detail what the child was like. Once this was planted firmly in her mind I asked her to imagine herself as an adult witnessing an adult, possibly in his thirties, approaching this child and behaving towards her in a sexual manner. I asked her to think about who was responsible for the sexual advance, the child or the adult, and she replied the man. When asked whether she could personalize the story to her own life she replied that she was too "passive" and others might not be as passive as she. It was apparent that it was too early in the treatment process to attempt to alter Lucy's perspective of this abuse experience. Lucy's self-blame may have been a way she coped and made sense of her abuse. It gave her the illusion of control which she needed to survive, which is not uncommon reaction for survivors of sexual abuse.

Lucy continued to struggle with her ambivalent feelings towards her mother and perpetrating brother. Lucy struggled between feeling angry at her mother for not supporting or believing her after she disclosed being sexually abused by her step-father and at the same time wanting to reconnect with her mother. Lucy reported that her mother would occasionally phone her and talk to her "as if nothing ever happened". She always put Lucy's step-father on the phone, which Lucy resented. Lucy said that both parents would behave as if the abuse never occurred. Lucy had difficulty in setting boundaries and keeping herself

safe from her family's continuing abuse.

It was important to assist Lucy in finding ways in which she could remain safe from further traumatization during these phone conversations. It was apparent Lucy was unable to set boundaries for herself and stop accepting phone calls from family members so it was critical to teach Lucy a strategy which would help her feel safe during these phone conversations. The "symbol for the present" (Dolan, 1991) was introduced to Lucy. She was asked to choose a article which reminded her of the present. Lucy chose her wedding ring as a reminder of the present and was then directed to describe what the ring represented. Once Lucy gave a short explanation I suggested whenever she felt threatened and "ungrounded" she was to touch her wedding ring with one of her other fingers and remind herself that she was no longer a child but an adult in the present and therefore safe from danger. This technique was utilized now and then throughout the treatment process.

At our fifth session, Lucy stated that her brother had called and left a message on her answering machine. Rather than returning his call, Lucy took the phone off the hook. This was the first time she had done this. The following week Lucy felt "guilty" because she was not being a good "Christian". Lucy also felt empathetic towards her brother because he was severely abused by her biological father and she

therefore rationalized his behavior towards her as a result of her brother's own abuse background.

Although Lucy continued to express ambivalence in relation to her brother she did not view her step-father in the same light. Lucy felt her step-father was smarter than her brother and therefore knew what he was doing, although she continued to accept some of the responsibility for his abuse.

During our seventh session Lucy shared her abuse experiences in more detail. She continued to discuss her symptoms which resulted from her step-father's abuse. She continued to be repulsed by oral sex and had difficulty brushing her teeth without gagging. Although Lucy was able to share her abuse experience perpetrated by her step-father, she had more difficulty accepting that her biological father had abused her and continued to struggle with that reality. Initially she disclosed that he had digitally penetrated her but then explained that he mistook her for his wife (she was nine years old at the time). Again it is not uncommon for survivors to experience ambivalence, deny and minimize their abuse during the first stage of their healing. It was clear that Lucy did not yet have the strength to accept that her biological father had also abused her.

Upon arriving at our eighth session Lucy claimed she had nothing to talk about and asked if I had anything I would like to discuss. I

suggested that rather than talk we try an art activity. I then introduced the self-portrait activity (Bell-Gadsby & Siegenberg, 1996) in which she cautiously agreed to participate. In spite of her cautiousness, Lucy used two big pieces of paper to do her drawings. She used a whole page to represent how she saw herself in the past, used up 3/4 of a sheet to draw a representation of herself in the present and used the least amount of paper for the representation of herself in the future. The past picture was of herself and was the most elaborate picture of the three. The present included her family and how she saw herself in relation to her family, and her future picture also included her family and the relationships within her family. In debriefing this activity Lucy had the opportunity to share some of her childhood experiences and how the experiences impacted her life.

I found the self-portrait activity (Bell-Gadsby & Siegenberg, 1996) reflected what was happening for Lucy during this point in her treatment. She was very much involved in dealing with her childhood which could explain why she spent so much time and energy on her picture from the past. In her present picture she appeared with her immediate family and everyone in the picture appeared somewhat detached from one another and unhappy. The final picture (future oriented) did not appear much different from the previous picture which is reflective of the difficulties survivors have in imagining a better

future for themselves.

After the Christmas break Lucy found out that her step-father was dying of cancer. Due to his impending death Lucy's mother wanted her to return home after sixteen years for a visit. During our tenth session we began discussing this possibility and Lucy's motivation for returning home was explored. Lucy had high expectations and had hoped because her step-father was dying she might get an apology. She also felt her mother was reaching out for the first time and Lucy was worried about her. When I reminded Lucy that she also had to consider her own well being she replied "I want a relationship with my mother, one that I never had as a child". Lucy wanted to capture as an adult what she had not received as a child.

We then discussed the various consequences to Lucy's returning to her childhood home after sixteen years. I suggested that going to see her step-father may not give her the results that she hoped for and that it may turn into a major disappointment. Lucy again attempted to blame herself by stating it was she that never gave him a chance to apologize because she had never discussed it with him. I told Lucy that it was not up to her to contact her step-father about an apology, but the other way around. If he had wanted to apologize at any time over all these years he would of done so. Lucy also discussed wanting to be there for her mother. She stated "although my mother made a lot of

stupid choices I still want a relationship with her". I asked Lucy what kind of a relationship she wanted with her mother and she could not imagine or answer.

We continued to discuss some hypothetical situations together regarding her relationship with her mother. At the end of our session I gave Lucy a homework assignment, a version of Dolan's (1991) healing letters exercise. I asked her to imagine that her step-father had written her two letters and the first letter was what she did not want to hear, that is, her worst case scenario, and the second letter was everything she wanted to hear, the best case scenario.

Lucy was not able to complete the homework assignment and by the thirteenth session had decided that she would return home in order to visit her mother. Prior to Lucy's leaving we again discussed her expectations and feelings about returning after sixteen years. This time Lucy explained that she hoped he would apologize for what he had done to her but that she was mostly going back to reconnect with her mother. In order to prepare Lucy for her trip home we did a role play of what it might be like if she was face-to-face with one of her perpetrators, her step-father. She had a difficult time with this activity and we were not able to complete it. I asked Lucy to keep a journal of her thoughts and feelings while she was on her trip and she agreed. Finally we practised utilizing her symbol for the present (Dolan, 1991) as

a way to keep herself grounded and in touch with her adult-self when she returned to her parent's home.

When Lucy returned from the trip she started having stomach problems with no known medical cause. I suggested it might be due to the stressful trip back home but she was unable to see the connection. During this session Lucy and I debriefed her trip home. The first night she arrived home her mother wanted her to visit her step-father in the hospital, and Lucy felt powerless to say no. Lucy spent her whole trip in and out of the hospital because she "did not want to hurt her mother's feelings". Lucy had mixed feelings toward her perpetrator. She would alternate between anger and pity. Lucy stated "even though he was sick he still tried to control me". When I asked Lucy how she was able to protect herself she stated that she used her wedding ring (symbol for the present) which she found very helpful. She stated that it reminded her that she was now an adult and he could no longer hurt her. Lucy also occasionally spoke with two doctors and a chaplain while she was at the hospital for support.

Debriefing Lucy's trip home continued on for the next couple of sessions. During our seventh session I asked Lucy if she felt any different having gone home and she said "more at peace that I dealt with the situation", she continued by stating, "knowing that I am strong enough to go through it". This was the first time I had heard Lucy

acknowledge her strength; it was wonderful to hear. She was beginning to recognize her inner strengths and resources which is reflective of survivors at stage two of the Dynamic Co-Creative Healing Model (Bell-Gadsby and Siegenberg, 1996). It was also during this session that Lucy acknowledged the impact the sexual abuse had on her as a child and how it had robbed her of her childhood. She was now able to recognize the abusive power her step-father had over her as a child.

Most recently Lucy confronted her brother for abusing her. Through the confrontation she was able to unearth more family secrets. Although she was distressed by these "family secrets" Lucy stated that she would rather know the "truth". Lucy's brother apologized for what he had done to Lucy. He disclosed that he was also abused as a child by an uncle and his step-mother. Although Lucy was angry with her brother she explained that she had more empathy for her brother because of all the hard times they had as children. But in spite of this she "would not want to live in the same city with him", in fact she "would move if he ever moved to Winnipeg". Lucy explained that the conversation with her brother was a positive move for her. She was beginning to recognize her own needs and was able to be clear about her boundaries with respect to her brother.

Closing Sessions

As our sessions were coming to an end we began discussing termination issues. I had made several calls to various agencies in order to find out what was available for Lucy over the summer or early fall. This information was passed on to Lucy. Lucy stated that she might take the summer off because she felt like she was doing better. I asked her in what ways and she replied, after talking with her brother and facing her step-father she felt like she had grown. She again brought up the utilization of her symbol for the present when she faced her perpetrator as being effective. She also asked whether she could call me once in a while over the summer. I told her over the next few weeks we would discuss the issue further.

Of the three sessions remaining, Lucy missed the next two. I contacted Lucy by phone in order to encourage her to come for our last session. Lucy appeared to be having a difficult time with termination and was clearly not ready to say good-bye. When asked how she felt about our ending she said it was hard, and she again asked if we could have a friendship after counselling. Lucy stated that I was the only one she felt safe to talk with and that she could not even talk with her husband about these issues because he would use it against her. Lucy appeared very anxious that we were planning to terminate even though she knew April 30th was our last day. Dolan (1991)

highlights that, "Difficulties with termination might indicate that the client is not yet ready to leave and has more work to do" (p. 204). At this point Lucy had not made contact with any other agencies so I decided to extend our sessions for another four weeks in order to assist in transition and termination issues. This four week extension appeared to help in reducing Lucy's anxieties about terminating therapy.

During our last session I asked Lucy what had changed for her since the beginning of our work together. She replied that she felt more assertive because she was able to confront her brother. Lucy claimed she felt less guilty about the abuse and realized that she was not to blame. She also came to the realization that by facing her step-father he was no longer able to hurt her. She also appreciated having someone with which to talk. I also asked Lucy if there was anything that was not helpful during our time together and she was not able to highlight anything. It may have been difficult for Lucy to share things not helpful due to her difficulty separating with the therapist and her need for acceptance.

Pre-test and Post-test Scores

The pre-test data from the Trauma Sequelae indicated that Lucy was experiencing symptoms consistent with post-traumatic stress disorder. The post-test data suggested that Lucy continued to experience PTSD.

This was not surprising due to the amount of work Lucy was engaged in prior to the ending of our sessions together e.g., going home after sixteen years, facing her step-father, and confronting her brother. Although Lucy continued to experience PTSD there were some changes in symptomatology. In particular Lucy responded positively to three additional intrusive symptoms in post-test. She had a sense of reliving her abuse experience, had flashbacks and had symbolic reminders of her experience. This was not a surprise considering the amount of stress Lucy had been under since she decided to return to her childhood home. In addition Lucy no longer deliberately avoided thoughts and feelings that reminded her of the abuse, although she responded positively to avoiding, deliberately, the activities or situations that reminded her of her abuse. There was a discrepancy in her positive response to the avoidance of activities item. Returning home after sixteen years and facing one of her perpetrators several times during her visit, did not seem consistent with avoidant behavior. Finally Lucy no longer had difficulty concentrating and no longer experienced being on "guard".

The results of the Beck Depression Inventory (Appendix E) suggest that Lucy's level of depression did not change dramatically over the course of treatment. Her score increased from fourteen in the pre-test, which is reflective of someone who is mildly depressed, to 15 in the

post-test, which again is reflective of someone who is mildly depressed. There were differences in the individual items. It appeared that Lucy perceived herself more of a failure after treatment than she did prior to treatment. During the initial stages of treatment Lucy was defensive and felt betrayed by the professionals involved with her son's case. It is possible her post-test scores reflected an increase in her level of trust in the therapeutic relationship and therefore perhaps she felt it was no longer necessary to hide her true feelings.

The BDI suggests Lucy's degree of guilt and self-blame decreased in the post-test. This was congruent with what Lucy stated during the end of our sessions together. Lucy's worry regarding her health and her interest in sex both increased in the post-test. Following Lucy's visit home, she visited her doctor in regards to stomach problems, and the doctor was unable to find a physiological basis for the problem.

The results of the Beliefs Associated with Child Sexual Abuse (BACSA) (Appendix F) indicate that Lucy had clinically distorted beliefs in relation to her experiences of childhood sexual abuse in both the pre-test and post-test. Although, Lucy's score decreased from 46 in the pre-test to nineteen in the post-test. The BACSA suggest that Lucy's level of self-blame decreased, her perception of having sexual rights increased, and her self perception improved in the post-test. These results were consistent with my clinical observations. She

moved from taking responsibility for her step-father's abuse to realizing how powerless she was against him as a child. In addition, Lucy realized that it was the male adults in her childhood that should have been responsible for setting sexual boundaries with her as a child and not the other way around. This insight was a significant step in Lucy's healing.

The results of the Solution Focused Recovery Scale suggest that Lucy had made considerable progress in almost all areas relating to her perception of her healing process.

Case Example-Client C-"Betty"

Betty was referred to the Elizabeth Hill Counselling Centre (EHCC) by her Child and Family Services Social Worker. Betty is a young caucasian woman in her early twenties. She has a young son who was sexually abused which triggered the reemergence of Betty's own sexual abuse history. Her social worker had strongly recommended that Betty seek help for her own abuse issues. Betty then gave her social worker permission to notify Elizabeth Hill Counselling Centre in order to set up an intake appointment.

Client biography

Betty was remarried during the treatment phase, was expecting a

second child in the spring and had a young son from her previous marriage.

Her biological father and mother had two children, Betty and a younger brother. During her mother's pregnancy with Betty, Betty's maternal grandmother was also pregnant with a girl. The father of both children was the same person, Betty's biological father, Tim.

Tim dated Betty's grandmother while Sue (Betty's mother) was an adolescent. Tim then started to abuse Sue. When Sue became pregnant at sixteen years old with his child, Tim married her . Betty's biological parents, Tim and Sue divorced when Betty was approximately six years old. Sue remarried, divorced her second husband and is now living with a third man with whom she has had two children. Tim remarried a woman who had three children of her own. Tim and she are no longer together.

Betty's earliest memory of sexual abuse occurred at the age of two. At the age of four Betty remembers disclosing to her mother that Tim (biological father) was sexually and physically abusing her. Her mother did not believe her and called her a "liar". Betty stated that her life became more difficult after she disclosed the abuse. Betty recollects being locked up in basements and attics as part of her punishment for misbehaving as a child. She remembers her father shooting at her and her mother's feet during one of his violent episodes. Sue's second

husband continued to sexually and physically abuse Betty until she reached the age of twelve.

Throughout Betty's adolescent years she was in and out of foster homes and group homes. In addition she spent some time in a youth detention centre. Betty began using drugs at the age of fifteen and quit at the age of seventeen because of her desire for a better life and to protect her unborn child.

Description of Difficulty

Betty was sexually and physically abused by her biological father until the age of six and by her step-father from the age of six to twelve. Betty had memories of being locked in basements and attics as punishment for minor offences during her childhood. In addition to the physical and sexual abuse Betty received from her father and step-father, her biological mother was also physically abusive towards her. Both biological parents also abused alcohol which resulted in Betty taking on many of the adult responsibilities, for example, caring for her two younger siblings, and cleaning the house.

Presenting Issues/Concerns

Betty's son was sexually abused by a nine year old girl which triggered memories of her own sexual abuse history. When Betty

arrived for our first session she expressed anger towards her Child and Family Services Worker because she felt the worker was pressuring her to go for counselling because of what happened to her son. She felt blamed for her son's victimization. After validating Betty's feelings I explained to Betty that in order for her to be accepted into the practicum she had to make her own decision on whether to attend counselling. It was her choice and her choice alone. Betty then replied " I know I have to do this for myself and my children".

Betty's main concerns on the onset of therapy revolved around her anger and her difficulty in dealing with her anger appropriately. She also discussed having difficulties in setting boundaries with family members, particularly her mother and grandmother.

Goals

Betty was clear at the onset of treatment that she only wanted to meet once every two weeks. During our second meeting, two weeks later, Betty filled out the pre-tests. Due to Betty's initial feelings regarding unhelpful professionals the first goal was to build rapport with Betty. I did this by allowing Betty to vent her frustrations regarding "unhelpful professionals" and gave her an opportunity to debrief her feelings regarding her son's victimization.

Betty's main goal for treatment was to work on her anger.

Apparently in the past her anger had a tendency to turn physically violent which often left her feeling remorseful and guilty. Therefore the following goals were established in order to address her concerns: explore and find alternative ways in which Betty could address her needs without using aggressive behaviours; explore the situations and or feelings that trigger her rage response; and assist Betty in making a distinction between anger and rage, reframing anger as a positive emotion. The final goal was to provide Betty with an opportunity to disclose her abuse and break her silence.

Treatment Process and Intervention Strategies

Betty and I had our first meeting on November 4th. She was escorted to her sessions by a support worker, hired through Child and Family Services, at this time and for subsequent counselling sessions she attended at EHCC.

Following our first meeting I did not meet with Betty until November 22nd, after her wedding day. When we met again Betty filled out the pre-test measures and we discussed the events which emerged from the wedding. Betty and her grandmother were arguing prior to the wedding ceremony because her grandmother was angry that Betty's father was going to give Betty away at the wedding (Betty's father was also her grandmother's previous common-law husband). During the

remainder of the session Betty shared her feelings and thoughts regarding her relationship with her family, particularly her grandparents.

The third session began with a discussion of Betty's tattoos. At the beginning of our session Betty kept her jacket on and stated that people treated her differently when they saw her tattoos. She continued by stating she hated the tattoos because they symbolized the traumatic events in her life. Apparently Betty had designed her own tattoos. I reframed Betty's discussion of her tattoos as a way she utilized her creativity in dealing with her trauma. She appeared proud about this and began telling me about the poetry she had written about her childhood. Eventually Betty was able to remove her coat for the remainder of the session. Betty continued to discuss her family of origin, the anger she felt towards her perpetrators, and her first marriage for the duration of the session. She stated that her first husband was abusive and the relationship ended shortly after they were married.

The Christmas holidays and Betty's prearranged alternate-week schedule meant that we were not able to meet until January 10th. When I called Betty to remind her of our next session, Betty told me she would not come if she was not able to get a ride from her support worker. I was somewhat surprised since I knew she did not live very far from the office. It was at this point that my initial intuition regarding

Betty's readiness for counselling reemerged, she was not ready for counselling.

Betty's support worker did give her a ride and therefore she showed up for our fourth session. During this session we discussed boundary violations from family members, specifically in reference to her mother, the adult responsibilities she was forced to take on as a child, and her frustrations with her new husband. Betty claimed that she became angry with her husband because he did not listen to her when she spoke to him. I asked her what other feeling she had besides anger when people did not listen to her and she replied, "I feel ignored and not important". Following this statement she began blaming herself for his lack of attention by stating "well if someone yelled at me I wouldn't listen to them either". She then suggested that she needed to work on her anger as one of the goals of therapy.

During the last two sessions I introduced the symbol for the present (Dolan, 1991) and Betty chose her wedding ring. Every once in awhile throughout our sessions I would ask Betty to explain the significance of her ring to me.

Betty missed our next session because of a residential move. During our fifth session Betty arrived 1/2 hour early. When our session began she shared an incident which occurred between her and her mother during the previous week. Apparently Betty confronted her

mother for not being there for her when she was being abused by her biological father. She "stood up" to her mother and told her mother not to come around her house anymore. Her mother left and Betty claimed that she cried in her room for two hours following the incident. When I asked her what she felt like after the incident, she initially did not know. She later stated that she thought she was crying because she was so angry and crying was a way to release her anger. She also stated that she felt like a weight was lifted off her shoulders.

As the session progressed I asked Betty if it would be acceptable to ask her some specific questions regarding her abuse experiences as a child and she stated it would be fine. I utilized some of Courtois's (1988) questions on incest. I also reminded Betty of her symbol for the present and asked her to utilize it if she needed. As I asked Betty questions she appeared more and more distressed and could not answer the questions. Her response to one of the questions was an angry "that's stupid!" She then stated that she was not ready to verbalize what happened; it was enough to simply say it happened.

It was apparent that Betty did not have the internal capacity to tolerate or discuss her abuse experiences. Briere (1996) stated:

> the survivor who becomes excessively angry, anxious, despondent, or fragmented in response to careful therapist attempts to address potentially upsetting material, for example may be revealing that she or he has insufficient self-capacities at the moment to

> tolerate much exposure to traumatic stimuli (p.118).

We ended the session by discussing her son's acting-out behavior and how she was able to discipline him differently than she had in the past. When I asked her what had changed for her in regards to disciplining her child, she stated that she felt less angry since she confronted her mother and therefore had more patience for her son.

Betty missed the following two sessions. I left a few messages on her answering machine but she did not return my calls. When I finally reached Betty she stated that her pregnancy was not going well and that she had been in the hospital for a few days. She then stated that she was not willing to return for counselling because of her pregnancy difficulties. I asked her if she would come in for one last session and although she sounded compliant over the phone, she did not show up. I sent the post-test questionnaires by mail. They were not returned.

Pre-test and Post-test Scores

The pre-test data from the Trauma Sequelae indicated that Betty was experiencing symptoms consistent with post-traumatic stress disorder. She experienced seven of the ten intrusive symptoms, three of the seven numbing symptoms and responded positively for all six of the hyperarousal symptoms.

The pre-test data from the Beck Depression Inventory (Appendix E)

suggest that Betty was moderately depressed. On individual pre-test items Betty responded most negatively to the following: as she looked back on her life all she could see was a lot of failures; she was highly dissatisfied with her life; she could no longer cry even when she wanted to; she did not have a good appetite and had lost more then fifteen pounds due to being ill. Her negative score on the last item was related to her pregnancy rather than to her sexual abuse issues.

The result of the Beliefs Associated with Childhood Sexual Abuse (BACSA) (Appendix F) indicated Betty did not have clinically significant distorted beliefs in relation to her experiences of childhood sexual abuse. Her highest scored item on the inventory was "it is dangerous to get close to anyone because they always betray, exploit and hurt you". This may reflect a possible reason for her total score being so low. Since Betty was experiencing difficulties with her Child and Family Services social worker, she may have thought the information would be used against her and therefore did not want to risk expressing her true thoughts or feelings. Due to the unavailability of the post-test scores there was no way to verify or support this hypothesis. The result of the Solution Focused Recovery Scale suggest that Betty's perception of her healing progress was high in the pre-test.

Closing Sessions

Due to Betty's stated pregnancy complications she did not return for a termination session, and post-test scores were not available.

Case Example-Client D-"Tory"

Tory was referred to Elizabeth Hill Counselling Centre (EHCC) by the Women's Post Treatment Centre (WPTC). She had contacted WPTC requesting services for child sexual abuse but they were unable to accommodate her for at least eight months. Due to their long waiting list it was recommended she contact Elizabeth Hill Counselling Centre.

Client biography

Tory is a middle aged woman of aboriginal descent, with two young adult children and an adolescent child. Tory's mother died in a house fire when she (mother) was in her forties, and her father died of a heart attack in his early 50's. Tory had 8 siblings (three girls and five boys), four of whom had different fathers. One of Tory's sisters is now deceased. Both of Tory's parents suffered from alcoholism and her father was also abusive towards Tory's mother.

Tory was taken from her family at the age of five and sent to residential school. She was not able to visit her parents over the holidays until she reached the age of eleven years. During the school

terms Tory continued to attend residential school until she was fifteen years old.

When Tory was able to return home for visits (at the age of eleven), she continued to witness her father's abusive behavior towards her mother. Her mother did not drink when Tory was a young child, but she began drinking more heavily over time, as her husband's beatings became more severe. Tory had memories of her mother trying to hide from her father in order to avoid the beatings.

As her mother continued to drink as a way to cope, she also began staying away from home which resulted in the neglect of her children. Their father was also neglectful and often took the children to unsafe places in which other adults were drinking.

A year after leaving residential school Tory began sniffing solvents which she later gave up for alcohol. Tory had attended several alcohol and drug treatment centres throughout her life.

Tory is a mother of three children. Two are young adults and one is an adolescent. Two of her children now live with her. Throughout Tory's adult life she has been involved in several abusive relationships. The cycle of violence and addiction continued in Tory's family which resulted in the neglect of her own children, her continued victimization, and the victimization of her children. One of Tory's sons is very violent and on one occasion he had threatened her life while under the

influence of alcohol. This occurred when Tory claimed she hit "bottom". When her son physically abused her she realized she had to quit or she would end up dead. At the time we began therapy Tory had been sober for nineteen months.

Tory was on social assistance during therapy, and lived in an apartment with her two children and male companion. Due to financial constraints Tory had spent many days lining up at food banks in order to feed herself and her children. There were times when Tory reported that she could not travel to downtown for counselling because she did not have enough bus fare.

Description of Difficulty

Tory believed she may have been sexually abused during her childhood but had no memories of the abuse during the onset of treatment. Prior to attending her first session at EHCC she had been attending a self-help incest survivors group in the basement of a church, which she found helpful. As a child Tory had witnessed her mother being beaten by her father and had also been a victim of violence in her adult life.

Presenting Issues/Concerns

Although Tory did not have any memories of child sexual abuse she

claimed that she "felt" like she was abused and wanted to attend counselling in order to explore further her feelings. When I asked Tory what gave her the feeling she was abused she claimed that she was repulsed by any sexual contact she had with her male partner. In addition to her repulsion to sex Tory claimed that prior to attending treatment she felt her partner raped her because he did not listen to her when she told him she was not interested in having sex. She was emotionally distraught as she talked about the experience.

Goals

The first goal of treatment was to establish a therapeutic alliance with Tory. She needed to feel safe and accepted if she was to find the answers she needed in order to heal. This was done by giving Tory the opportunity to explore her thoughts and feelings for believing why she may have been sexually abused as a child.

The second goal was to allow Tory the opportunity to discuss her relationship with her male partner, and safety issues with regards to the relationship. It was also apparent that Tory had endured many losses in her life and therefore it was important that she have the opportunity to begin grieving some of those losses during our time together.

Treatment Process and Intervention Strategies

Following our first meeting Tory returned and filled out the pre-test measures. During the remainder of the session Tory discussed her unsatisfying relationship with her male "friend". She disclosed that after she told him she did not want to have sex he forced himself on her. She indicated that it felt like he raped her. I supported her feelings by reflecting back to her, her understanding that "no means no". When she confronted him a few days later he replied "I thought you wanted it because you didn't stop me". On another occasion, when she refused to have sex with him, he told her "you just want someone to beat you up". Tory continued to share how hurt she felt by his comments and expressed ambivalence about continuing the relationship. I continued to validate Tory's feelings throughout the session.

For the next few sessions we continued to discuss relationship issues. During our third session Tory discussed her family of origin. As a young child Tory recalled watching a man walk towards an outhouse where her mother was passed out. She was standing close by and remembered yelling at the man to leave her mother alone. Four of Tory's siblings had different fathers and, therefore, I suspected that her mother may have been raped at least once, and possibly in front of Tory. Before finishing our session I asked Tory to do a homework assignment. The assignment was to write a letter to herself from her

future self (Dolan, 1991). This was suggested in order to instil hope within Tory that healing was possible.

At the next session Tory reported that due to the lack of privacy in her apartment, she found it difficult to complete the task from the previous week. Tory stated that after she left the last session she was upset and had cried for her parents. She was surprised at her reaction because she did not think that she still had unresolved issues regarding her parents. This led to a discussion on "crying" and Tory's reluctance to cry in front of people because of being shamed in the past. She also stated that "people step on you when you're down".

For the remainder of the session we continued to discuss family of origin issues. I asked Tory if there had been a history of sexual abuse in her family and she replied that her father had raped her step-sister when she was an adolescent. In addition Tory believes her brother sexually abused his step-sister while he had guardianship following their mother's death. Tory initially blamed her brother's wife "for not giving him enough sex". She now realizes her response was wrong and her sister-in-law was not to blame. I utilized Tory's story as an opportunity to provide information to Tory on issues of sexual abuse, specifically in regards to where the blame ultimately lies, on the perpetrator and how women are often blamed because of traditional socialization of men and women.

Tory appeared to be distressed during our next session. Apparently her daughter and son had a fight which became violent. They both threw hot coffee on each other and her son held a knife to his sister's throat. Tory claimed that the same son slashed the top of Tory's eye lid with a broken beer bottle when he was an adolescent. She cried as she talked about her children and her inability to stop the violence within her life. I validated Tory's feelings and emphasized the importance of establishing a "bottom line" and developing a safety plan for herself and her daughter. We then spent time discussing what a safety plan might entail. Tory continued to struggle with boundary issues in regards to her children. Her guilt for not being there when her children were younger continued to interfere with her ability to stick to her "bottom line".

Following our discussion on developing a safety plan I asked Tory to choose a rock from the various rocks I had set out on the table. The rock was to be a symbolic reminder that Tory had come along way in the last couple of years. After she chose a rock I asked her why she chose the one she did and she replied, "it wasn't to big or to small, it represented getting half way there". Within the session Tory shifted from feeling helpless and hopeless about her future to acknowledging that it was hope that had got her this far.

During the next session Tory discussed her own physical and

emotional abuse of her daughter. She claimed that she treated her daughter more harshly than she did her sons. As she shared her story her eyes filled with tears. This lead into a discussion of the violence and addictions Tory witnessed as a child.

Tory had two different ways of evaluating her parent's drinking behaviours. One way was to judge her mother's drinking harshly and blame her mothers victimization on her drinking behavior. The second way was to excuse her father's abusive behavior because of his drinking. At this point in Tory's healing she, like many survivors, over identified with the perpetrator and blamed the victim. She blamed her mom for getting beaten because she drank and minimized her father's abuse because he was drinking.

Tory recalled a time when she was approximately twelve and her mother took her and her two siblings to Brandon where their father was in jail at the time. Their mother told them to wait on a city bench for her and that she would be right back. She never returned. Her eyes filled with tears and I asked her how she felt recalling the image and she replied "I feel sad for them". I repeated my question and she again said "I feel sorry for my brother and sister and me" and she ended by stating " I feel sad for me". In order to enhance Tory's emotional self-awareness I often asked her what her emotional response was and where in her body she felt the response. The previous statement was

significant for Tory since she often struggled with expressing how she felt. Following a gentle prompt Tory was able to verbalize her sadness.

Following Tory's story of abandonment she expressed frustration at not having any memories of child sexual abuse. I emphasized that she continue to trust her instinct and in addition, I gave her a handout from the Courage to Heal (1988) about women who had no memories of abuse. My intention was to validate Tory's experience and help her understand that she was not alone. Many women experienced what she was experiencing.

Tory did end up reading the article for the next week and found it very helpful. During this session Tory agreed to do the self-portrait activity (Bell-Gadsby and Siegenberg, 1996). She drew a representation of herself as a child, herself in the present and herself in the future. In Tory's first picture she drew herself as a young child in residential school wearing her uniform. She described herself as very shy and self-conscious. Her cheeks were red and she appeared very boxed in, everything was square. Her second picture was of a flower which emerged from under a rock which was struggling to reach towards the sun. She explained that the flower could go either way, it could flourish or it could die because it was not getting enough sun. The third picture was a picture of herself as a bird. It represented freedom. Tory expressed wanting to be free from her past. An example of being free

was being able to let go of her children, letting them do what they wanted without feeling guilty or responsible.

Over the next few sessions we continued to discuss Tory's relationship with her male friend whom she described as emotionally controlling. I then suggested we look more carefully at what Tory was looking for in a relationship. On a flip chart I began documenting the qualities Tory highlighted as important. I asked Tory if her male friend had any of the qualities she was looking for and she replied "some". The second activity involved brainstorming the strengths and weaknesses of their relationship in order to enhance awareness.

Due to Tory's disinterest in sexual intercourse she often stated that she could not understand why her partner continued to pursue the relationship. This belief corresponded with Tory's high score on the BACSA Inventory in which women survivors often have difficulty believing a man could care for them without a sexual relationship.

Tory missed the next session because she did not have a bus pass. During the eleventh session Tory arrived reporting that she had read "Home Coming" by John Bradshaw and emphasized that she realized how difficult it was for her to get in touch with her feelings. She claimed there were never any feelings attached to her memories, only visual images. Tory continued to discuss several traumatic events which occurred during her young childhood years and adult years. Tory

often jumped from reporting on one experience to reporting on another within our sessions. This made it difficult to elaborate on any one event.

During the next session I explained to Tory that sometimes when people discuss difficult subjects they may talk about many things at once as an avoidance technique. I then asked her if she was aware that she discussed many things one after the other during our sessions and she replied "maybe because I'm avoiding the hurt feelings". Tory then told me about her ex-partner who continued to phone her in the middle of the night when he was drunk. In the past, she would speak with him because she felt guilty, but this time she told him not to call her anymore. Tory was beginning to develop a stronger sense of boundaries in her personal life.

Tory missed the next two sessions. She returned the third week and immediately began discussing several concerns. Tory had been on welfare for several years and since her daughter was turning eighteen in the spring, she would no longer be considered Tory's dependent. Therefore under the new welfare regulations, Tory would receive city welfare which provided considerably less financial support than she had previously received with a dependent. Tory had not worked in years due to her addiction and therefore felt intimidated about looking for a job. She feared that she might be forced to return to her reserve which

she felt was not in her best interests. Tory explained that when she went back to the reserve over the holidays she was afraid that she would start drinking again, but did not. I reframed her fear as an "ally". Her fear was a reminder of the negative impact her past drinking behavior had on her life, and she agreed. She also stated that her sister told her she was doing really well and Tory did not want to disappoint her. She continued by explaining that in the past welfare had always paid her rent and bills and now the responsibility was falling on her. Tory was afraid that she might make the wrong choices and go out drinking instead. I reminded her of the other times in which she felt the urge to drink but overcame her desire and again made the right choices. She acknowledged this and declared that the anniversary celebrating her two years of sobriety was fast approaching. I attempted to highlight Tory's strengths and resources throughout the session which appeared to be effective in reducing her fears.

Following our previous session Tory began thinking of her future. She explained that she wanted to go back to school and get a social work degree. She went to the University of Manitoba to speak with an advisor in order to find out the prerequisites for the social work program. In addition she signed up for upgrading classes. Tory continued by stating "I realized I could be a nurse's aide but I don't want to be just that, I want to do something I like". Tory emphasized

that she knew it was not possible in the near future but "maybe in the next five years". Tory then asked me if school was hard and this gave me an opportunity to disclose my own educational experiences with Tory. I felt that this session was hopeful and inspiring. Not only was Tory able to contemplate her future but she was also realistic in regards to how long it might take her to achieve her goals.

The following session Tory arrived appearing flustered and stated that initially she was not going to attend the session because she had a fight with her partner and he was planning to leave her. She forced herself to attend anyway. The fight triggered unpleasant memories from her past relationships. She shared stories about past abusive partners and I asked her what she continued to be afraid of in the present? She replied "abuse...rape". I asked her if she had been raped and her eyes filled up with tears and she replied "sort of". She continued to disclose an attempted rape incident which occurred when she was sixteen. She then disclosed a second incident which occurred while Tory was hitchhiking with her one year old son. At the time of the incident Tory was on her way to visit the child's father who was jailed in Brandon. The man that picked her up raped her while her young son was present. He then left them both on the side of the road. As she disclosed her story she wept and stated that she never "saw it as a rape until recently". I validated her story and emphasized that she was

correct and that he had raped her. Apparently Tory blamed herself for the rape because she was hitchhiking and she had her son with her. She was very distraught as she discussed her experience. Shortly after Tory changed the subject to something less painful. Prior to her leaving I asked her how she felt and where in her body she felt it. Tory replied that she was starting to feel something around her heart area and that talking about the rapes was painful. Tory highlighted that she has a tendency to distract herself as a way to cope with uncomfortable situations. She indicated that in the past if she did not want to come to a counselling session she would have cancelled it, but this time she did not make that choice, and was glad she chose to come for the session. She smiled as she articulated this point.

The next week Tory arrived again appearing upset. Apparently Tory had a sexual encounter with her male partner which triggered painful memories for Tory. She disclosed that she cried for hours and it was the first time she cried for herself and cried because she wanted to drink but knew she could not. She was not willing to lose everything she gained in the last two years. Tory then disclosed additional stories of abuse she endured as a young adult. She was raped by her sister's husband when she was twenty and sexually exploited by an uncle as a young adult. As she continued sharing her stories Tory explained that she often feared her own anger and was afraid she might turn into her

father. Tory continued by disclosing two traumatic events in which her father was abusing Tory's mother. On both occasions Tory could only remember half of what actually happened. I believe that due to the traumatic nature of the event Tory dissociated as a way to survive the ordeal.

Over the following week Tory discussed the content of our session with her sister. She told her sister about the memory of their mother being dragged off the bed and explained to her sister that she had no memory of what followed. Her sister who was also present at the time of the abuse, confirmed that their father had raped their mother in front of them. Apparently this occurred on other occasions as well. I asked Tory how she responded to her sister's disclosure and she replied " I was shocked". She had a difficult time envisioning her dad as someone who would do such a thing, but replied "I believe it". I then asked her if she felt she was any closer to her original question of whether she was sexually abused as a child, and she replied "it is becoming clearer". She started to realize that witnessing the rape of her mother could be considered sexual abuse. I asked her to identify at what point she realized being a witness to her mother being raped could be considered sexual abuse, and she replied "last night when I was reading a segment from the book *Courage to Heal* (Bass and Davis, 1988).

The remainder of our sessions revolved around her relationship with her male partner and her children. Tory continued to struggle with boundary issues in her intimate relationships and her destructive fantasy life during sexual encounters. In the past the only way Tory could reach an orgasm was when she had self-destructive fantasies. We discussed how her self-destructive fantasy life might be connected to the trauma she experienced as a child and how witnessing her mother being raped could effect her present relationships.

In addition we discussed termination issues and whether Tory had contacted any other agencies in order to continue therapy. Apparently Tory had already made the appropriate arrangements and would be attending a group at another agency.

During the final session in which I saw Tory we debriefed her group experience. She expressed feeling insecure in the group but stated that she would continue attending. Even though she was attending a group we agreed to continue our sessions until the end of the practicum which was April, 30th. I reminded Tory that I would be away for two weeks at the end of March and that I would see her again in early April, which she agreed. At this time Tory was planning to move but was unsure of her city destination, therefore I could not get an address or new phone number prior to our break. This was the last session I saw Tory. Apparently she called me while I was away and asked the

administrative person if she was suppose to come in for an appointment. She was reminded that I was away. She left her old phone number and when I tried to reach her upon my return the number was disconnected. I believe that Tory, like many survivors, would have found it to difficult to terminate and therefore decided to avoid the termination process altogether.

Pre-test and Post-test Scores

Due to Tory's early termination and the break in our regular meetings, the post-test scores were not collected. The pre-test data from the Trauma Sequelae indicated that Tory was experiencing symptoms consistent with post-traumatic disorder. Initially Tory indicated that she had no memories of sexual abuse therefore she responded to the Trauma Sequelae in relation to a traumatic event which excluded sexual abuse. The revised version of the Trauma Sequelae requests that the client respond to the questions in reference to a sexual abuse experience, therefore the measurement could not be used for the purpose of this practicum.

The pre-test results of the Beck Depression Inventory (Appendix E) suggested that Tory was severely depressed. Her pre-test score was 31. In regards to individual items in the pre-test Tory perceived herself as failing in her life, and as someone who was being punished. She felt

irritated all the time, found that she could not make decisions in her life, believed that she had permanent changes in her appearance that made her look unattractive, had trouble sleeping, felt tired from doing almost anything, had no appetite, and had no interest in sex. Her perception of self-blame, her inability to make decisions and disinterest in sex was consistent with my clinical observations. One of the first symptoms Tory discussed during the assessment phase was her disinterest in sex with her partner.

The results of the Beliefs Associated with Childhood Sexual Abuse (Appendix F) indicated that Tory had significant clinically distorted beliefs. Her pre-test score was forty seven. On the individual items Tory scored high on the following: no man could be trusted, I must have permitted sex to happen because I was not forced into it, I don't have the right to deny my body to any man who demands it, I must have been seductive and provocative when I was young, and it is dangerous to get to close to anyone because they always betray, exploit or hurt you. In particular Tory's score on her perception of self-blame and self-worth was consistent with my clinical observations. For example, she could not understand how her male partner would stay with her when she refused him sex. Tory believed that men only wanted her for sex. Therefore she was frequently suspicious of her partner's motives for staying with her.

Tory responded negatively to "enjoys lovemaking" and "initiates lovemaking" in the pre-test of the Solution Focused Recovery Scale which was consistent with Tory's presenting concerns during the beginning phase of treatment.

Case Example-Client E-Jill

Jill was transferred internally from another therapist working at the Elizabeth Hill Counselling Centre (EHCC). She was transferred because her therapist was leaving and Jill wanted to continue with individual counselling in order to work on her sexual abuse issues. Jill is a caucasian woman in her mid twenties and a mother of three. Jill was sexually abused by her father during her childhood.

Client biography

Jill was the eldest daughter of three children. She had two younger sisters both of whom are now adults. Jill grew up in a two parent family. Jill remembers being afraid of her father and recalled him being abusive in various ways towards his family. She described him as "living the single life as a married man". Jill was sexually abused by her father until she was approximately nine years old. Apparently the second eldest child was also sexually abused by her father. Her youngest sister lives out of province and Jill does not know if she was sexually abused.

According to Jill her father had a good relationship with his parents during his childhood. When Jill was a teenager her aunt disclosed that her brother (Jill's father) had sexually abused her as a child. Her aunt's disclosure was ignored and Jill's father stopped talking to his sister for two years following the disclosure.

Jill described her mother as "someone who did not like to hear any bad news" and who is quite secretive about her past. Jill's mother grew up in an alcoholic home in which both of her parents were verbally abusive towards each other. Jill indicated that she preferred the company of her maternal grandparents over her paternal grandparents even though they were verbally abusive towards each other. Both Jill's maternal grandparents have passed away and her paternal grandparents are still living.

Jill and her youngest sister were considered the "rebels" within the family and the middle child was seen as the "good one". Jill completed her high school and continued on to get her healthcare aide certificate as a young adult with little support from her family.

Prior to treatment Jill had two young children, both under the age of three years. During the course of treatment Jill became pregnant with her third child. Jill has been in a relationship with a man for the last couple of years. He is the father of her children and their relationship has been unstable since its inception. In the last year her partner has

walked out on her three times promising never to come back. Each time he had returned after approximately a week. A few months before we ended our counselling sessions her partner left again and still had not returned when treatment ended.

Jill is employed on a casual basis. When she first started attending counselling she was coming off of her maternity leave and had anticipated taking more time off due to the arrival of her third child.

Description of Difficulty

Jill reported suffering from symptoms that are consistent with survivors of incest. She disclosed that her father had sexually abused her as a child. Her most vivid memories of the abuse are at age nine, although she suspects the abuse began even earlier as she suffered from chronic bladder infections as a young child. After her father stopped sexually abusing her he became more verbally abusive towards Jill, often calling her "fat" and "lazy". As an adolescent Jill disclosed to her doctor that she had been sexually abused by her father. Her doctor asked her if "she hated him" and she replied "yes". That was all he said and he never brought up the incident again. Jill thinks he may have told her mother but nothing, to her knowledge was done about it.

Presenting Issues/Concerns

At the beginning of counselling Jill was put on medication by her family doctor for anxiety due to depression and for her sleep disturbance. By our fourth session her medication had been increased slightly. Jill presented with relationship difficulties. She explained that she felt like "giving up and walking out of the relationship for good". She explained that she experienced "fits of rage" because she believed her boyfriend was cheating on her. Her family doctor suggested Jill discuss what triggered her rage with her counsellor. As we explored this in more detail a pattern emerged. Prior to 10 pm Jill recalled that she usually had a tendency to get down on herself when she and her partner sat down to watch TV in the early part of the evening. She constantly compared herself with other women on TV and thought her partner was fantasizing about the women on TV. This negative self-talk would fuel her feelings of rage which usually began around ten o'clock in the evening. Another point at which Jill became enraged was while her partner had a bath. Apparently her own abuse had often occurred in the bath tub.

Goals

The first goal was to develop a therapeutic relationship with Jill and monitor her suicide ideation. Secondly, it was important that Jill have

the opportunity to disclose her abuse and, finally, to break the silence which had cloaked her life thus far. It was also apparent that Jill needed to become more aware of her negative self talk and the source of the negative talk in order to deal with her rage. The final goal was to educate Jill on the effects of sexual abuse in order to "normalize" her experiences and decrease her self-blame.

Treatment Process and Intervention Strategies

Our sessions began with an intake session, followed by a session in which Jill filled out the pre-tests. Prior to our third meeting I called Jill on the phone because I was concerned about her scoring high on the Beck Depression Inventory for suicide ideation. I asked her whether she was at risk in hurting herself and she replied "no". When she arrived at our next meeting I had Jill sign a suicide contract in which she agreed to keep herself safe between sessions. Jill reported that she would never commit suicide because of her children. I also gave Jill the number for the crisis line at Klinic which she was encouraged to use if the need arose. We reviewed the contract over the next few sessions until such time we both felt it was no longer necessary.

Following Jill's description of her difficulties and a brief history of her family of origin, Jill disclosed that her mother cared for her sister's young child during the week. The child was cared for in her

grandmother's home and the abuser was in and out of the house during the course of the day. Due to my legal obligation to report suspected child abuse I was required to report this arrangement to Child and Family Services. I reminded Jill of my legal obligation and she appeared to understand.

When we met again Jill explained that she had disclosed to her sister for the first time that her father sexually abused her. Apparently her sister responded in a positive way and disclosed that she was also abused by their father. Her sister told Jill that she would no longer take her child to be cared for at at her parent's home. When I asked Jill how she felt receiving such a positive response, she replied "good". She was glad they had the opportunity to share their abuse experiences with one another.

During the fifth session I asked Jill to tell me as much as she felt I needed to know about the abuse, and only as much as she was comfortable sharing with me. Jill explained that the abuse occurred at night when her mother was out playing bingo. Her father took Jill from her bed at night and made her watch pornographic videos with him. As he forced her to watch the videos he often told her that "this is what your not suppose to watch". After the pornographic videos ended he often directed Jill to assist him with his bath and or go to his bedroom where he continued to abuse her. As she disclosed her abuse she

appeared agitated. Shortly after, she changed the subject and I did not push Jill to disclose any more then she was comfortable sharing. At the end of the session I congratulated Jill on her hard work.

By our next session Jill claimed that her relationship with her partner had deteriorated and that if things did not improve she was planning to leave him by the end of the month. At one point she claimed things would only change if a miracle happened. I then asked her a short version of the miracle question (Dolan 1991). If a miracle happened over night how would things be different for you? She would feel better about herself, she would trust people more (particularly men), she would not feel threatened when her partner went out and she would not constantly compare herself to other women. She then shared an experience she had while sitting in the waiting room of EHCC in which she immediately disliked someone she saw. She felt guilty about her feelings because she did not know this person but had made judgments about her. I attempted to reframe her experience by suggesting that she utilize her judgments as learning opportunities. As I asked her various questions regarding the woman in the waiting room, Jill realized that the woman reminded her of her partner's ex-wife. The thought of her partner's ex-wife reminded Jill of the discomfort she experienced each time her partner went out late at night. Jill concluded that when her partner went out at night she was reminded of her father

who continued to have extra marital affairs during her childhood.

During our seventh session we continued to discuss Jill's reaction towards her partner when they watched TV. Jill revealed that she felt her partner wanted the women on the TV and not her. She then changed the subject and declared that her partner did not care for her when she got sick. I asked her how she was treated as a child when she was sick. Apparently bladder infections were common during her childhood and on one occasion she was very sick and her father refused to take her to the hospital. Jill and her mother were forced to take a cab. It was during this session that Jill began to connect the bladder infections she had as a child to her father's sexual abuse.

I began the next session with a song by Suzanne Vega called "Bad Wisdom". After listening to the song, Jill discussed her relationship with her mother and how her mother was unable to support her when she was being abused by her father. Jill believes after she disclosed the abuse to her doctor, her doctor told her mother. Apparently, her aunt asked Jill if she was telling the truth about the abuse and Jill believes the only way the aunt would have known was if her mother had told her. Even after Jill confirmed the abuse, nothing was done. Jill continued to struggle with the issue of why her mother chose to stay with the perpetrator after she found out that he was sexual abusing their daughter.

Following each session I encouraged Jill to participate in a self nurturing activity between sessions. We brainstormed various activities she enjoyed and she was to pick at least one between each session.

Jill missed our next session because she was delayed at her doctor's office. The same day she called me sounding very distressed and claimed that she was pregnant. We set up another appointment because she was not feeling able to come in that day. Our next session revolved around her relationship with her partner. Jill was also taken off her medication due to the pregnancy. She had to see a specialist in order to find out whether the baby had been harmed by the medication at which point she had to make a decision of whether to continue or terminate the pregnancy. It was eventually determined that the baby was healthy and Jill chose to continue with the pregnancy.

Jill arrived at our next session but did not have much to say. She appeared nervous and her foot was shaking. I asked her what her foot was trying to tell her. She laughed nervously and replied "Ben always makes comments about my foot shaking, he gets mad at night because I have to shake my foot to get to sleep". I asked her if she felt nervous and she replied "yes". When I asked if she knew why, she replied "it is silent". We then explored what silence meant to her and she revealed that when people were silent she felt they were mad at her because when she is mad she gets silent. I then asked her if she thought I was

mad at her because of the silence and she said "no". I also asked if she was mad at me and again she said "no". I then asked Jill how she would know if therapy was useful? She replied "I won't be so anxious in the evening". She stated that her anxiety comes up like "clock work, it's like an alarm clock going off". I then did an anxiety rating scale (Dolan, 1991) with Jill in order to assist her in monitoring her anxiety. The scale ranged from not anxious to severely anxious. On the scale I asked her where she positioned herself at present and she replied moderately anxious. She would see a change if she moved from moderate down to somewhat anxious. Jill defined moderately anxious as "overwhelmed with noise in the house, feeling like she wants to run, becomes angry when partner takes long baths, irritable and unable to concentrate". Jill stated that she becomes angry with her partner when he takes a bath because she thinks he is masturbating and that he would rather masturbate than have sex with her. Jill claimed that in the past she had burst into the bathroom while her partner was bathing and accused him of masturbating. She then feels remorseful for her behavior. In addition, Jill has difficulty with her ability to concentrate. She use to be able to read a book but now is unable to focus. She finds it difficult being in another room than her partner because she constantly worries about what her partner is doing and /or watching on television.

Jill defined somewhat anxious as, "allowing her partner to have a

bath without being concerned that he is masturbating, being able to read a book in another room without being overly concerned about what her partner is doing, not feeling overwhelmed or like running". Jill highlighted that if she no longer felt concerned about whether her partner was masturbating during his baths and did not barge in on him she would recognize significant change. We continued to use this scale periodically throughout our sessions together.

The following session was devoted to discussing Jill's relationship with her partner. She then did not show up for her next appointment and did not phone to cancel. I had not heard from Jill for almost two weeks and called her to find out if she was going to make her next appointment, which she did.

By the thirteen session Jill, her partner and the children were getting ready to move into a house at the end of the month. We started the session by discussing the move. On the anxiety scale Jill had dropped down to somewhat anxious. When we first started using the scale Jill's goal was to reach somewhat anxious and by this session she had achieved this goal. When I asked her what had changed, she replied that she did not feel as anxious because she was too busy packing for the move. She also felt tired more easily because of the pregnancy therefore she did not have extra energy to fight or worry. Apparently Jill realized it took to much energy to try and control her partner's

behavior so she decided it was no longer worth the effort. During the past week her partner had a bath and although she thought he was masturbating she did not barge in the bathroom. She stated that it did not bother her as much because she knew he was not with anyone and therefore she was able to stop the negative self-talk.

Upon arrival at her next session Jill claimed she had nothing to say. Jill's behavior during sessions seemed to alternate between anxiety and talkativeness to an opposite where she appeared tired, distant, and virtually silent. My observation of these extremes led into a discussion on the types of coping skills Jill utilized as a teenager. I asked her how she survived as a younger child and she replied that most of the time she was scared of her father because he had a bad temper except when he was sexually abusing her. At this point she became tearful. When I asked what was happening in the moment, Jill stated that she did not think she was "normal" because she was not scared of her father during the abuse. I validated Jill's observation by confirming that it makes sense that she would not be scared of her father if he was behaving less threatening during the abuse in contrast to every other time in which he appeared threatening to Jill. She then indicated that as children, every time their father came home, Jill and her siblings would hide because they were afraid of him. She indicated that at the age of nine or ten she told her father not to touch her and he stopped. She

blamed herself for not saying "no" earlier because she felt she could have prevented her own abuse. As Jill shared her story I explained to Jill the power difference between a child and a grown man and that his reasons for stopping had little to do with her. Whether she said "no" earlier probably would have been ineffective. Jill stated that she suspected he may have started abusing her younger sister which I agreed was a possibility.

Jill did not attend her next meeting and did not return my phone calls. At this point I was not sure if Jill would return. It was over a month before I heard from Jill again. In early December, Jill recontacted the office and wanted to attend a session. Just prior to Jill's session she called to cancel because she could not get a babysitter so I told her to bring her kids with her. During the session Jill discussed the deterioration of her relationship with her partner. Apparently he had left her and she felt it was for good this time. Prior to their breakup the family had moved into their new house and now Jill could no longer afford the rent on her own. Although Jill expressed feeling scared and alone, she did emphasize that since he was gone her concentration had improved to the point that she could now read a book. The remainder of the session was utilized to discuss her present circumstances and her plans for the future.

When Jill arrived for our 16th session her partner had returned.

Therefore I decided to ask Jill about her missed sessions over the month of November. She responded that she thought she was getting better, and therefore did not need to attend anymore. She later realized that things were not getting better and that she wanted to continue with counselling. We also decided that meeting once a week would be adequate since Jill had progressed since our initial sessions.

Jill cancelled the next two sessions. When she returned in January once again her partner had left the family only to return a week later. Jill began blaming herself for his leaving although as she continued to discuss the situation she realized that he was also responsible for the difficulties in their relationship. Jill realized each time he left she felt a little stronger and could actually envision her life without him, and it being "ok". This was a positive step for Jill. Her partner had left her several times since they had been together and usually when she believed she most needed him, for example, during her pregnancy with her first child, and during Christmas.

Jill cancelled her next session and again I did not hear from her for several weeks. When Jill returned she told me that she had left her partner three weeks previously. It was the first time she had ever left him. Jill and her children had moved into a new apartment and her partner was no longer in contact with them.

Due to the many changes in Jill's life it was difficult to continue

working on her sexual abuse issues. Jill was living from crisis to crisis and therefore required interventions which were supportive in nature. Our remaining sessions consisted of building on Jill's resources, supporting Jill in dealing with the loss of her partner, assisting Jill in planning for the arrival of her new baby and giving her emotional support, and assisting Jill in setting up counselling opportunities in anticipation of termination of our sessions together.

Closing Sessions

Prior to termination Jill contacted another agency on her own behalf. She was put on a eight week waiting list. Two weeks prior to our sessions ending, Jill appeared to be having difficulty with termination. Jill explained that she felt she was being abandoned when she most needed support. Although my practicum ended on April 30th, I decided to extend my work with Jill for an extra four weeks, or until she gave birth. When we terminated Jill still had not heard from the other agency. I then spoke with the counsellor at Elizabeth Hill Counselling Centre who had worked with Jill previously and she agreed that she could meet with Jill if the need arose prior to Jill's acceptance into the other program.

Pre-test and Post-test Scores

The pre-test data from the Trauma Sequelae indicated that Jill was

experiencing symptoms consistent with post-traumatic stress disorder. The post-test data suggested that Jill continued to experience PTSD but experienced some changes in the symptomatology. In particular, Jill no longer felt the memories of her abuse intruded on her life. Although in the post-test she was more distressed when reminded of her experience following treatment than she had been prior to treatment. Jill no longer felt cut off from others, no longer felt emotionally numb, no longer felt pessimistic about her future and was no less interested in things which use to be important to her. She also perceived herself as sleeping better, and she experienced an improvement in her ability to concentrate. The improvement in her concentration was consistent with my clinical observations. During the course of treatment Jill claimed that if she could concentrate long enough to finish reading a book she would notice a decrease in her anxiety level. Her concentration improved to the point that she was able to read a book from cover to cover. In addition, Jill no longer felt watchful or on guard and she no longer felt that she was reacting physically to things that reminded her of the abuse.

The pre-test results of the Beck Depression Inventory (Appendix E) suggest that Jill's level of depression decreased substantially over the course of therapy. Her score decreased from 35 in the pre-test, which is reflective of someone with severe depression, to 10 in the post-test,

which is reflective of someone who is mildly depressed. In the pre-test Jill scored above two on pessimism and suicide ideation. A score higher than two for both of these items may indicate the client is contemplating suicide. Although Jill had a high score on both these items she claimed that she would not kill herself because of her children. In the post-test Jill's score on these two items had dropped significantly. In fact, at termination Jill had a difficult time believing that her pre-test scores on these two items were so high. In addition to the previous items, Jill no longer felt she was being punished, she was disappointed in herself but no longer hated herself, and her body distortion had improved.

The pre-test results of the Beliefs Associated with Childhood Sexual Abuse (Appendix F) indicated that Jill had clinically distorted beliefs in relation to her experiences of child sexual abuse. Although her pre-test score decreased from thirty-five to a post-test score of six. The most drastic changes following treatment occurred in how she perceived herself: she no longer believed that she was worthless and bad. Her level of self-blame decreased, she was more concerned about her well being and she no longer felt that only "bad and worthless guys" were interested in her.

The result of the Solution Focused Recovery Scale suggest that Jill's perception of her healing progress improved in most areas of her life

except in her ability to initiate conversation with acquaintances and strangers.

Case Example-Client F- Sabrina

Sabrina was self-referred to the Elizabeth Hill Counselling Centre (EHCC) for childhood sexual abuse. Sabrina is a woman of aboriginal descent and is the mother of two children.

Client biography

Sabrina was born on a reserve in Manitoba. Both her parents are still alive and reside under the same roof with six of their grown children and several of their grandchildren. Sabrina's two children remain under the care of their grandparents on the reserve. Sabrina does not have a place of her own and therefore lives a transitory life, moving between her parent's house and the city.

Sabrina's father drank during her childhood and was both physically and verbally abusive towards her and her siblings. She remembered being struck by her father with various objects. On one occasion her father hit her with a "two by four".

Sabrina was sexually abused several times during her childhood. As an adult, Sabrina disclosed to her mother that she was sexually abused and her mother responded by "laughing" and dismissing her experience.

As Sabrina got older she began to use alcohol as a way to cope with

her trauma and although she continued to drink she realized it no longer had the numbing effect it once had.

Sabrina now lives in the city and moves back and forth between her cousin's and boyfriend's place.

Description of Difficulty

Sabrina was self-referred to Elizabeth Hill Counselling Centre for child sexual abuse. She was sexually abused by an uncle, cousin and gang raped by five males during her childhood.

Presenting Issues/Concerns

During her childhood Sabrina was raped twice by an uncle. She was sexually abused by a cousin at the age of thirteen, and gang raped by five males at the age of fifteen. A week before Sabrina arrived for her first session she was raped by someone she met at a bar.

Sabrina was still using drugs and alcohol as a coping strategy during our time together. She needed to learn more effective ways in which to deal with her past and cope with life stresses in general . Sabrina had difficulties setting personal boundaries and had a tendency to put herself in potentially unsafe situations, for example she stayed overnight at a stranger's house (someone she met in the bar a few hours prior).

As an adult Sabrina continued to experience flashbacks of her

uncle raping her, particularly during sexual intercourse with her lover. As Sabrina disclosed this information her whole body shook and she said "I feel gross". Sabrina continued by stating that she faked orgasms and left her body during intercourse which she was very concerned about. Sabrina also stated that she had difficulty expressing anger and that she usually kept it bottled up inside.

Goals

Due to Sabrina's continuing struggle with alcohol I did not feel she had the emotional strength to deal with her sexual abuse. I felt it would be more beneficial for Sabrina to get her addiction under control before delving into her child sexual abuse issues. Therefore Sabrina was referred to an alcohol and drug treatment centre. In order to support Sabrina I decided that I would continue to see her on a weekly basis until she was accepted into the treatment program. Due to Sabrina's apparent need for support I set up another appointment.

Treatment Process and Intervention Strategies

Sabrina arrived, with her boyfriend, forty-five minutes early for her intake session. Her boyfriend did not participate in the intake session. As I discussed the practicum she became teary eyed and began disclosing her abuse history. She disclosed that she had been raped

the Sunday prior to our first meeting by someone she had met at a bar. The police were notified but she was unsure if she was going to charge him. Sabrina continued to disclose the sexual abuse she experienced as a child and the lack of support she received from her mother. Sabrina stated that she had a history of drug and alcohol abuse but no longer felt that it made her feel any better, she stated "I still think about what happened to me". When I asked her if she continued to use alcohol as a coping strategy she replied "no".

Prior to our next meeting Sabrina called and requested that I get her into a treatment centre for her drinking problem. Apparently she met with a family member who herself was going for treatment. This family member was able to convince Sabrina that she required assistance with her drug addiction. Sabrina then expressed an interest in attending the same treatment centre with this family member. I then contacted the treatment centre and requested Sabrina be admitted at the same time as her support person. Unfortunately this was not possible and Sabrina had to wait until the next intake date.

During our next session Sabrina again arrived forty-five minutes early. She discussed her stay at her parent's house and her concerns regarding the younger children living there. She felt that the children were being neglected in spite of the fact that there were several adults living in the same house. Sabrina also stated that her father slept in the

same room as his adult daughter and her foster child, while his wife slept in another room. I reminded Sabrina of my legal obligation to report suspected child abuse and told her I would have to call CFS because of my concern regarding the younger children in the house. We agreed I would make the call. Sabrina continued by disclosing that she was abused by a cousin at the age of 13 and recalled her aunt telling her that she witnessed Sabrina's brother sexually abusing her (Sabrina) when she was a child. Sabrina continued to have no memories of her brother's alleged abuse. Sabrina and I continued to discuss what was required of her in order to prepare for her admittance into the treatment centre.

During the fourth session Sabrina discussed her family of origin and the difficulties she was having in her day to day life which resulted from her sexual abuse history. Particularly distressing to her was her inability to stay present during sexual intercourse with her boyfriend. She also experienced flashbacks during intercourse. I attempted to normalize Sabrina's reactions as reflective of someone who had been sexually abused and suggested to her that her responses were not uncommon experiences for survivors. We then continued to discuss Sabrina's eventual admission into treatment and she continued to express an interest in attending.

Prior to the Christmas break, everything was set up for Sabrina's

stay at the treatment centre. When I returned from my holidays I called the treatment centre to follow up on Sabrina's referral and was told that she had not appeared at the treatment centre. I attempted to contact her at her boyfriend's home and eventually received a letter from her boyfriend stating that they were no longer together and that he assumed she had returned to the reserve. I eventually found out that she had not returned to the reserve and I had no other leads on how to contact her. I did not hear from Sabrina again.

Pre-test and Post-test Scores

The pre-test data from the Trauma Sequelae indicated that Sabrina was experiencing symptoms consistent with post-traumatic stress disorder. Due to Sabrina's early termination I was not able to collect post-test data on any of the measures.

The results from the Beck Depression Inventory (Appendix E) suggested that Sabrina was moderately depressed. Her pre-test score was twenty one. On individual items Sabrina scored most negatively in regards to feeling like a failure, self-dislike, and somatic preoccupation. Although Sabrina claimed that she had flashbacks and often left her body during sexual intercourse, she did not highlight this as a deterrent to her interest in sex on the Beck Inventory. That is, she did not notice any recent changes in her interest in sex due to these symptoms. On

the Solution Focused scale Sabrina responded to enjoying lovemaking "just a little". So although Sabrina experienced symptoms and enjoyed sexual intercourse "just a little", this had not, apparently, interfered with her interest in sex. Although at first glance this may appear contradictory, a possible explanation may be that Sabrina's interest in sex may not be purely physical. Survivors are sexualized at a young age and therefore having sex with someone may be the only way the survivor knows how to get attention and therefore feel wanted, even when it is detrimental to their well being (Browne and Finkelhor, 1986).

The results of the Belief Associated with Childhood Sexual Abuse (Appendix F) indicated that Sabrina had clinically distorted beliefs in relation to her experiences of child sexual abuse. Her pre-test score is nineteen. Sabrina scored highest on the following individual items: Sabrina perceived herself as seductive and provocative when she was young, she felt it was dangerous for her to get to close to anyone because they always end up hurting, betraying or exploiting her, she felt she would have great difficulty leading a normal life and that mostly the damage was permanent.

The result of the Solution Focused Recovery Scale suggest that Sabrina's perception in her ability to choose supportive relationships was low and that she perceived herself as having difficulty in taking protective measures inside and outside her house.

Again, I was not able to contact Sabrina after the Christmas break and therefore was unable to acquire post-test scores.

CHAPTER 5

CONCLUSION

Student's Learning

In my clinical work with women survivors of childhood sexual abuse I have learned how complex, sometimes overwhelming, and sometimes inspiring and hopeful this type of work can be. I have not only achieved the learning goals I originally set out for myself (learning, for example various techniques relevant to the treatment of women who have been sexually abused as children, and developing an awareness of post traumatic stress disorder and its relation to childhood sexual abuse) but have accumulated additional learnings as well. I will now conclude my report by highlighting several of these learnings, including what I learned from utilizing the Dynamic Co-Creative Healing Model and whether time limited treatment was appropriate with my clients.

Being sensitive to timing regarding when to utilize specific techniques was one of my first learnings. In the initial phase of treatment with the women I did not find the solution focused approach always effective. For example, during the initial phase of treatment with Anna (client A) I requested that she do the letter from the future (Dolan, 1991) activity as homework. When she returned the following session, I asked her if she was able to complete the task and she replied that she

was not able to picture herself in the future. Anna was experiencing what Terr (1995) referred to as "futurelessness". Anna's sexual abuse experiences had clouded her ability to envision her future self. In addition Anna often discussed feeling extremely lonely and empty. On one occasion I constructed a solution focused loneliness scale in order to rate her level of loneliness and explore ways in which to decrease her levels of loneliness. On the first attempt Anna participated in the activity but during future sessions refused to utilize the scale. I do not think Anna was ready to hear solutions but rather I believe she wanted to have the opportunity to express her pain and have her pain validated. That is why I believe the box of sorrows was so effective with Anna, -it validated her sorrows. Giving voice to Anna's pain/sorrow was what was important in her healing, not finding solutions to her pain, or finding times in which she did not feel the pain (exceptions).

When I asked Tory (client D) to complete the letter from the future (Dolan, 1991) activity as homework, she also did not complete the activity. Tory's response differed from Anna's in that it was the lack of privacy in her home which prevented her from completing the activity. There are many factors in the lives of survivors that influence their treatment process and progress, factors such as poverty, involvement in abusive relationships, pregnancies, changing residences, drug and

alcohol abuse, childhood abuse and neglect. For the therapist it was not only important to highlight how these factors may have impacted the lives of the women but also what specific dilemmas these factors presented to the practitioner.

In addition to the lack of privacy Tory experienced in her life, she was also on financial assistance. It was not uncommon for Tory to stand in line at the food bank in order to feed her family. On occasion Tory's financial status impacted the therapeutic process due to her inability to attend her appointments. She did not always have the bus fare to make it downtown.

Tory was a woman who overcame tremendous obstacles. As a child she had witnessed the severe abuse of her mother at the hands of her father, was neglected due to her parents' alcohol addiction, was sent to residential school at the age of five and was not able to see her parents for six years, was herself abused by various perpetrators throughout her life, and spent over half of her own life addicted to drugs and alcohol. By the time I met Tory she had been drug and alcohol free for nineteen months and was seeking assistance to heal from her traumatic past.

In a time of cut backs in which agencies provide few bus tickets, if any, what is the responsibility of the therapist? How much assistance should the therapist provide to her clients? Here was a client that

wanted to attend therapy and was working very hard but could not make all of her appointments because she did not have enough bus fare. In this particular situation I chose to provide bus tickets to Tory because I felt it was in the best interest of my client. As clinicians work more and more with clients that have similar hardships this dilemma will persist and I suppose each therapist will have to make up her own mind.

The issue of who to accept or not accept for treatment was another dilemma I was presented with during the onset of this practicum project, particularly in regards to Sabrina and Betty (clients F and C). Sabrina endured tremendous hardships (childhood abuse, neglect, abusive adult relationships and drug addiction) in her life and was voluntarily seeking therapy in order to deal with her childhood sexual abuse. At the time Sabrina first entered my office she was addicted to drugs and alcohol and lived a transient life style moving back and forth from the reserve to the city. In working with survivors, the therapist's first goal is to assist the client in creating safety within their living environment. The drug and alcohol addiction jeopardized Sabrina's level of safety as did her transient life style. I was faced with the dilemma of whether to accept Sabrina as a voluntary participant of the practicum, with the knowledge that she lived in an unsafe environment, or to refuse her service.

When I originally created the criteria for this project I did not state that I would refuse service on the basis of a woman's addiction unless it directly influenced the therapy sessions, for example, if the client arrived for a session under the influence of alcohol. In this particular situation I did not deny services to Sabrina and she very quickly realized her need for drug and alcohol treatment. In fact she called me on the telephone from the reserve and asked me to assist in referring her to Pritchard House. One of the key issues in deciding to accept Sabrina as a participant was that she had voluntarily requested services which I thought was significant. Significant because in spite of her current struggles she was reaching out for assistance.

Betty presented me with another dilemma in regards to participant selection. When Betty first arrived she appeared angry and stated that she had felt coerced by Child and Family Services to attend therapy. Therefore Betty was an involuntary client rather then a voluntary client. Again I was faced with a dilemma, do I accept this client if she does not want to be in treatment, with the hope that she might eventually change her mind and therefore become voluntary, or do I refuse her service which may potentially make her appear unmotivated to her CFS worker and potentially make her life more difficult.

In Betty's case I explained to her that she had to make her own decision about participating in the practicum and she stated that she

did want services. I felt I had to believe the client's intent although my "gut feelings" were telling me otherwise. I felt that Betty was putting in her time in order to appease her CFS worker. In the end Betty made her choice and terminated therapy due to her pregnancy. Due to the feeling of powerlessness many survivors experience I am satisfied that Betty was able to retain control and make her own decision on terminating therapy. I did not think refusing her treatment would have been in her best interests. I believe as therapists we have an obligation to work with voluntary and involuntary clients. For me the key issue in working with involuntary clients is how long we work with involuntary clients when they remain adamant that they do not want to be in therapy. Since every situation is unique, I suppose every therapist will have to make up her own mind in answering this question.

In the initial phase of treatment the first task of the therapist is to build a therapeutic alliance with her client. In my work with Jill (client E), I was concerned that this alliance would be threatened once she disclosed that her niece was potentially at risk of being abused by her grandfather (Jill's father). Although each woman was told during the first session about my legal responsibility to report suspected child abuse, I was concerned Jill may have forgotten and therefore react negatively to the therapist's actions. For the client, I assume the first session is often filled with apprehension and anxiety, and given

this, it is difficult to know how much information the client retains. In any case, I was required by law to report my suspicion and potentially lose a client. In this particular case the outcome was positive. Jill was able to disclose her abuse to her sister, put a temporary stop to her sister taking her child to her parents' home and created an ally within her family. Prior to termination Jill disclosed that her sister had resumed leaving her daughter at her parents' home and I again had to report my concerns to the proper authority.

Although some clinicians may declare that the law is the law and feel that this issue is fairly straight forward, I do not. Attempting to build a relationship with someone who is already filled with fear and apprehension and then potentially sending them into a further crisis by reporting suspected abuse can be upsetting for both parties. I do not suggest that suspected child abuse not be reported but rather felt it necessary to emphasize the difficulty faced by therapists on this issue.

As my work with these women progressed so did my understanding of the term co-creation. In learning how to co-create with clients there are many challenges for the novice therapist. The following three examples will highlight my success at co-creating with my clients, with the additional example of an unsuccessful attempt at co-creating with a client.

When Jill (client E) arrived for her sixth session she appeared

discouraged and claimed that her relationship with her boyfriend had deteriorated. She continued by emphasizing that the only way things would change was if a miracle occurred. In co-creating with Jill I listened to her frustration and responded to what she presented me with, and that was the question of a miracle. I pursued her invitation by asking Jill, that if a miracle happened over night how things would be different for her. Jill responded by stating that she would feel better about herself, she would trust men more, she would not feel anxious when her partner went out, and she would not constantly compare herself to other women. The eventual outcome of the session was that Jill realized when her partner went out at night she felt threatened. Her partner reminded Jill of her own father who often had extra marital affairs. Jill learned from her father that "men" could not be trusted and therefore she thought her partner was also having affairs. In co-creating with Jill and utilizing the information she gave me during the session Jill was able to develop self-awareness regarding her reactions to her partner going out at night.

Utilizing the symbol for the present (Dolan, 1991) was another way in which I co-created treatment with my clients. Prior to Lucy (client B) returning to her parent's home after 16 years, I reminded her of her symbol for the present (her wedding ring) which she practised utilizing during the last session before leaving for her trip. Lucy applied her

symbol for the present several times when she was away and therefore exercised her own resources which she found empowering. This activity would not have been effective had it not been co-created by the therapist and client. The activity met Lucy's needs and was reintroduced at the appropriate time for the client.

In different situations I found it helpful to implement a direct approach in co-creating with particular clients whereas in other situations it was not helpful. In particular, during one session I asked Anna (client A) to change seats with me because I felt she was immobilized by her feelings of hopelessness and thought by shifting her position she might get another perspective on her issues. This intervention was effective: Anna returned the following week and discussed several ideas she had thought of since the intervention. It appeared by shifting her position within the session she was able to shift her perception of her abuse. Apparently Anna had a new understanding of her biological father's negative reaction to her rape disclosure. This new perspective decreased her level of self-blame which was a significant step in Anna's recovery.

During approximately the fourth session with Betty (client D) I felt that I did not have enough information regarding the circumstances surrounding her abuse. I felt in order to assist her effectively this information was required and therefore decided to direct the session

by asking her some abuse specific questions. With her permission I began asking her questions from Courtois's (1988) Incest Questionnaire. As I continued to ask Betty specific questions regarding her abuse experiences she appeared more and more agitated. At one point she became angry and said that one of the questions was "stupid"! She said later that simply admitting that the abuse happened was "enough". The abuse specific direct approach was not effective with this particular client at this stage of her healing. In retrospect I also feel that the intervention was not co-creative in that I was not utilizing what Betty was offering me during the session. I was more concerned about moving ahead with my own agenda. O'Hanlon and Weiner-Davis (1989) emphasized this point by stating:

> a clear sign that therapy has gone astray occurs when clients disagree with or object to comments or suggestions made by the therapist (unless this is the therapist's intent). If the therapist does not change directions at this point, he risks losing his client or, minimally, impeding the change process (p.171).

Through this experience I learned that in order to co-create with a client the therapist must listen carefully to what her clients are expressing, non-verbally and verbally. Specifically, Betty's agitation was a clue that "therapy had gone astray".

In working with survivors of childhood sexual abuse I also realized the importance of the therapist's self-care. Listening to stories of trauma can have a detrimental effect on therapists if self-care is not part of their daily routine. This was highlighted for me during my work with Tory.

I distinctly remember two separate occasions in which Tory shared traumatic material. On both occasions I felt traumatized by the material Tory was sharing. During one session my heart raced and I felt anxious as she shared her trauma story. I found that in order to reconnect with Tory I had to disconnect briefly from what she was telling me in order to ground myself. What I specifically learned from this incident was that it is very difficult to remain continually attuned to your client during every moment of a session, particularly with trauma victims. Pearlman and Saakvitne (1995) highlight this point by stating: "Trauma material is difficult to hear and both parties are effected by it. Clients know this, but therapists often feel they must deny it" (p.17). The authors continue by stating that "psychotherapy does not promise perfect attunement or mirroring, but entails repeated cycles of connections and disconnections and then repair and reconnection" (Pearlman and Saakvitne, 1995, p.17).

On another occasion I had a difficult time letting go of an image which again resulted from one of Tory's traumatic experiences. It

entailed a conscious effort on my part to rid myself of the traumatic image. Realizing as a therapist that one will be affected by what people reveal, and creating methods of "letting go" after particularly stressful sessions was a valuable piece of learning for me. My methods of "letting go" involved debriefing with my advisor, meditation and prayer, relaxation exercises, and taking long walks.

Effectiveness of the Dynamic Co-creative Healing Model

In concluding this report I will briefly discuss what I learned from utilizing the Dynamic Co-Creative Healing Model in working with survivors of childhood sexual abuse. Bell-Gadsby and Siegenberg (1996) state:

> In delineating the stages of healing presented in this book, we realize that everyone is different and that while these stages have proven, in our experience to be valid, each therapist and client must decide which tools to employ at what time according to each client's need (p. 26).

Recognizing people's differences is an important point in utilizing any model. One of my criticisms of models in general is based on the likelihood that any model tends to ignore the uniqueness of each individual and the differences among people. If I had followed this model rigidly it would have been at the expense of my clients' needs. For example, in stage four of this Healing Model the authors highlight

grief work to be a major task. If I had rigidly adhered to this model I would not have introduced the box of sorrows to Anna when I did. In my opinion, Anna was in between stage one and two of her healing. The initial stages of the model did not highlight grief work as an integral task at those stages. Yet it was apparent that Anna was ready to begin her grief work, although she was not at stage four of the healing model. If I had chosen to ignore this fact and adhere to the model I may have lost Anna as a client and not been as successful in nurturing her growth.

The authors also recommend various techniques such as metaphor and stories. These techniques were presented as examples and it was up to the therapist to create metaphors and stories which reflected their own client's uniqueness. Although I can see the value in utilizing metaphors it takes skill and experience to co-create metaphors with your client. I did not feel confident enough at this stage of my learning to attempt this technique. So although the authors attempted to create a "user friendly" text, in my opinion some of the techniques would be difficult for therapists who have never utilized metaphors as a intervention strategy. As I become more acquainted with this technique I will eventually implement it in my work with future clients.

In utilizing the Dynamic Co-Creative Healing Model (DCCHM), I found that stage four was somewhat similar to the later stages of the

abreactive models discussed previously. The patterns for survivors at stage four of the DCCHM consist of the survivor exerting energy outwards by getting involved in various social causes/issues and being more future focused. In the final phases of the abreactive models the survivor's recovery is described in a similar fashion. Herman (1992) states the task for the survivor during the final phase of treatment is to "become the person she wants to be" (p.202) which suggests a future orientation. Herman (1992) continues by stating, "the sense of participation in meaningful social action enables the survivor to engage in a legal battle with the perpetrator from the position of strength" (p. 210). Therefore in the later stages of the healing process these various models seem to have more similarities than differences.

Time Limited Therapy

The authors of the model do not offer a time frame for treatment, possibly due to their belief that each individual is different and therefore the length of treatment for each person will vary according to their needs. When Dolan (1991) is asked whether she does brief therapy in her work with survivors she responds by emphasizing that she works with clients "as long as it takes for them to experience relief from symptoms, resolution of the intrusive traumatic memories, and acquisition of a hopeful and nonsymptomatic orientation towards the

future" (p. 203). Dolan (1991) continues by stating that therapy usually lasts anywhere from several months to three years.

In my situation time limited therapy was chosen because of the time constraints of the practicum. What I learned from utilizing a time limited framework was that it was not effective for all my clients, particularly Jill and Lucy (clients E and B). For example, according to the post-test data Jill was more distressed when she was reminded of her sexual abuse experiences following treatment than she had been prior to treatment. It was not until Jill started therapy that she began to discuss and be reminded of her abuse experiences and therefore her increased distress was a natural outcome. Her increased distress following treatment was a strong indicator that Jill required longer term treatment in order to develop healthier coping strategies in dealing with her distress. Therefore I do not feel six months of treatment was an adequate length of time for Jill.

Lucy was also anxious about ending our sessions. On several occasions Lucy asked me if we could continue with our relationship after the practicum ended. In addition she had not contacted any other agencies regarding future support for herself. This was worrisome to me since Lucy had only recently confronted her brother and faced her step-father. Dolan (1991) states that "difficulties with termination might indicate that the client is not yet ready to leave and has more work to

do" (p. 204). I believe this to be true in both Jill and Lucy's situations. In order to assist both Lucy and Jill during this transition period while keeping in mind my own time constraints, I extended their sessions for another four weeks. I felt four weeks would give Lucy adequate time to contact other agencies for future assistance and because Jill was already on the waiting list at another agency and was going to give birth to her child four weeks later, the time length was adequate for her present needs.

Reflections of Practicum Project

The practicum has provided the student clinician with invaluable skills in working with women survivors of childhood sexual abuse and in developing the clinician's self-awareness. In working with women survivors of childhood sexual abuse I felt my intuition, sensitivity and compassion were my most valuable assets. It was not solely the techniques that I employed or my knowledge of the model that influenced my clients' progress, but I believe my clients responded and progressed in part because they knew I cared. In part my compassion and sensitivity towards my clients were developed from my own personal experiences of family violence and addictions. I also believe that my dedication to learn and develop as a clinician influenced my work with the women, for example, if my clients presented me with

questions that were beyond my present knowledge base or if I felt "stuck" in terms of my ability to respond I actively researched solutions or answers through supervision and reading additional resource material.

Supervision was provided on a weekly basis with my advisor Shirley Grosser. Our sessions involved reviewing and discussing segments of video-taped sessions which I found to be an effective and important component of my learning process. Therefore for training purposes I recommend the utilization of video-taping in developing the student therapist's skills. Throughout the project my committee member Linda Perry was available for consultation when Shirley Grosser was not available. Through my work I realized the importance of not isolating oneself when working with sexual abuse survivors. Debriefing sessions with Linda or Shirley after particularly stressful sessions was helpful. It is recommended that counsellors working with survivors of sexual abuse have adequate support systems in order to prevent vicarious traumatization or other forms of emotional stress related to the work.

In conclusion, each one of the women I worked with were survivors of terrible offences committed against them. The most important learning I gained from my work with Lucy, Tory, Jill and Anna was the insight gained from witnessing the strength and resiliency they had in spite of their traumatic pasts. In particular, Lucy had progressed to a

point in which she could face two of her offenders and walk away from them knowing they no longer had power over her. Her strength and courage were inspiring to me and taught me that although survivors are not always aware of their resources, those resources exist.

References

Anderson, G., Yasenik, L., and Ross, C. (1993). Dissociative experiences and disorders among women who identify themselves as sexual abuse survivors. *Child Abuse & Neglect.* 17, 677-686.

Archer, Darlene. (1995). *Time-Limited Therapy with Adult Survivors of Child Sexual Abuse: Matching Client Needs with Effective Treatment.* Unpublished Practicum Report, Master of Social Work, University of Manitoba, Winnipeg, M.B..

Badgley, R., et al. (1984). *Committee on Sexual Offences Against Children* (Vol. 1) Ottawa: Canadian Government Publishing Centre.

Bass, E., and Davis, L. (1988). *The Courage to Heal.* New York: Harper & Row Publishers.

Beck, A.T.. (1978). *Depression Inventory.* Philadelphia: Centre for Cognitive Therapy.

Beck, A.T., Rush, A.J., Shaw, B.F., and Emery, G. (1980). *Cognitive therapy of depression.* New York: Guilford Press.

Beitchman, J., Zucker, K., Hood, J., DACosta, G., Akman, D., and Cassavia, E. (1992). A Review of the Long Term Effects of Child Sexual Abuse. *Child Abuse and Neglect,* 16, 101-118.

Bell-Gadsby, Cheryl and Siegenberg, Anne. (1996). *Reclaiming Herstory: Ericksonian Solution-Focused Therapy For Sexual Abuse.* New York: Brunner/Mazel.

Briere, John. (1996). *Therapy for Adults Molested as Children: Beyond Survival.* New York: Springer Publisher.

Brown, A. and Finkelhor, D. (1986). Impact of Child Sexual Abuse: A Review of the Research. *Psychological Bulletin,* 99 (1), 66-77.

Combs, Gene and Freedman, Jill. (1990). *Symbol, Story and Ceremony.* New York: W.W Norton & Company.

Conte, Jon. (1985). The effects of sexual abuse on children: a critique and suggestions for future research. *Victimology: An International Journal,* 10 (1-4), 110-130.

Courtois, Christine. (1988). *Healing the Incest Wound.* New York: W.W. Norton & Company.

Dolan, Yvonne. (1991). *Resolving Sexual Abuse: Solution-Focused Therapy and Ericksonian Hypnosis for Adult Survivors.* New York: W.W. Norton & Company.

Dominelli, Lena. (1989). Betrayal of trust: a feminist analysis of power relationships in incest abuse and its relevance for social work practice. *British Journal of Social Work,* 19 (4), 291-301.

Edwards, P. and Donaldson, M. (1989). Assessment of symptoms in adult survivors of incest: a factor analytic study of the responses to childhood incest questionnaire. *Child Abuse and Neglect,* 13, 101-110.

Finkelhor, David. (1984). *Child Sexual Abuse: New Theory and Research.* New York: The Free Press.

Fischer, Joel and Corcoran, Kevin. (1994). *Measures for Clinical Practice.* New York: The Free Press.

Geffner, Robert. (1992). Current issues and future directions in child sexual abuse. *Journal of Child Sexual Abuse,* 1 (1), 1-13.

Gil, Eliana. (1988). *Treatment of Adult Survivors of Childhood Abuse.* California: Launch Press.

Gil, Eliana and Johnson, T.C. (1993). *Sexualized Children: Assessment and Treatment of Sexualized Children and Children Who Molest.* Rockville, MD: Launch Press.

Grammer, H. and Shannon, J. (1992). Survivor's group: clinical intervention for the sexually abused child in treatment foster care. *Community Alternatives: International Journal of Family Care,* 4 (1), 19-32.

Hajes, Albert. (1990). *Adult Victims of Childhood Sexual Abuse: Treatment of Post Traumatic Stress Responses Through Relaxation Imagery.* Unpublished Practicum Report, Master of Social Work, University of Manitoba, Winnipeg, MB.

Hanna, C., Koverola, C., Proulx, J., and Battle, P. (1992). *Psychometric Properties of Four Diagnostic Measures for Identification of PTSD.* Poster presented at the Eighth Annual Meeting of the Society for Traumatic Stress Studies, Los Angeles, California.

Hartman, Carol and Burgess, Ann. (1989). Sexual abuse of Children: Causes and Consequences. In Dante Cicchetti and Vicki Carlson (Eds.) *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (95-126). New York: Cambridge University Press.

Haugaard, J. and Emery, R (1989). Methodological Issues in Child Sexual Abuse Research. *Child Abuse & Neglect.* 13, 89-100.

Health and Welfare, Canada. (1990). *Reaching for Solutions: The Report of the Special Advisor to the Minister of National Health and Welfare on Child Sexual Abuse in Canada.*

Herman, Judith. (1992). *Trauma and Recovery.* New York: Basic Books.

Hite, Shere. (1981). *The Hite Report.* New York: Dell Publishing.

Jehu, Derek and Klassen, Carole and Gazan, Marjorie. (1986). Cognitive Restructuring of Distorted Beliefs Associated with Childhood Sexual Abuse. Journal of Social Work and Human Sexuality, 4 (1/2), 49-69.

Jehu, D., Klassen, C., and Gazan, M. (1985). Common therapeutic targets among women who were sexually abused in childhood. *Journal of Social Work and Human Sexuality,* 3 (2-3), 25-45.

Jehu, Derek. (1988). *Beyond Sexual Abuse: Therapy with Women who were Childhood Victims.* Chichester: John Wiley & Sons.

Jehu, Derek. (1989). Mood disturbances among women clients sexually abused in chldhood. *Journal of Interpersonal Violence.* 4 (2), 165-184.

Kane, Ron. (1994). *Group Therapy with Young Female Victims of Intrafamilial Sexual Abuse.* Unpublished Practicum Report, Master of Social Work, University of Manitoba, Winnipeg, MB.

Karpel, M., and Strauss, E. (1983). *Family Evaluation.* Needham Heights, MA: Allyn and Bacon:

Keyser, D. and Sweetland, R. (1985). *Test Critiques, Volume II.* Kansas City, Missouri: Test Corporation of America.

Kiser, D., Piercy, F., and Lipchik, E. (1993). The integration of emotion in solution-focused therapy. *Journal of Marital and Family Therapy,* 19, (3), 233-242.

Koverola, C., & Pound, J., & Heger, A., & Lytle, C. (1993). Relationship of child sexual abuse to depression. *Child Abuse and Neglect.* 17, 393-400.

Lipchik, Eve. (1994). The rush to be brief. *Networker.* March/April, 35-39.

Maltz, W. and Holman, B. (1987). *Incest and Sexuality.* Massachusetts: Lexington Books.

McEvoy, Maureen. (1990). Repairing Personal Boundaries: Group Therapy with Survivors of Sexual Abuse. In Laidlaw, Toni and Malmo, Cheryl, *Healing Voices: Feminist Approaches to Therapy with Women.* (62-79). San Francisco: Jossey-Bass.

Molnar, A. and de Shazer, S. (1987). Solution-focused therapy: toward the identification of therapeutic tasks. *Journal of Marital and Family Therapy.* 13 (4), 349-358.

O'Hanlon, W. and Weiner-Davis, M. (1989). *In Search of Solutions.* New York: W.W. Norton & Company.

O'Hanlon, Bill. (1988). In Zeig, J. K. and Lankton, S. R.. *Developing Ericksonian Therapy: State of the Art* (93-111). New York: Brunner/Mazel.

Pearlman, L.A. and Saakvitne, K.L.. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.* New York: Norton and Company.

Perry, Linda. (1994). *Traumatized Families: Assessment and Treatment.* Unpublished Thesis Report, Master of Social Work, University of Manitoba, Winnipeg, MB.

Peters, S.D.. (1988). Child Sexual Abuse and Later Psychological Problems. In Gail E. Wyatt and Gloria J. Powel's *Lasting Effects of Child Sexual Abuse* (101-118). Newbury Park, California: Sage Publications.

Renvoize, Jean. (1993). *Innocence Destroyed: A Study of Child Sexual Abuse.* New York: Routledge.

Rowan, A., Foy, D., Rodriguez, N. and Ryan, S. (1994). Post traumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse and Neglect,* 18, 51-61.

Rush, Florence. (1980). *The Best Kept Secret: Sexual Abuse of Children.* New York: McGraw-Hill.

Russel, D., Shurman, R. and Trocki, K. (1988). The long term effects of incestuous abuse: a comparison of afro american and white american victims. In Gail E. Wyatt and Gloria J. Powel's *Lasting Effects of Child Sexual Abuse* (101-118). Newbury Park, California: Sage Publications.

Sandberg, D., Lynn, S.L., and Green J. (1994). Sexual abuse and revictimization: mastery, dysfunctional learning, and dissociation. In Steven Jay Lynn and Judith W. Rhue's *Dissociation: Clinical and Theoretical Perspectives.* Guildford Press.

Schlesinger, B. (1986). *Sexual Abuse of Children in the 1980's: Ten Essays and an Annotated Bibliography.* Toronto: University of Toronto Press.

Sgroi, Suzanne. (1982). *Handbook of Clinical Intervention in Child Sexual Abuse.* Lexington, MA: D. C. Health.

Stehouwer, S. (1985). Beck Depression Inventory. In D. Keyser and R. Sweetland (Eds.) *Test Critique, Vol. II.* (83-87). Kansas City, Missouri: Test Corporation of America.

Terr, Lenore, C.. (1995). Childhood traumas: an outline and overview. In D. Meichenbaum (Series Ed.), G. Everly, and J. Lating (Vol. Eds.), *Psychotraumatology: Key Papers and Core Concepts in Post-Traumatic Stress* (pp 301-320). New York: Plenum Press.

Walker, Lenore. (1995). *Abused Women and Survivor Therapy.* Washington, D.C.: American Psychological Association.

Walter, J.L. & Peller, J.E.. (1992). *Becoming Solution-Focused in Brief Therapy.* New York: Brunner/Mazel.

Wells, Mary. (1990). *Canada's Law on Child Sexual Abuse: A Handbook.* Communications and Public Affairs, Ottawa, Ontario.

Weiner-Davis, M. (1990). In praise of solutions: focusing on what works in client's lives. *The Evolving Therapist.* March/April, 173-179.

Wyatt, G. and Powel, G., J.. (1988). *Lasting Effects of Child Sexual Abuse.* Newbury Park, California: Sage Publications.

Wynkoop, T. & Capps, S. & Priest, B. (1995). Incidence and prevalence of child sexual abuse: a critical review of data collection procedures. *Journal of Child Sexual Abuse,* 4 (2), 49-65.

VISAC. (1988). *The Integrated Treatment Model for Sexually Abused Children and Their Mothers.* Vancouver Incest and Sexual Abuse Centre, Final Report. Vancouver, B.C..

APPENDIX A

Please Note

Appendix A

Please Note

Appendix B

Please Note

Appendix C
(Focused Recovery Scale For Survivors Of Sexual Abuse)

APPENDIX D

UNIVERSITY OF LEICESTER
CENTRE FOR APPLIED PSYCHOLOGY · UNIVERSITY ROAD · LEICESTER LE1 7RH · UK

RECTOR
or E MILLER

116 252 2481
116 252 3994
em22@le.ac.uk

CAL STAFF
S LEVEY
C McCREA
UNDERLAND

116 252 2466

ical Tutors
ATIMILEHIN
F FURNISS

116 252 2492
0116 252 2503

NSIC STAFF
P ALEIXO
sor G DAVIES
C HOLLIN
G SATTAR

0116 252 2481
0116 252 3994

DJ/SYW

13th August 1996

Margaret Dicks,

Winnipeg,
Manitoba,

Canada

Dear Margaret Dicks,

Thank you for your letter. You are welcome to make any use you wish of my Belief Inventory at no costs. Best wishes for your practicum.

Yours sincerely,

PP Professor Derek Jehu

NIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba Canada R3T 2N

Tel: (204) 474-9222
Fax: (204) 474-6297

MEMORANDUM

To: Ms. Tamara Dicks
Elizabeth Hill Counselling Centre

From: Catherine Koverola, Ph.D., C.Psych
Department of Psychology,
University of Manitoba

Date: August 12, 1996

This memo constitutes my permission for you to use the Trauma Sequelae questionnaire in your research project. Please ensure that the measure is correctly cited in any written work that you submit, either for your M.S.W. or for publication.

UNIVERSITY OF
PENNSYLVANIA
MEDICAL CENTER

Department of Psychiatry
Psychopathology Research Unit

Dear Ms. Dahls -

On behalf of Aaron T. Beck, M.D., I am responding to your recent inquiry regarding our research scales.

You have Dr. Beck's permission to use and reproduce the scale(s) checked below only for the designated research project that you described in your letter. There is no charge for this permission.

However, in exchange for this permission, please provide Dr. Beck with a complimentary copy of any reports, preprints, or publications you prepare in which our materials are used. These will be catalogued in our central library to serve as a resource for other researchers and clinicians.

/ ___ Beck Depression Inventory (BDI)
___ Beck Anxiety Inventory (BAI)
___ Hopelessness Scale (HS)
___ Suicide Intent Scale (SIS)
___ Scale for Suicide Ideation (SSI)
___ Cognitive Checklist (CCL)
___ Sociotropy-Autonomy Scale (SAS)
___ Other _____

___ Weekly Activity Schedule (WAS)
___ Daily Record of Dysfunctional Thoughts (DRDT)
___ Patient's Guide to Cognitive Therapy (PGCT)
___ Patient's Report of Therapy Session (PRTS)
___ Anxiety Checklist (ACL)
___ Beck Self-Concept (BSCT)
___ Dysfunctional Attitude Scale (DAS)

If you have any further questions, feel free to contact me.

Hard copies via mail

Sincerely,

K Dahlsgaard

Katherine Dahlsgaard
Research Assistant to Aaron T. Beck, M.D.

NOTE: Permission for inclusion of the BDI, BAI, HS, SSI, and BSCT in any publication must be obtained from The Psychological Corporation; telephone # 1-800-228-0752.

Room 754 Science Center • 3600 Market Street • Philadelphia, PA 19104-2648 • Tel: 215-898-4102 • Fax: 215-573-3717

University of Pennsylvania Health System

Subject: Re:

8/13/96

Ms Dicks:

Provided that the figure you wish to use is uncredited in our work as having come from another source and that you credit our work as your source of the material in each copy reproduced, this message will grant you permission to reprint the material in your Report, including all copies to meet University requirements.

Sincerely,

Frederick T. Courtright
Rights and Permissions Manager
W. W. Norton & Company, Inc.

_____ Reply Separator _____

Subject:
Author: umdicks@cc.UManitoba.CA (tamara dicks) at internet
Date: 8/9/96 12:12 PM

Dear Fred Courtright,

RE: Permission to use the Solution-Focused Recovery Scale For Survivors of Sexual Abuse for my graduate work.

I am requesting permission to reprint the scale identified below for the purpose of my Master's Practicum Report. The title of my proposal is "Co-creating Treatment with Women Survivors of Child Sexual Abuse: A Time Limited Approach". I will be working with 5-7 women as part of my project and would like to utilize the scale as part of my evaluation. I would also like to reprint the scale for my final report.

Figure 1, Solution-Focused Recovery Scale For Survivors of Sexual Abuse. Dolan, Yvonne, Resolving Sexual Abuse: Solution Focused Therapy and Ericksonian Hypnosis for Adult Survivors, p.32.

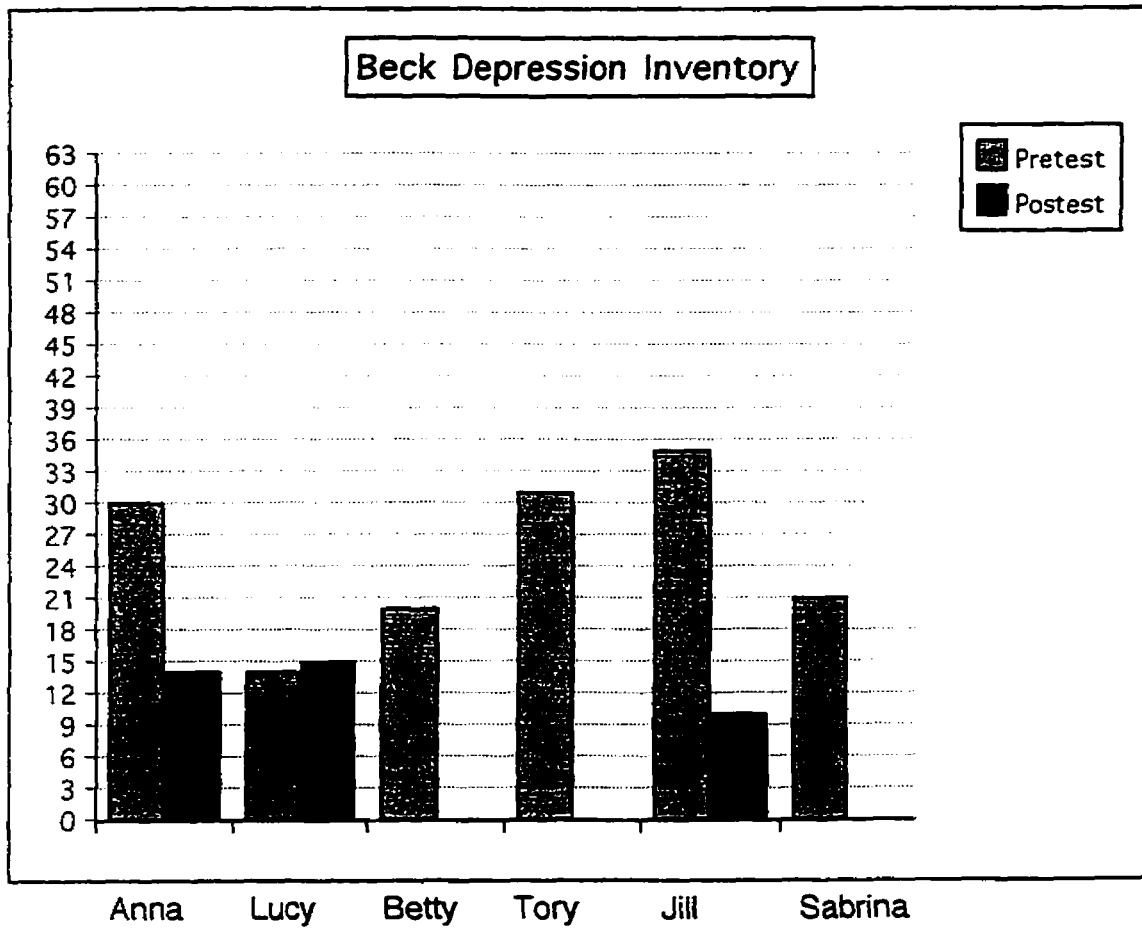
If possible, please send me a reply to this e-mail address or fax your response to the following number; 204-943-4073. I would appreciate your earliest reply on this manner. Thank-you for your time and consideration.

Sincerely,

Margaret T. Dicks

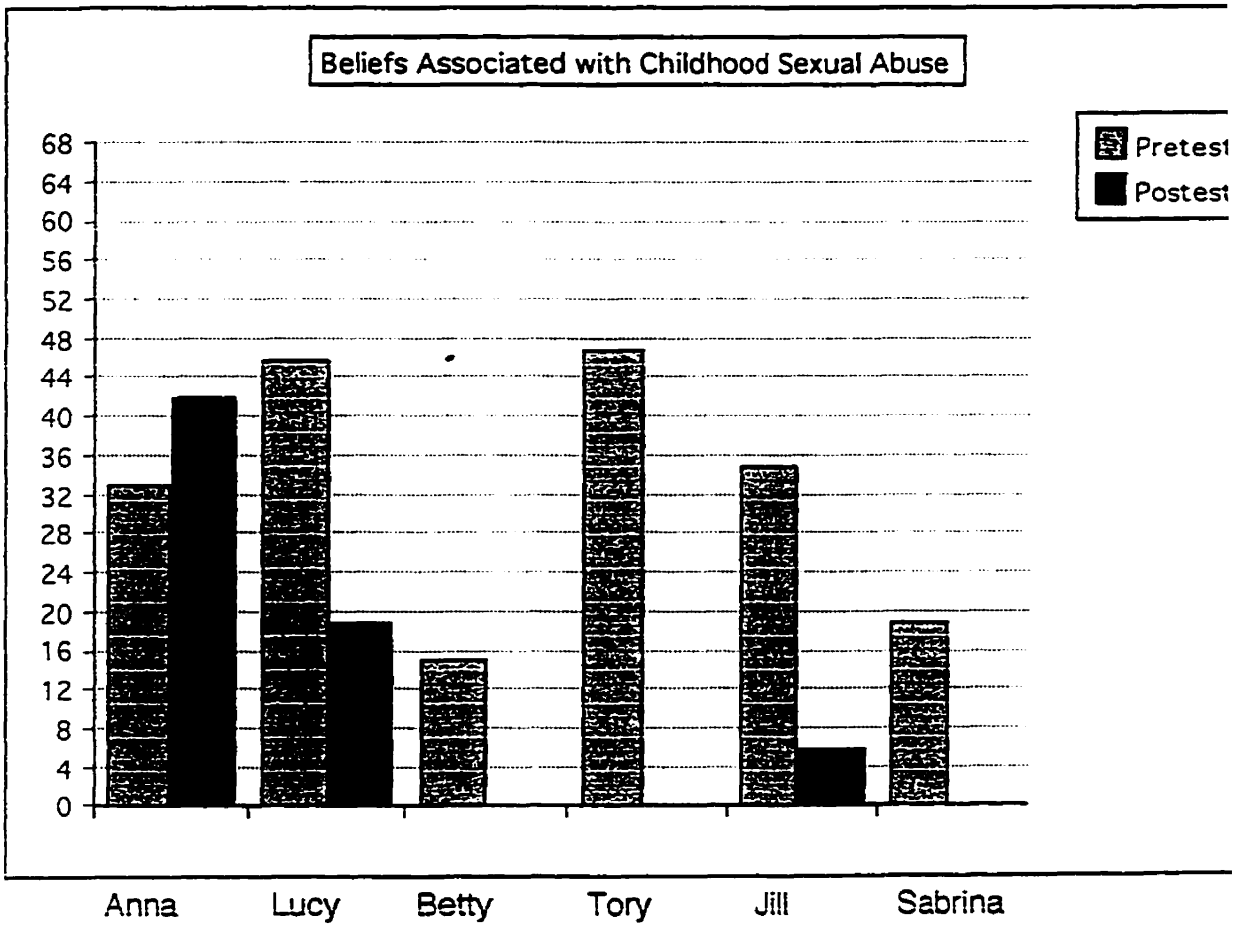
APPENDIX E

APPENDIX E


Beck Depression Inventory
Pretest
Postest
63
60
57
54
51
48
45
42
39
36
33
30
27
24
21
18
15
12
9
6
3
0
Anna
Lucy
Betty
Tory
Jill
Sabrina

APPENDIX F

APPENDIX F


Beliefs Associated with Childhood Sexual Abuse
Pretest
Postest
68
64
60
56
52
48
44
40
36
32
28
24
20
16
12
8
4
0
Anna
Lucy
Betty
Tory
Jill
Sabrina

APPENDIX G

Consent Form

The focus of this project is to assist women in their recovery from childhood sexual abuse. The women who participate in this practicum will receive assessment and treatment from a social work graduate student under the supervision of Shirley Grosser, Associate Professor at the University of Manitoba.

Your participation in this project will mean that you will complete four questionnaires. You will be asked to fill out the questionnaires twice, once before treatment begins and again at the end of treatment. All the information gathered will be confidential. All the therapy sessions will be videotaped and used only for the supervision of the therapist. These tapes will also be kept confidential.

Your participation in this practicum is strictly voluntary. You are free to withdraw at any time.

I have been informed and agree to participate in this practicum.

_____ _____

Witness Signature

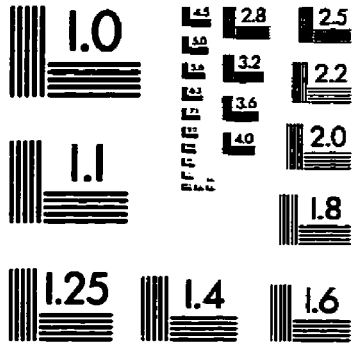
_____ _____

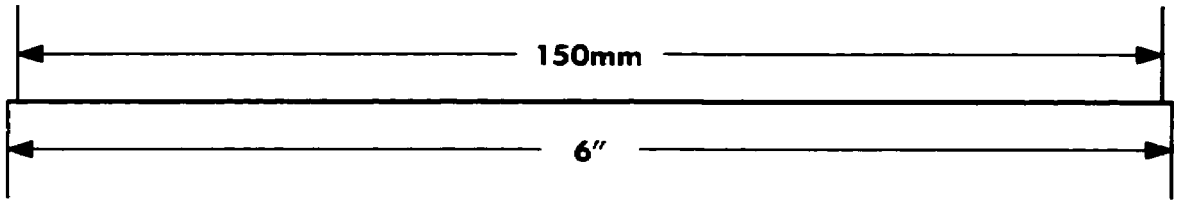
Witness Signature

_____

Date

TEST TARGET (QA-3)





APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989