THE RELATIONSHIPS BETWEEN COUNSELLORS' ORIENTATION, EXPERIENCES AND TRAINING AND THEIR CONCEPTUALIZATION OF THEIR TASKS IN THE HEALING PROCESS IN SEXUAL ABUSE COUNSELLING: A QUALITATIVE ANALYSIS

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ABSTRACT

Eight counsellors registered with the Accident Compensation Corporation as sexual abuse counsellors participated in qualitative research employing semi-structured, in-depth interviews. A qualitative approach was used to explore previously unidentified variables in sexual abuse counselling, and the relationships among these. Transcribed interviews were analysed for recurrent regularities in themes and dynamics. Four overall themes emerged that appeared most salient in influencing counsellor's conceptualization of the tasks and processes involved in treating the effects of sexual abuse. These themes were (1) counsellor's orientation; (2) training and development; (3) understanding of the dynamics, issues, and effects of sexual abuse; and (4) personal experience of abuse. These variables have implications for both the practice of sexual abuse counselling and for future research.

PREFACE

The writer's interest in the area of sexual abuse counselling stems from working for several years as a residential social worker with (adolescent) young women, the majority of whom had been sexually abused. This experience led to an awareness that expertise in sexual abuse counselling largely comes from experience, and that validation of the methods counsellors use is usually derived from sharing experiences with other counsellors. While the effectiveness of current therapeutic interventions has strong clinical support, it is largely empirically untested.

The writer's objective in undertaking the present study was to attempt to learn about and understand, first hand, the experiences of a small number of people providing counselling for survivors of sexual abuse. By exploring with them their perception of the important factors in the healing process, the present study attempts an analysis that is grounded in the practice of sexual abuse counselling.

It is the writer's belief that the concepts (including therapist and treatment variables) pertaining to sexual abuse healing have not been fully identified, and that the relationships between variables are insufficiently understood and conceptually undeveloped. So rather than *testing* the relationships among variables, the present study attempts to *discover* the relevant

concepts and categories pertaining to sexual abuse counselling and the relationships, if any, among them.

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The extent and seriousness of the problem of sexual abuse in New Zealand has received unprecedented acknowledgment in the last decade. It is an issue with which mental health professionals are increasingly confronted. This section considers the context for sexual abuse counselling in New Zealand; reviews the literature relating to both the causes and effects; considers the issues involved in the healing process and, finally, reviews current approaches to treatment of the diverse effects of sexual abuse.

THE NEW ZEALAND CONTEXT

In 1988 the Woodhouse Report to the New Zealand Accident Compensation Corporation (ACC) recommended that injuries (including mental distress) arising from sexual assault be included in the ACCs ambit. Since January 1989, survivors of sexual abuse have been able to claim lump sum compensation for pain, suffering, and loss of enjoyment of life. In the ensuing period to the end of June 1991, the ACC paid out $3.6 million for 65,000 counselling sessions.

In December 1989, the ACC Working Party on the Funding of Sexual Abuse Counselling Services established a pilot project for the development of competency guidelines to address the issues surrounding "*...the lack of competency guidelines to ensure that those registered with ACC have sufficient experience and*

knowledge to provide an appropriate counselling service" (Martin, Thompson, and Uta'i, 1989. p.5). The Pilot Project adopted the Working Party's definition of sexual abuse counselling, which had been broadly defined as:

> . . . the *employing of specific skills* to *assist survivors of sexual abuse and those close to them in healing from the trauma of sexual abuse.* (Martin et al, 1989, p.33).

Counsellors throughout New Zealand were interviewed individually and in groups. "*They were queried about what they thought made them competent and how they would assess another's competence. The most frequent responses have been included in the guidelines*". (Martin et al, 1989, p.44).

The resulting guidelines include criteria for assessing *counsellor qualities* such as ability to establish a therapeutic relationship, *knowledge and skill base,* and *training.* In so far as they formalize prescriptions for counsellor's activities, these competency guidelines feed into the development of treatment methods. In the absence of substantiating evidence for the effectiveness of treatment methods other than the prevalence of their use by counsellors, there is a danger of legitimizing and institutionalizing unproven methods and fostering an illusion of their validity.

The following section considers the potential and limitations of the available sexual abuse literature for aiding the development of prescriptive guidelines for sexual abuse counselling.

Sexual Abuse Literature

Methods for treatment of the effects of sexual abuse are still developing and undergoing rapid change. The sexual abuse literature is comprised of two main bodies. The first is the theoretical literature that informs knowledge about the causes and dynamics involved in sexual abuse. The other is the clinical literature that informs approaches to treatment of the effects of sexual abuse.

While research efforts into the etiology and dynamics of sexual abuse have intensified in recent times, there remains a dearth of material concerning specific treatment modalities and techniques. With a few exceptions, the treatment literature that does exist has tended to focus on children and families involved in ongoing abuse. Intervention with adult survivors has received less emphasis. At present, treatment for the effects of sexual abuse is grounded in the available theory from the fields of feminism, traumatic stress/victimization, self-development, and loss. While the effectiveness of therapy underpinned by these theories has strong clinical support (Courtois, 1988) it is largely empirically untested. The absence of sound criteria to guide the professional in the healing process has been noted by several

authors (Renshaw, 1982; Mayer, 1983; Courtois, 1988) who conclude that clinicians have *had to* develop and apply their own strategies and techniques in a trial-and-error fashion.

LIMITATIONS OF SEXUAL ABUSE RESEARCH

Apart from the newness of the field, the factor most often cited as explaining the absence of empirically tested, prescriptive guidelines is the highly controversial nature of the available literature. The sexual abuse literature in general has been highly criticized for its methodological errors. With a few exceptions most studies are: of reported cases; of people *seeking* treatment; from *selective* settings (Faller, 1988). These clinical samples have been criticized for leading to speculation rather than to valid generalizations (Mayer, 1983; Finkelhor, 1986).

A related problem is the absence of a universally acceptable definition of sexual abuse, although recently several approaches to classification have been developed (Faller, 1988). The general sexual abuse literature usually draws a clear distinction between rape and incest, especially with regard to the different dynamics involved in intrafamilial abuse. This distinction is not as clear in the available treatment literature. For the majority of feminist authors the *absence of informed consent* to a sexual act, regardless of the relationship between the perpetrator and victim, is what defines sexual abuse.

Because it is an area that involves many disciplines, definitions of what constitutes sexual abuse tend to reflect the philosophies and goals of the professionals or agencies involved. For example, the medical profession generally defines sexual abuse by consequence - the presence or absence of physical trauma. Mental health professionals are more likely to apply a broader definition, consistent with their belief in the benefits of therapy (Alpert & Paulson, 1990). Even within disciplines, what constitutes abuse involves a subjective element, for example whether non-contact abuse (such as voyeurism) and abuse by peers are included in the definition. These differences influence which situations fall within the realm of both clinical and research interest.

Establishing causal links between abuse and particular factors subsequently found in a victim (such as socio-economic status) has proven to be an impossible task (Report of the Advisory Committee, 1988). However, the literature is consistent in concluding that sexual abuse has adverse effects for the majority of people. These effects have been found to vary along a number of dimensions according to an equally diverse range of variables. Those most commonly accepted mediating variables include the nature of the abuse; the relationship between the abuser and the victim; the age of the victim and the abuser; and the use of force (Finkelhor, 1986). Other factors found to be associated with differential impact include the victim's receipt of some kind of reward; their efforts to avoid or resist the

abuse; and the victim's perception of her relationship with the abuser as otherwise positive (Conte & Schuerman, 1987). When family and personality variables are added, it becomes increasingly difficult to tell whether trauma is attributable to the effects of abuse or is a result of a complex interaction between the abuse and a number of coexistent variables. These factors mitigate against the development of a unitary approach to treatment.

THEORIES ABOUT THE CAUSES AND DYNAMICS OF SEXUAL ABUSE

The dynamics and characteristics of sexual abuse are discussed in the literature from several perspectives. These include:

The Psychodynamic perspective

The early psychoanalytic doctrines of Freud and his followers explained away accounts of incest as either elaborate childhood fantasies or, in the face of indisputable evidence, placed responsibility on the child victim and her unresolved and conflicted sexual feelings for her father. Psychodynamic thinking has been blamed for distorting the facts about the prevalence of sexual abuse, minimizing its psychological effects, and for influencing the *'blaming the victim'* attitude of generations of Freud's followers.

Brownmiller (1986) cites the writings of Kinsey (*'America's own original sex expert'*) as an example of the legacy of Freudian psychology and its influence on popular conceptions of sexual assault. According to Brownmiller, Kinsey was once reported as saying that the difference between a good time and a rape hinged on whether the girl's parents were awake when she finally arrived home. In an attempt to deal with the astonishing incidence of sexual assault reported by respondents in one of his studies, Kinsey concluded that it was difficult to understand why a child, except for its cultural conditioning, should be disturbed by having its genitalia touched, or by seeing the genitalia of another person.

Later psychodynamic theorists modified the classic psychoanalytic formulations of sexual abuse. While still emphasizing the personality dynamics of family members and their interactions, they espoused the usefulness of analytic techniques with survivors of childhood sexual assault within a framework of advocacy and belief in the survivors subjective experience above all else.

The family systems perspective

This perspective locates abuse as a function of the dynamics, interaction patterns and role arrangements of individual family units. Incest is a manifestation of family dysfunction that is supported by intergenerational family processes. Some family therapists view incest as a defence designed to maintain this

dysfunction (Kaplan & Sadock, 1988). The underlying assumption is that the intergenerational transmission process can be interrupted, and family role definitions and boundaries can be reconstructed with the goal of re-establishing the family as a functioning unit. This way of conceptualizing sexual abuse has been criticized for not taking into consideration the societal context which shapes notions about family and the roles of family members (Laing and Kamsler, 1990; Brickman, 1984).

The sociocultural perspective

In the 1960s, the sociological/sociocultural perspective moved away from specific theories of deviancy and toward a more general examination of social and cultural patterns. Sexual assault, rather than being a manifestation of individual pathology, was seen as an act of power and degradation located within a social context. This perspective focused on those social and cultural factors conducive to the development and support of sexual abuse such as the diminished status of women and the socialization of children into prescribed gender-roles.

The feminist perspective

This perspective, more than any other, has been attributed with bringing family violence and violence against women to public awareness (Courtois, 1988). Feminist writers (Rush, 1980; Herman, 1981) argue that sexual abuse is an inevitable by-product of a male-dominated society. A feminist perspective goes beyond the family unit and analyses family functioning in

the context of societal norms and sex-role stereotyping, reconstructing the sociological perspective in terms of women's reality. Thus women are socialized to be dependent on men and passively accepting of the unequal power relationships that render them vulnerable to victimization. Sexual violence, or the threat of sexual violence, has served the critical social function of *'keeping women in their place'* (Brickman, 1984) and incest is seen to be the extreme expression of a patriarchal society (Swink & Leveille, 1986).

THEORIES THAT INFORM TREATMENT

As well as the theoretical perspectives relating to the causes and dynamics of sexual abuse, theories derived from a number of disciplines and perspectives inform approaches to treatment.

Victimization/traumatic stress

Burgess and Holmstrom (1979) conducted a study which identified a number of physical and emotional characteristics typically manifested by women who had been raped. They described these as the Rape Trauma Syndrome. The syndrome consists of an acute phase during which the rape is the central focus of the woman's concern. She may display a wide range of both expressive and controlled reactions. The acute phase is then followed by an extended period of reorganization, and regaining control over her reactions and her life takes precedence over the experience. Contrary to their expectations, Burgess and

Holmstrom found that fear rather than shame and guilt was the primary reaction to the experience of rape.

Experiences of victimization commonly involve a series of losses that include loss of self-esteem, status, and perceived control. A pervasive feeling of loss of possibility - of who one might have been had the abuse not occurred - is common to sexual abuse survivors. Assumptions about the world as an orderly and predictable place are also seriously challenged, resulting in increased perceptions of vulnerability.

Studies of psychological responses to victimization have suggested there may be common psychological experiences that are shared by a wide variety of victims. The most common reactions include shock, confusion, helplessness, anxiety, fear, and depression. Janoff-Bulman and Frieze (1983) cite the *American Psychiatric Association's DSM 111's* Post Traumatic Stress Disorder (revised in *DSM 111-R,* 1987, to include both chronic and delayed reactions) as best describing the severe psychological reactions resulting from victimization. Diagnostic criteria for this disorder include: 1) re-experiencing the trauma via memories, intrusive thoughts, or dreams; 2) numbing of responsiveness demonstrable by feelings of detachment from others, constricted affect or diminished interest in specific activities; 3) other symptoms including exaggerated startle response, sleep disturbance, guilt, memory impairment or trouble

concentrating, and phobias about the activities triggering recollection of the event.

In an introduction to her widely-acclaimed resource book for therapists working with adult incest survivors, Courtois (1988) describes Post Traumatic Stress Disorder as the most accurate diagnosis for incest response. The degree of trauma varies according to a diversity of variables, including age, duration of the abuse, the type of relationship with the offender, the presence or absence of coercion, personality characteristics and ego-strength. However, conceptualizing the after effects of abuse within a traumatic stress framework provides a model for understanding the complex symptom-picture that survivors often present and a concrete orientation for treatment understandable to both client and therapist.

Accommodation Syndrome

Summit (1983) classified the most typical reactions of normal children to sexual assault as the Child Sexual Abuse Accommodation Syndrome. The syndrome consists of five categories. Two - secrecy and helplessness - are preconditions for abuse to occur. The remaining three - accommodation; delayed, conflicted and unconvincing dislosure; and retraction - represent a sequence of contingent responses.

The syndrome has implications for adult survivors of childhood sexual abuse in that the same mechanisms that ensure the child's psychic survival become handicaps to effective adult functioning. While there is a lack of consensus about the *'existence'* of the syndrome, it provides a common language for communication among professionals and, like the Rape Trauma Syndrome, provides guidelines for recognizing and managing the traumatic effects of sexual abuse.

Feminist theory

Brickman (1984) argues that however divergent theoretically, *'traditional'* models of therapy are dangerous to the health of women because their basic tenets are grounded in men's reality. A classic study frequently cited by feminists to illustrate the pervasiveness of male perceptions of well-being was conducted by Broverman, Broverman, Clarkson, Rosenkrantz and Vogen (1970). Psychologists were asked to indicate their perceptions of a healthy adult, a healthy male adult and a healthy female adult. A healthy adult and a healthy male adult shared similar characteristics. but a healthy female closely resembled an unhealthy male.

Several more recent studies have shown that clinicians' definitions of mental health are related to traditional, stereotyped notions of masculinity and femininity (Webb, 1986). Feminist theory challenges the assumption that generalizations

about men hold true for humankind, when they may only apply to mankind. Psychological models and treatment strategies are analysed for their sexist assumptions and sexist interventions, not as side issues but *the* issue on which each intervention stands or falls (Brickman, 1984).

As noted previously, feminism has been the major catalyst for bringing the magnitude of both the occurrence and effects of sexual abuse to public awareness. It continues to inform and influence the practice of sexual abuse counselling perhaps more than any other single theoretical perspective. With the reality of women as its focus and the belief that individuals are the experts on their own subjective experience, feminist therapy seeks to validate this experience. Symptoms are reframed as survival skills, and those which are functional in facilitating a completion of the developmental process that has been interrupted and distorted by the abuse are identified. The feminist therapist focuses on re-establishing the personal power and control that has been negated by the abuse.

Self-development

Abuse of any sort occurring during childhood has the potential to interrupt normal development. Sexual abuse by a family member frequently occurs during the critical stage of development between early childhood and adolescence, by which stage children have formed generalized views about the world, authority figures, and themselves in particular. Survival

strategies in the form of defence mechanisms and symptoms are frequently integrated into the developing personality. The mastery of developmental tasks, crucial to the child's developing sense of self, are severely interfered with. The result is commonly a shamed sense of self and subsequent low self-esteem, identity diffusion, and difficulties in intimate relationships and productivity.

An important goal for therapy is to reverse the developmental deficits caused by the abuse and dysfunctional family dynamics and to rebuild a new self - one capable of self-acceptance, self-confidence, self-expression, and self-love (Swink & Leveille, 1986). In order to achieve this goal, the therapist not only needs to be able to help the survivor develop these skills, but may also need to adopt a surrogate parenting role in order to provide nurturance and modelling of a healthy, non-exploitative relationship.

THE RECOVERY PROCESS AND THERAPIST SKILLS

Apart from the clinical literature, the prescriptive guidelines available to sexual abuse counsellors and therapists are contained in a handful of publications. The issues and effects of sexual abuse are frequently interrelated with stages in the recovery process, and so are generally written about in that context rather than as separate issues.

There is some evidence that therapy is most effective when issues are allowed to emerge in a patterned sequence (Coker, 1990). An extensive consideration of the issues and tasks is included here in order to illustrate their diversity and to provide a background for discussing the different approaches to treatment. While there are other important issues, most can be subsumed under the following most frequently documented general headings (Courtois, 1988; Bass & Davis, 1988; Swink & Leveille, 1986).

Developing a commitment to treatment and establishing a therapeutic alliance

Issues of trust and commitment to the therapy process are central to developing a therapeutic relationship. For incest survivors, the crisis is about the revelation as much as the abuse itself. Developing a commitment to treatment and establishing a therapeutic alliance directly counters feelings of being alone, worthless, and undeserving. The relationship between the client and her therapist serves as a model of a healthy, non-exploitative, and growth-promoting relationship. A therapist who conveys genuine concern, is respectful, non-judgemental, and immune to shock or embarrassment, offers a safe and trusting relationship within which the client can explore her experiences in a way that enhances her sense of self. The therapist needs to gently encourage the person to discuss the abuse and then help her bear the painful feelings during the retelling process.

Acknowledgement and acceptance of the abuse as a reality

In order to begin the process of recovery from the effects of sexual abuse, survivors must break through the denial which had previously protected them. Denial and blocking are often the only defence mechanisms available to abused children. Breakdown of these defences (and accompanying denial and fantasies) involves the survivor believing her experiences and memories and re-experiencing the feelings and thoughts that were initially avoided.

Recounting the abuse

Disclosure of the details of abuse is a highly variable process. Whether abuse is recounted during initial assessment or uncovering the trauma becomes a therapeutic task depends on a number of factors. These include the recency of the abuse, the stage of the recovery process the survivor has reached before presenting for counselling, the degree of trust she has in the therapist, as well as the degree of denial present.

A vital variable in the recounting process is the degree of repression that has been employed by the survivor to protect herself from the sometimes overwhelming memories of the abuse. This may lift gradually during the course of therapy or may need to be broken down by the cautious use of techniques to aid recall and encourage expression of repressed feelings. Generally, the literature cautions against the use of cathartic

techniques. These should only be used if certain conditions prevail, such as when there is clear evidence of dissonance and anxiety as manifested by specific behavioural and neurotic symptomology (Mayer, 1983). Inappropriate and unskilled inducement of repressed material can further traumatize the survivor.

Clarifying the myths and facts about incest

Survivors feel varying degrees of guilt and responsibility for their abuse. Identifying their beliefs about incest (for example, that the child must have been seductive; that she could have stopped it if she wanted to; that abused children can never be fully functioning adults) enables responsibility for the abuse to be acknowledged as the perpetrator's. This shift enables the survivor to reframe her psychological reactions as coping and survival efforts.

Breakdown of feelings of isolation and stigma

The need to maintain secrecy means that children in incestuous families are usually discouraged from making contacts outside the family. Although the boundaries in the family are often enmeshed, relationships are not close so the abused child is often also isolated within the family. Extreme reactions to avoid the abuse are withdrawal or excessive gregariousness, both of which leave the victim feeling alone and isolated and may continue as patterns in adulthood. Courtois (1988) describes some of the more persistent effects of abuse as perceiving

oneself as being different from *'normal'* people and as malignantly powerful. The therapist can facilitate breakdown of these feelings by referring women to a group and assisting them to establish links with their natural support networks.

Recognition, labelling and expression of feelings

Intrusive symptoms such as dreams, niqhtmares and flashbacks are experienced by most survivors when they are ready to begin facing the abuse (Swink & Leveille, 1986; Bass & Davis, 1988). Previously repressed and denied feelings can be frightening and leave the survivor feeling re-victimized or fearful she is losing her mind. By predicting these symptoms and reframing them as a natural process, they can be re-labelled as resources useful for increased self-understanding. Talking about the experience(s) weakens the potency of the trauma and channels energy previously used to repress the trauma into dealing with it.

Grieving

Following ventilation of anger, the re-conceptualization of the abuse results in feelings of sadness and loss and of being denied a *'normal'* childhood. The incest survivor mourns the loss of her pre-incest identity, her potential had the abuse not occurred, and her family relationships. This process is described as *'orphanization'* by Swink and Leveille (1986). The survivor must give up attempts to control that which she cannot and accept the losses involved in abuse. As multiple losses are processed, she realizes that she cannot change what happened but can control

her future. The therapist's function is to encourage grieving and then to foster the conditions which allow it.

Self-concept

The low self-esteem typical of survivors may manifest itself in a number of ways. Body image is often distorted and incongruent with appearance. Survivors may go to extremes - either to look unattractive and thus avoid sexual attention, or dress seductively to play the role they have been trained for. Feelings of hopelessness and worthlessness engendered by the scapegoat role may result in varying degrees of self-destructive behaviour - from taking care of others at the expense of their own needs, to alcohol and substance abuse, and suicide. Treatment programmes for substance abuse are reporting up to 90 per cent of women were sexually abused as children. It is widely accepted that secondary problems related to abuse must be dealt with before treatment can be effective in other areas (Courtois, 1988; Skorina and Kovach, 1986).

Physical symptoms

These may be both direct consequences of the abuse (such as infections, hemorrhoids and backache), or stress and anxiety-related (migraines, ringing in the ears. lethargy and muscle fatigue).

Relationship difficulties

A lack of trust and related fear of intimacy, low self-esteem, and absence of appropriate modelling of healthy relationships often results in survivors experiencing difficulties in a range of relationships with others.

Sexuality

For many survivors, sex is central to their self-image but may be fear-inducing and frustrating as sexual activity evokes flashbacks, especially when it is reminiscent of the past abuse. Fear of relinquishing control results in an inability to enjoy pleasurable feelings. Incest victims have often learned to dissociate during the incest experience, and in their adult sexual functioning pleasurable feelings may be unavailable even when desired.

Self-blame

Self-blame is a common reaction to victimization (Janoff-Bulman,1979). Most survivors of sexual abuse attribute some degree of responsibility for their abuser's behaviour to themselves. It goes without saying that such responsibility rests squarely with the abuser. However, while an obvious role for the therapist is to constantly reframe the abuse and interrupt self-blaming and negative self perceptions, there is empirical validation for the claim that attributing blame to the self is not always maladaptive. The attributions that survivors of a traumatic experience make about causation may in fact partly

account for the differing reactions to victimization (Peterson & Seligman, 1983).

Social psychologists have studied the relationship between attributions for an event and the effectiveness of subsequent coping strategies. Bulman and Wortman (1977), for example, found that the degree of self-blame evidenced by victims of negative events correlated positively with subsequent coping.

Janoff-Bulman (1979) distinguishes between behavioural and characterological self-blame in the attributions of rape victims. What differentiates these is perceived controllability. Behavioural self-blame is control related, involves attributions to a modifiable source (one's behaviour), and is associated with a belief in one's ability to avoid negative outcomes and to effect positive outcomes in the future. Characterological self-blame is esteem related, involves attributions to a relatively unmodifiable source (one's character), is associated with a belief in personal deservingness for past negative events, and reflects feelings of hopelessness. The author stresses: "...the *victim's self-attributional strategies (i.e., self-blame) do not reflect an accurate appraisal of the woman's causal role in the assault*" (p.1801) but may represent "*...a control maintenance strategy, a functional response to a traumatic event.*" (p.1806). The author believes that recognition of these two different types of self-blame may have important therapeutic implications, and

that ignoring them "*...blurs important distinctions between adaptive and maladaptive responses.*" (p.1807).

This point may be best illustrated in relation to counselling child victims of sexual abuse. For a child with a perception of adults as all-powerful, assertions by another adult that there was nothing they could have done to prevent the abuse, although meant as reassuring, may in fact be traumatagenic. The point is that counsellors must be aware of the way in which they respond to attributions of self-blame, and recognize them as perceptions of vulnerability to further victimization. Failure to recognize the adaptive, control-related component of self-blame may lead to reinforcement of the perception of self as a helpless victim rather than the empowerment intended.

Searching for meaning

Silver, Boon and Stone (1983), in a study of adult women who were sexually abused as children, found the extent to which subjects were able to find meaning in their experiences was related to effective coping. Compared to the women who had made sense of their experience, those who were unsuccessful reported significantly more recurrent, disruptive, intrusive and painful ruminations, significantly greater levels of psychological distress, and significantly lower levels of social-functioning, self-esteem, and self-reported resolution of the experience.

The ways in which women attempted to make sense of their abuse indicated a need to understand the dynamics which allowed it to occur. Those who were seen to have made sense of the abuse did so by examining the character, motives, or behaviour of their fathers, or by noting the abuse as an explainable consequence of circumstances such as the death of their mother or absence of a sexual relationship between their parents. Formulating a dynamic explanation reconciles the meaning of the event and the circumstances surrounding its occurrence (Dixon, 1979).

The relationship and similarities between searching for meaning and self-blame are immediately obvious. The assumption that these processes are necessarily maladaptive for all people may mean that opportunities to assist survivors of sexual abuse to fully utilize their own coping resources are lost. Therapeutic implications differ according to each individual's need to find meaning and the period of time over which the search for meaning has gone on. Deciding *when* the process is maladaptive for the survivor may be a crucial task for the therapist. Techniques to interrupt and modify unwanted and intrusive thoughts generated by the search for meaning should then be employed (Silver et al, 1983).

Reintegration of the traumatic experience

During this stage of therapy, the focus is on completion of as much unfinished business related to the sexual trauma as the client feels able to undertake, and integrating the traumatized

child with the fully-functioning woman. The therapist can assist the survivor to identify what the child who experienced the trauma needs and work with her to help the child. This enables the survivor to be the protecting mother she never had, at the same time as realizing her own innocence.

Self-development and behaviour change

Throughout the healing process a stronger more positive self is formed. Survivors learn to see themselves and others from a new perspective as they make the transition from victim to survivor. Learning new roles and ways of relating requires rehearsal, repeated encouragement and patience. The therapist may need to function as a surrogate parent and educator in teaching basic life skills, and encourage clients to join appropriate community groups.

Identification

The sexual abuse literature is consistent in its conclusion that therapists' own bias and identification can impede the recovery process and maintain survivors in a victim role. For this reason, a careful and honest analysis of one's motivation to become involved in sexual abuse counselling is needed. The practice of therapy should not afford the therapist an opportuninty to work through his or her own unresolved issues.

APPROACHES TO TREATMENT

Having considered the issues and tasks most commonly mentioned in the available literature, some of the current approaches to treatment are reviewed in order to convey something of the scope and range of interventions being employed by therapists to approach the problems arising from sexual abuse. Treatment methods vary in modality, duration and focus, the specific techniques used, and according to the orientation and training of therapists.

Individual or group therapy are the most common modes of intervention. Couples and marital therapy are also utilized depending on the most salient issues for the survivor. Family therapy is not usually used with adult survivors, although family members may be included at different stages in the healing process.

Because individual therapy broaches the subject of abuse in a private and confidential context, it may inadvertently serve to maintain rather than expose the secret. Group therapy, conducted concurrently or consecutively, is recommended by some authors as the most effective treatment for incest trauma (Courtois, 1988; Sprei & Unger, 1986). However, the relative effectiveness of individual and group therapy has yet to be systematically evaluated (Jehu, Gazan, & Klassen, 1985). The benefits that may be achieved more quickly and more thoroughly in a group setting, according to Courtois (1988), include identification with other

members and recognition of commonalities, consciousness-raising about sexual abuse, triggering previously repressed or denied aspects of own abuse, insight into maladaptive interactional patterns, and challenging negative beliefs and childhood messages. Groups also serve as valuable support networks and new or surrogate families. They are potential sources of reparenting, often providing the nurturance denied by survivors' families.

In terms of the duration and focus of therapy most therapists, regardless of orientation, agree that the effects of sexual abuse require long-term treatment (Feinauer, 1989). However, therapy may be either time-limited or of indefinite duration. It may focus on strategic or global issues, depending on the needs and wishes of the client. Short-term work is usually focused and is indicated when the client presents in crisis. As with any crisis intervention, stabilization and restoration of function to the pre-crisis level is the goal. Mrazek (1981, cited in the Report of the Advisory Committee, 1988) warns that prior to crisis intervention, the therapist should determine who precisely is having the crisis - the client, her family, or the therapist.

Time-limited, goal-oriented counselling is also used in non-crisis situations for a specific purpose, for example, learning how to be assertive with a particular family member.

Treatment of longer duration offers the opportunity for more complete assessment and treatment of a range of both conscious and unconscious material. Most experts in the field agree that the depth of the issues to be addressed in the recovery process generally require treatment of one to several year's duration.

With regard to specific treatment techniques, the effects of sexual abuse are so wide-ranging that a repertoire of techniques drawn from the diverse theories of personality and psychotherapy is useful. The choice of technique should be determined by the needs of the client, her personality characteristics, the phase and intensity of her stress response, and the most salient dynamics and issues resulting from the trauma. Courtois (1988) mentions four overlapping categories of techniques. These are stress/coping, expressive-cathartic, exploratory/psychodynamic, and cognitive/behavioural techniques.

Stress-coping techniques include crisis therapy to provide psychological first-aid; techniques for intrusive symptoms such as flashbacks, sleep disturbance and recurrent dreams; and techniques for numbing-denial symptoms, such as depersonalization and dissociation.

Experiential/expressive-cathartic techniques promote ventilation and break through denial, and include gestalt techniques (such as empty chair, role play and role reversal, and

body awareness); psychodrama (such as family sculpting); expressive art, movement, music and writing techniques; and guided imagery to aid remembering and to promote insight and mastery. Imagination is a readily available vehicle for most survivors because it has not been punished in the past.

A strong therapeutic alliance and prerequisite skill are vital conditions for using cathartic techniques. Relinquishing control may be so anxiety-provoking for some clients as to be life-threatening. Some clients spontaneously engage in expressive techniques to communicate or understand their experience, for example by keeping a diary or seeking reading material on sexual abuse. However, the client may inadvertently overload herself or use the material as self-punishment. Pacing is a critical counsellor skill (Joy, 1987), which involves careful monitoring of the survivor's responses to the therapeutic interventions to ensure she is not overwhelmed by the emotions that are aroused.

Exploratory/psychodynamic techniques are used to express unconscious as well as conscious material and include free association and dream analysis; analysis of transference and counter-transference issues; and hypnosis to utilize clients' learned ability to go into trance.

Cognitive/behavioural techniques are useful for both denial-numbing and intrusive symptoms and include cognitive restructuring, which is based on the premise that beliefs

significantly influence feelings and action; guided imagery and metaphor, alone or in conjunction with relaxation or hypnosis; and behavioural techniques such as relaxation, desensitization, assertiveness training, problem-solving and goal-setting and sex therapy. Stress inoculation and stress-management training aim to manage anxiety, rather than eliminate it. Components of these interventions include relaxation, breath control, role-playing, covert modeling, thought-stopping and guided self-dialogue.

The objective of this chapter was to provide a backgound for understanding some of the problems involved in developing prescriptive guidelines for sexual abuse counsellors. The complex nature of the problem of sexual abuse and the various approaches to both understanding the phenomenon and treating its effects have been discussed.

The following section considers some of the problems of constructing adequate knowledge about sexual abuse; discusses the limitations of traditional quantitative methodologies in an area of human behaviour as complex as sexual abuse; and discusses the case for alternative methods.

II SEXUAL ABUSE RESEARCH

OBJECTIVITY

The emotionally-laden and complex nature of sexual abuse renders it an area of investigation open to claims of bias and subjectivity - both in relation to assumptions about its causes and effects, and in the gathering and interpretation of data.

> *Unfortunately, this emotional climate precludes the likelihood of objective data gathering, as there is a strong tendency for defenses...to operate among researchers and readers alike. Data is often distorted and used selectively to corroborate notions based on personal values and moral assumptions. The process snowballs as values and defenses influence the formation of initial assumptions and continue to serve as variables distorting the entire scientific inquiry.* (Mayer, 1983, p. 11).

There is an assumption implicit in such critiques that *'scientific'* approaches in the area of sexual abuse produce adequate knowledge. Rather, the absence of substantiating data and clearly defined variables seems to result in part because it is an aspect of human behaviour of such complexity that adequate knowledge

has proven to be largely inaccessible by many modes of scientific enquiry. Morgan and Smircich (1980), arguing that the appropriateness of a research approach derives from the nature of the phenomena to be explored, warn that the nature of what constitutes adequate knowledge changes as we pass from assumption to assumption along the objective-subjective continuum.

Lather (1986) takes issue with claims of objectivity and neutrality in traditional scientific research, and argues that new visions are required in the human sciences as a response to the inadequacies of positivist assumptions in the face of the complexities of human experience. Just as the true prevalence of sexual abuse may never be known because of the difficulties involved in identifying victims, truly '*objective*' facts about its dynamics, the nature and extent of its effects, and the processes involved in healing from its trauma, may prove to be as elusive. Meanwhile, mental health professionals are confronted with a problem of such magnitude that many *routinely* consider sexual abuse as a factor contributing to a diverse range of emotional problems in their clients. While awaiting expansion of the professional literature and the development of more effective means of making use of information from survivors themselves, practitioners must continue to identify for themselves the variables involved in successful clinical intervention.

Experiential approaches to developing prescriptive guidelines, like those recommended by the ACCs Pilot Study, while being vulnerable to the charge of contributing to the reification of treatment approaches based on poorly founded theory (Mayer, 1983), may have advantages over practice derived solely from theories based on flawed methodology. Treatment models that take cognizance of the experiences of people and feed these experiences back to check the validity of the developing theory, have the potential to create grounded theory that is dynamic and subject to ongoing verification (Lather, 1988). When empirically validated findings from the available literature are used as a further validity check, the theory's ability to discern the truth is enhanced.

THE PRESENT STUDY

The present study's purpose was twofold: first, to describe the *meanings* that counsellors attach to their experiences of sexual abuse counselling and, secondly, to attempt to identify *relationships among factors* associated with the process of counselling. While the meaning of sexual abuse has been relatively well documented in terms of the experiences of survivors, it is the goal of the present study to attempt to discover the idiosyncratic meanings of counsellors.

Information gathered as a result of qualitative research conducted with eight sexual abuse counsellors is presented. By

drawing from the available sexual abuse treatment literature and matching some of these findings to the experiences of people doing the work, the present study attempts to understand how these experiences might contribute to the construction of knowledge in the area of sexual abuse counselling. Stiles (1990) calls the process of constructing knowledge based on connection and personal familiarity with the object of knowledge *"connected knowing"* and contrasts it with the objective, adversarial approach. Connected knowing *"...involves developing procedures for gaining understanding, but these involve gaining access to another's frame of reference rather than argument."* (p.21).

The present account does not presume to describe actual counselling behaviour. Rather, it reports what counsellors think they are doing and their intentions. By consulting people's accounts of themselves, initial insight into the manner of understanding unfolding action may be gained (Gergen & Gergen, 1984).

III RESEARCH PROCESS

THE CASE FOR A QUALITATIVE APPROACH TO ENQUIRY IN PSYCHOLOGY

The value of research is often determined against prior research alone without consideration of its social relevance (Kressel, 1990). Increasingly, the essential criterion for research in the social sciences is the illumination of the lives of the people studied and the promotion of self and social understanding. Concern for *applicable* as well as *applied* research has been the hallmark of sociological feminist research and neo-Marxist ethnography. By emphasizing change-enhancing action rather than the accumulation of knowledge for its own sake, research methodologies which seek to transform the lives of the researched have been described by Lather (1988) as contributing to emancipatory theory-building.

The assumption that the practice of science is value-free, coupled with an over-emphasis on causality and a failure to view human problems holistically, have been cited as contributing to the artificiality and triviality of much social science research (Allen, 1978). Problems not able to be approached in a '*scientific*' way have often been ignored.

Research in the area of sexual abuse is difficult for a number of reasons. Among these are the differences between disciplines in defining what constitutes abuse and the sensitive nature of the problem. Ethical issues, especially relating to the potential for further (albeit unintended) abuse, and the need for prerequisite skills for researchers to deal with issues that may arise for participants in the course of talking about a traumatic experience, contribute to the labyrinth of considerations and the resulting critical need for research to further current understanding of the complex processes involved in sexual abuse.

With the growing holistic and ecological orientation of research and theory in psychology (Rappoport, 1984), there has been a developing awareness of the limitations of research methods derived from the natural sciences to discover knowledge about complex human behaviour. Royce (1982, cited in Rappoport, 1984), calls for integrative and interpretative methods in psychology, and cautions against methodological rigidity. The focus on data gathering, research design, and statistical analysis, necessary in the early phases of psychology's history are, he claims, insufficient to deal with its future. Methodological diversity is required to facilitate the construction of explanatory theory that parallels the complexity of human experience.

An expanding body of psychological literature takes issue with the assumption that facts can only be discovered by the so-

called *scientific* means of quantitative methods (Miles & Huberman, 1984; Lather, 1986; Rosenwald, 1988; Packer & Addison, 1989; Stiles, 1990). These commentators argue that the traditional positivist approach, although the prevailing research paradigm in contemporary psychology, is not the final answer. It is questionable whether truly objective findings are even a realistic goal in psychology, where the *'next case'* always represents a possible threat to generalization. In Stiles' (1990) view, facts, as products of interpretation reflecting the observers values, are subjective - or at least not as objective as adherents to the *"rituals of* science" (Rosenwald, 1988) would have us believe. Brickman (1984) also challenges the assumption that objectivity is achievable on the grounds that all psychological information has a subjective core. Regardless of the sophistication of the experimental methodology or quality of the clinical material, a subjective reality is contained in the objective one.

Feminist researchers have been arguing for some time that the demands of science, the needs of researchers, and the best interests of research participants do not necessarily coincide. Oakley (1981) suggests that the researcher's emphasis on objectivity and detachment, rather than personal involvement and responsiveness, perpetuates the hierarchical relationships between the powerful and powerless in society and is therefore morally indefensible. As well, the nature of the phenomenon being studied may preclude the application of absolute standards

of 'scientific objectivity' in the process of data collection. For example, half the participants in the present study volunteered during the course of the interview that they had experienced abuse in their childhoods. There is no reason to believe that this occurrence is not representative of people involved in sexual abuse counselling. It is argued that a detached, objective approach to disclosures of this nature would not only be impossible, but that a collaborative, phenomenological approach minimizes the risk of perpetuating the effects of an unequal power differential. Rather than further exploiting women as sources of data, the researcher can enhance the potential for understanding by collaborating with them in the construction of the meaning of their experiences in relation to their work as sexual abuse counsellors.

By emphasizing the need for empathy in order to gain understanding, qualitative approaches generate rich and context-embedded data that has the potential to yield fresh perspectives on the phenomenon being studied. Their aim is exploration, identification, and description of potentially important variables relating to the phenomenon being studied for subsequent explanatory or predictive research using qualitative methods. Kirk and Miller (1986) suggest that much of the technology of confirmatory non-qualitative research may actually prevent discovery, because when confirmatory research goes smoothly everything comes out precisely as expected. Qualitative methodologies, they argue, help researchers move beyond

preconceived explanations of phenomena and are therefore more likely to lead to unexpected findings and to new theoretical formulations.

What is Qualitative Research?

Qualitative research is a broad term that is applied to research whose findings are not arrived at by statistical procedures or other means of quantification (Strauss & Corbin, 1990). While data may be gathered by a variety of methods, including quantitative ones, qualitative research employs non-mathematical procedures for data analysis.

Characterized by adjectives such as *naturalistic, ethnographic,* and *participatory* (Kirk & Miller, 1986), qualitative methods appear under a number of exotic labels including phenomenology, symbolic interactionism, hermeneutics, and grounded theory. Some commentators suggest that the qualitative label makes sense only when it is set against something which it is not, and contrast its methods with the hypothetical-deductive procedures of scientific empiricism. Within this paradigm, quantitative methods seek to discover facts based on objective observations of causal relationships using linear statistical models. Qualitative research, on the other hand, accepts verbal information based on empathy with other people and reports this information in its context, without requiring that it fit into a linear causal framework (Stiles, 1990).

Negotiated meaning

The core objection (Stiles, 1990) to the traditional positivistic view is that observations do not produce facts. Rather, facts are seen as products of interpretation, and meaning depends on the context in which understanding takes place. Qualitative methodologies emphasize that trustworthy knowledge comes from personal experience rather than just propositional logic. Events are interpreted and reported in their context rather than as isolated and abstracted units of observation. The focus of qualitative research therefore, is the *meaning* rather than the *frequency* of a particular event or phenomenon, and meaning is negotiated and constructed jointly by all participants in a collaborative research enterprise rather than being imposed by the researcher. In this way, the interactions between the assumptions of the subjects, the observer, and the reader of a study, all contribute to meaning in context.

The experiential-discovery focus of qualitative research

Qualitative research includes experience as primary though not exclusive data, and seeks to understand how experience relates to the construction of knowledge. Freire (1973) called this knowing reality in order to transform it. Because human experience cannot be quantified, data gathering and analysis rely on empathy with peoples' experience, which is as important as behavioural observations and seeking proof or evidence.

Understanding comes from gaining access to another's frame of reference.

Because of the experiential-discovery nature of qualitative approaches, goals emerge in the course of a study along with the methods. As problems are dealt with, new ones emerge and these may be solved differently than previous ones. In this way, data gathering and analysis are intertwined and grounded in the context of the research setting.

The qualitative-quantitative continuum

There is considerably greater agreement about what qualitative research *isn't* rather than what *it is.* However, while a comparison with quantitative methods aids understanding, qualitative research is a systematic process defined by its own history and not merely a residual grab-bag comprised of all things that are not quantitative (Kirk & Miller, 1986). Although there are no agreed on prescriptive guidelines that parallel the canons of the traditional paradigm, qualitative research assumes that systematic inquiry must take place in a natural setting, and must value participants' perspectives on their worlds and seek to discover these in an interactive, collaborative process.

Miles and Huberman (1984) argue that qualitative and quantitative approaches form an epistemological continuum, not a dichotomy, and that many of the best studies employ some combination of both methods. Like other opponents of the either-

or distinction, Morgan & Smircich (1980), emphasize that qualitative research stands for an approach rather than a particular set of techniques, and its appropriateness - like that of quantitative research - is contingent on the nature of the phenomenon to be studied.

For the present study, an exploratory, qualitative approach was chosen as the most appropriate method for a number of reasons. In the area of sexual abuse counselling there is emerging clinical evidence for a general pattern of effective counselling processes. However, there is no evidence in the literature of attempts to understand the relationships that exist among variables - for example, therapists' orientation and training and their own experiences of abuse, and the way they conceptualize the healing process. Marshall and Rossman (1989) describe qualitative methods as best suited for engaging in exploratory research where the relevant variables have not been identified, and which is intended to uncover patterns to better understand complex interactions, tacit processes and often hidden beliefs and values.

Elliot (1987, cited in Packer & Addison, 1989), comparing the theory testing focus of quantitative research paradigms with the experiential-discovery focus of qualitative methodologies in therapy research, argues that historically, the most clinically useful therapy research has evolved from a qualitative exploration of therapy processes. The basis of this assertion is that: "*...greater clinical relevance is likely to result from therapy*

research that corresponds more closely to the qualitative clinical approach of skilled practitioners". (p. 67).

Dialogue and interpretation are common to the process of therapy, and their parallel use in both collecting and discussing data may serve to capture the richness and breadth of the *art* of therapy more accurately than experimental procedures, thus ensuring ecological validity.

BACKGROUND TO THE RESEARCH

This study was conceived and developed within a framework of the author's own interest in the area of sexual abuse and experiences working with survivors, and the lack of attention in the literature to prescriptive guidelines for counsellors. While there is an emerging body of literature that outlines general patterns of therapeutic processes, attempts to look at a broader conceptualization of relationships among variables involved in the process of counselling are rare.

In addition to the sexual abuse literature, a second body of literature contributed to the development of the study. This related to research methods, particularly the emergent but burgeoning use of empowering and feminist methodologies in psychology. The author's attempt to integrate feminist theory and methodology also reflects a belief that the dearth of prescriptive

treatment literature is related to the limitations of traditional research methodologies in the area of sexual abuse.

Sample

Counsellors registered with ACC to counsel adult survivors of sexual abuse were chosen as the appropriate unit of study. Sampling was on the basis of representativeness of the people known to be doing sexual abuse counselling in the Palmerston North area.

Data collection method

In-depth interviewing was used in order to best capture the kinds of information sought and to parallel the clinical approach of counsellors. Questions and areas for exploration were based on concepts derived from the literature and the author's own experience. Following a pilot interview using the Interview Schedule A (Appendix A), a more loosely structured Interview Schedule B (Appendix B) was used to allow more flexibility for other potentially relevant concepts to emerge.

IV METHOD

Eight counsellors registered with ACC participated in the present study. Four were selected from a list supplied by ACC to the Applied Psychology Clinic at Massey University. Four were recruited by word of mouth. Participants were engaged at different stages of the study according to the need for representativeness in the sample and as the nature and characteristics of the people doing this work became more clear from information obtained from each interview. The choice of participants was therefore purposive rather than random, and sampling aimed for representative diversity (Miles & Huberman, 1984). The sample includes an approximation of the characteristics of ACC counsellors in terms of race, gender, education and training.

All but one potential participant was sent a letter (Appendix C) outlining the objectives and qualitative nature of the study and invited to participate. One person was known to the author and was asked directly. Most were met with individually. This was in order to establish contact and to provide a description of the study. The procedure to be used was explained, confidentiality ensured, and verbal informed consent obtained. Three participants were not available for this initial meeting, and

extra time was taken before these interviews commenced for further clarification and to establish rapport.

The loosely-structured interview format was used to facilitate discussion about the way in which participants came to be doing sexual abuse counselling, their theoretical orientations, the knowledge they believed sexual abuse counsellors needed to have in order to be effective, their understanding of the dynamics of sexual abuse in terms of how and why it occurs, and their experience of its most salient effects for their clients. A standard case vignette (Appendix D) was presented that included presenting problems most frequently cited in the literature, and the counsellors were asked to describe how they would respond. The length of interviews varied from one to three hours, with an average two hours in length.

Participants included six Caucasian women, one Maori woman and one Caucasian man. Three were in full-time paid employment, three were employed part-time by agencies and one of these also had private clients, and two were in private practice. They reported educational qualifications ranging from none to post-graduate professional diplomas, and were in the age range twenty-five to sixty years. Four of the participants volunteered the information that they were survivors of childhood sexual abuse.

In-depth interviewing and a loosely structured interview schedule were used in order to allow for a broad range of topics to emerge in an exploratory way. The questions were asked in the context of an evolving conversation, and while the interviewer remained aware of a format, it was considered more important that the meaning, rather than the wording, of questions was predetermined and standardized across interviews. For example, the interviewer took time to ensure the meaning of concepts such as 'self-blame' was shared by all participants, although a specific question about the concept was asked at different places in the interviews according to the context of the evolving conversation. Mishler (1986) argues that variability in how questions are asked is the key to good interviewing, not a problem to be solved by standardization. The interviewer reformulates questions and respondents frame answers in terms of their reciprocal understanding as they attempt to make sense of what they are saying to each other. Because meaning is negotiated according to the context in which understanding takes place, variations are viewed as significant data for analysis rather than errors. Terms are given meaning within the evolving context of each interview. They take on specific and contextually grounded meanings which continually inform the data collection process. For example, the majority of counsellors mentioned they use 'hypnosis' as a therapeutic intervention. Further exploration of the meaning of this term revealed a range of idiosyncratic applications.

The interviewer was experienced in client-centred counselling techniques. The interview questions presumed neither neutrality nor objectivity on the part of the interviewer, but revealed her personal interest in the participants as well as in the research project. In-depth interviewing has been called the science of subjectivity (Paget, 1983), because the interviewer is always implicated in the construction of the phenomenon analysed. This view of endemic subjectivity is shared by Mishler (1986), who stresses that the problem of how to take the interviewer's role into account is not solved by making the interviewer invisible and inaudible by painting him or her out of the picture. Rather, the researcher's feelings and reactions throughout the processes of conducting the investigation and developing the interpretation are important data and form part of the context of the results and the interpretation.

VALIDITY CHECKS

Because of their methodological and epistemological differences, constructs that reflect the assumptions of the quantitative paradigm are inappropriate for assessing the validity of qualitative research. Marshall and Rossman (1989) propose alternative criteria for evaluating the soundness of qualitative research.

The first criterion relates to **credibility.** In terms of the *truthfulness,* or internal validity of the findings, the goal is to

demonstrate that the study was conducted in such a way as to ensure that participants are accurately identified and described. In the present study, the extensive interview summaries are included as illustrative study data in order to meet this requirement.

The second criterion refers to the **transferability** of the findings. Via the process of triangulation, data from different sources (in the present study, from the clinical and theoretical literature as well as from the interview data) are presented to corroborate, elaborate, and illuminate the phenomena in the context in which it is studied. Because generalization to other contexts is not the aim of qualitative research, the burden of demonstrating the applicability of findings to other contexts rests with the investigator who would make that transfer.

The aim of the present study was not to generalize as such, but to specify the conditions under which certain phenomena exist (for example, what factors influence counsellor's understanding of why abuse occurs), the action/interaction that pertains to them, (what facilitates or constrains action) and associated outcomes or consequences of this action. Findings would thus be generalizable to those specific situations and contexts only.

Qualitative research does not pretend to be replicable. Even if the same subjects were studied, the context would change. Rather, changing conditions in the phenomena, as well as changes in the

design created by an increasingly refined understanding of the setting, must be accounted for. In this way, **dependability** is enhanced.

Finally, qualitative research makes no claims to the neutrality of the researcher. Therefore **confimability** of the findings rests on an evaluation of objectivity of the data themselves rather than on characteristics of the observer.

Ethical and technical reasons precluded participant observation of actual consultations to assess the degree of consistency between attitudes and ideological stances expressed by counsellors during the interview and their actual behaviour with clients. A case vignette was used in an attempt to provide a standardized stimulus. A review of the available literature on sexual abuse as it relates to treatment issues and processes was used as a supplement to the interview and as an additional source of validation of the applicability of the emerging concepts and categories.

After each recorded interview was transcribed, participants were asked in a letter (Appendix E) to review these for accuracy both in terms of interpretation and their meaning. This process, according to Stiles (1990), provides testimonial validity. Roberts (1986) makes the point that there is little point in congratulating ourselves on the fact that the validity of interpretive data can be checked by participant review if it can

only be understood by an elite group of professionals. Interpretation was therefore kept to a minimum and only used when a passage of taped transcript was inaudible or the meaning was not obvious. When a passage was not transcribed verbatim it was enclosed in brackets to emphasize this.

Misinterpretation (or lack of empathy) was guarded against by ensuring an issue was approached from a number of different perspectives. When it seemed there was more than one interpretation of a response, further questions were posed until clarity was reached. This safeguard against misinterpretation has been called *triangulation* by Stiles (1990) and as well as asking lots of questions, involves seeking information about a phenomenon from multiple sources, methods and prior theories or interpretations and assessing their convergence. (For example, the issue of self-blame emerged as important both from the victimization and the sexual abuse literature. It was approached from these perspectives as well as from the more commonly accepted feminist perspective in order to ensure counsellors' meanings of the concept were understood).

INTERVIEW SUMMARIES

Information from each of the interviews is summarized, including a brief overview of demographic features and a synopsis of the counsellors' orientation. Names have been changed to preserve anonymity.

Marcia

Background and training

Marcia is a registered clinical psychologist who, as an aspect of her job, works one day a week in a clinic where victims of sexual abuse self-refer or are referred by agencies such as the Police or ACC for both assessment and ongoing intervention. She sees about two clients each week.

Orientation and Conceptualization of abuse

Marcia described a broad-based therapeutic framework from which she draws particular theoretical formulations according to their appropriateness for a particular client. She emphasized a Rape Trauma Syndrome/Post Traumatic Stress Disorder framework as a 'template' for assessment; a developmental growth and self-actualization model for conceptualizing the client's potential to emerge from traumatization/victimization to an enhanced level of functioning; and a grief model for understanding the stages of healing.

Marcia sees sexual abuse arising as an interaction between a number of interacting causal factors including societal-environmental factors, intergenerational patterns within families, and factors related to individual adaptive strategies. She believes the effects of sexual abuse are dependent on the stage in the life cycle that the abuse occurred, and on

differentiating factors such as the duration and degree of intrusiveness of the abuse, the relationship of the perpetrator to the victim, and the reactions of significant others.

Carla

Background and training

Carla has been working for ten years in an organization whose primary objective is to prevent child abuse. Her training includes ongoing self-awareness work, including many hours of Gestalt, bioenergetics and hypnotic trance work, as well as participation in physical and sexual abuse workshops and training seminars.

Orientation and conceptualization of abuse

Carla described a client-centred, Rogerian orientation. She emphasized listening and observing as the most important therapist qualities, as well as creating a relationship of trust and unconditional love. Within this context, people are able to walk back through the traumatic experience with their adult perceptions and reframe it as abuse, rather than as something to feel guilty about and '*hate*' themselves for. She has a strong belief in the capacity people have to heal themselves, and feels that the helping person more often than not gets in the way of that process.

Carla sees abuse as a cyclical phenomenon, and believes that violence by women is a hidden aspect of parenting that is both a

cause and an effect. She sees the reactions of adults to a child who has been abused coupled with the stigma attached to pleasure as having the potential to cause more damage than the actual experience. The most profound effect of sexual abuse is the distortion of sexuality with all its ramifications, and Carla believes people engaged in sexual abuse counselling must have done their own healing and be constantly involved in their own self-awareness work in order to be effective.

Anne

Background and training

Anne is employed as a counsellor in a health centre, where she works with women, couples and families. She worked as a social worker in a voluntary agency for a number of years prior to taking up her current position. More than half of the women she sees have been sexually abused, although this may not always be the presenting problem. She sees four or five clients a day.

Anne has a tertiary/professional social work qualification and has completed an extensive counselling course as well as sexual abuse training workshops and seminars. Her counselling training covered models including Psychodrama, Gestalt and Transactional Analysis. Anne includes her work with clients, reading, and sharing experiences with other counsellors as important aspects of her training.

Orientation and conceptualization of abuse

Anne works from a Christian perspective, and describes her model for counselling as having a biblical theoretical base to which she adds techniques derived from her training. Her approach to her work includes exploring with clients how they have survived thus far, and reframing symptoms as coping mechanisms that have enabled them to survive.

Anne sees abuse as the result of a number of interacting variables, including personal, family, and social factors. She believes that there is a need for a greater focus on intervention with offenders in order to break the cycle of abuse.

Heather

Background and training

Heather has worked on a part-time basis in a voluntary, community-based agency for about two years. She has an average case-load of three women, who she sees once a week for an average of eight to ten weeks. Heather has a tertiary qualification and is currently completing a Master's degree in psychology. She completed the sixteen hour general training course run by her agency, which covered issues such as oppression and the Treaty of Waitangi, and procedures relating to child sexual abuse. The course did not include counselling skills, which the agency encourages workers to acquire by funding their attendance at training seminars and workshops. The demands of

full-time study have excluded Heather from additional training. Her university course covers some counselling and therapy skills although not specifically in sexual abuse counselling.

Orientation and conceptualization of abuse

Heather explained that while a strong feminist orientation is a prerequisite for working in her agency, she does not agree totally with the perspective of other agency workers. While she sees abuse as an act of aggression against women and children, she believes it occurs for reasons that relate to the individual as well as for structural and social reasons. She believes that, for some women, a male counsellor can be more effective than another woman and that counsellor-client match should involve the client's needs and feelings.

Heather described the way she works as eclectic, drawing from a basic cognitive-behavioural approach to which she adds specific techniques - for example, specific behavioural interventions and family therapy. The approach she uses is determined by the individual needs of the women she works with. Heather said she refers women on for specialist help if she believes she doesn't have the necessary expertise to help, for example if a woman seems severely depressed.

Frances

Background and training

Frances has been working with a voluntary women's organization for nearly five years, and now works exclusively with Maori women. While the organization works with victims of violence in general, most are survivors of sexual abuse. The workers are Maori and are survivors of physical and/or sexual abuse. Frances described the training, for which she is largely responsible, as very intensive and focusing on self-awareness. There is a specific focus on the experience of being Maori women.

Orientation and conceptualization of abuse

Because of the oppression of Maori women generally and their lack of identity and resulting low self-esteem, Frances believes sexual abuse just adds another layer to existing feelings of powerlessness. The kaupapa of the agency is self-awareness, both for the workers and the women they work with. Frances believes that Maori should work with Maori because of the issues that only Maori together can resolve, and which need to be addressed within Maoridom.

Frances described a client-centred counselling approach and emphasized the need to support women and to move at their pace. She believes a holistic approach to healing is needed, and that the physical, emotional and spiritual parts must be in harmony in order for the person to be healthy. She sees different

perspectives as being important, and necessary for people to have choices and to get the sort of help they need.

The agency views abuse as a product of socialization and violent ancestry, handed down from one generation to another, and an aspect of their culture that must be acknowledged before it can be addressed. There is a belief that each person must look inside themselves before attempting to change others, and for this reason an important aspect of training is about women's violence. Frances believes that this process has meant that while women are striding ahead in terms of their own identity as Maori, men are being left behind. The agency is committed to developing initiatives to address this.

Chris

Background and training

Chris has been involved in community and social work in different agencies for about six years. She has had experience working with abused women and psychiatric patients, and has worked as a counsellor and trainer for a church-based agency. She is currently in private practice, primarily as a sexual abuse counsellor, and has been registered with ACC for a year. Chris described her training as largely experiential. To her own personal work, she adds knowledge and skills derived from training seminars and workshops, for example *Parentline* and Family Therapy training courses.

Orientation and conceptualization of abuse

Chris felt she didn't have a framework for her work nor that she needed one, although she described her approach to counselling as an eclectic, client-centred approach. She works largely from a feminist perspective and sees abuse as a reflection of the power differentiation between men and women and the oppression of one group in society by another. She doesn't differentiate between physical and sexual abuse, and believes the dynamics are the same. Her primary goal is to empower the women she works with. She described the process for healing depicted in '*The Courage To Heal*' as similar to the way in which she works.

Roger

Background and training

Roger has been involved in counselling and therapy for about twenty years in his full time work, as a Marriage Guidance counsellor, and in private practice. He has a diploma in Professional Counselling and Psychotherapy (USA) and is a registered Fellow in Clinical Hypnotherapy (USA). He has been registered with ACC for eighteen months, after finding that a number of clients with whom he was using hypnotherapy were sexual abuse survivors. Roger has tertiary qualifications in the social sciences and is currently completing a Master's Degree in psychology.

Orientation and conceptualization of abuse

Roger described his approach as an eclectic one. He uses trance as an adjunct to therapy, unless a client is specifically seeking hypnotherapy, because he finds it an effective and economical way to work with issues that otherwise take a long time to surface, or which remain out of the client's awareness. He finds Neurolinguistic Programming techniques useful and also uses David Groves' model of sexual abuse healing, which is based on the use of the client's epistemological metaphors in order to heal the 'child within'.

Roger sees sexual abuse as the result of an interaction between the way people are socialized, and family and economic factors. He believes that education and awareness about sexuality and intimacy are lacking and that boys grow up with an exaggerated sense of entitlement which girls are socialized into accepting, and accommodate to.

Bev

Background and training

Bev has a nursing qualification and works for an educational organization. Her part-time work involves counselling women who have been sexually abused, and she also sees people privately. Bev has been doing sexual abuse counselling for about eight years, and registered with ACC four years ago. She described her training as largely learning from the women she

works with and sharing experiences with other sexual abuse counsellors. She was involved in setting up a counsellors' support network which evolved from just *support* to learning from each other. Bev reads a lot about sexual abuse healing and uses, '*The Courage to Heal*' books in her work with women. She has attended a number of sexual abuse training courses and seminars as well as general counselling courses and a Family Therapy course.

Orientation and conceptualization of abuse

Bev works from a feminist perspective, which for her means believing the experiences of women and attempting to empower women to redress the imbalance of power that exists between men and women in society. She described an eclectic approach to her work, using techniques that seem appropriate for a particular client. As adjuncts to client-centred counselling, she does empty chair work and uses expressive techniques such as drawing, writing, and clay sculpting. She stressed the importance of a holistic approach which takes into account the emotional, physical and spiritual dimensions and needs of clients.

Bev believes sexual abuse is inter-generationally transmitted in families, and has been struck by the disproportionate number of her clients whose mothers were also abused. She uses genograms to educate women and to attempt to interrupt the cycle of abuse.

V ANALYSIS

DATA REDUCTION PROCESS

The taped interviews were transcribed and analysed. This analysis involved reducing the narrative data to make it more manageable, then subjecting the reduced data to a process to facilitate the search for meaning. Because qualitative data analysis involves a search for general statements about relationships among categories of data, the first task involved noting regularities in the data in order to identify recurring concepts, ideas, attitudes, and patterns of beliefs. These phenomena were then grouped into significant classes, or categories, of phenomena.

A list of categories was compiled and significant topics and concepts suggested by the literature and included in the interview schedule were added (Appendix F). Each interview transcript was then examined and concepts were sorted according to this list. Eleven initial sub-categories emerged (Appendix G) and re-sorted to include demographic data (Appendix H). These categories were then further examined for similarities, synthesized, and re-grouped into six categories and related sub-categories (Appendix I).

Following this process of data reduction, categories were then hypothetically linked via questions about the nature of the relationships between them. For example, were there differences in the way people with informal, experiential training conceptualized abuse compared to those with formal training? Was personal experience of abuse related to conceptualization of the therapeutic tasks? Does a counsellor's understanding of the dynamics of abuse have a bearing on the intervention strategies they use? According to Marshall & Rossman (1989) this process identifies the salient, grounded categories of meaning held by participants in the study.

These six categories were synthesized into four final categories. **Training and development** remained; *therapist attributes* and *conceptualization of the healing process* were merged to become **conceptualization of the tasks and process of therapy**; *sexual abuse knowledge base* and *common issues* became **knowledge of the issues, dynamics and effects of sexual abuse**; *knowledge and methods of treatment* became **specific intervention techniques and models that inform them**. Table 1 presents a summary of the final four categories and their related sub-categories.

Table 1 : SUMMARY of CATEGORIES and their SUB-CATEGORIES

Training and development
Informal training
Formal training
Accountability and supervision

Knowledge of the issues, dynamics and effects of sexual abuse
Conceptualization of why and how abuse occurs
Knowledge of issues, dynamics and effects
Conceptualization of the recovery process

Specific intervention techniques and models that inform them
Primary intervention
Other models that inform intervention strategies
Specific techniques
Rationale for using a particular technique

Conceptualization of therapeutic tasks and process of therapy
General relationship qualities
Counsellor self-awareness
Assessment
Counselling
Education and teaching
Termination and referring on
Prevention

In order to facilitate the search for relationships between categories, Strauss and Corbin's (1990) Paradigm Model (Figure 1) was used to develop each of the categories (phenomena) in terms of their conditions, contexts, strategies, and consequences. This process identifies the causal conditions pertaining to phenomena, the context in which they occur, the action strategies taken in resonse to them, the conditions that facilitate or constrain this action, and the consequences of action strategies.

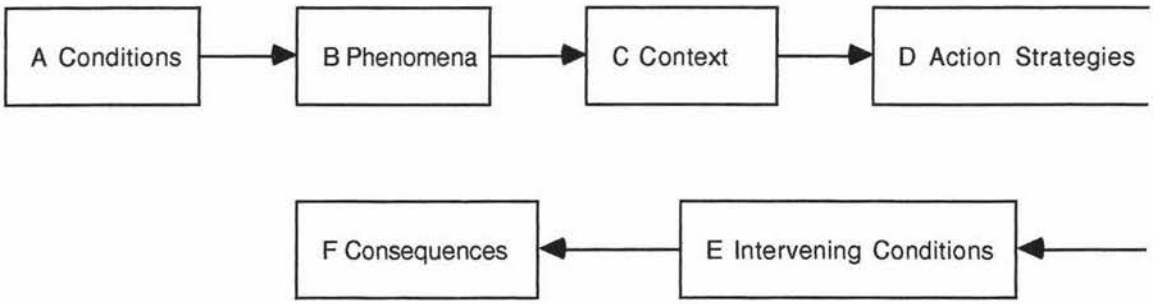

FIGURE 1 : PARADIGM MODEL

Conditions

Each category is specified in terms of the conditions that give rise to it. These are identified in the data by terms such as *because, due to, since,* or by looking for events that precede a phenomenon. For example:

> *Because I am Rogerian, I count the people I work with as my major learning source.*

Thus, the counsellor's orientation becomes an antecedent condition for beliefs about requisite skills and training.

Phenomena

These are the categories themselves.

Context

These are the specific properties of a category that vary along a dimensional range. They are identified in the data by terms denoting quantity, quality, frequency, intensity or duration. The context describes the conditions within which action/interaction

is taken to carry out or respond to a specific phenomenon. For example:

> *I would use the Beck Depression Inventory to assess the severity* [of depression], *and if I'm feeling out of my depth I'd refer on.*

Thus, under conditions of acknowledgement of the parameters of her expertise, this counsellor would suggest a referral to a medical practitioner.

Action/interactional strategies

These are goal-oriented behaviours carried out in response to a phenomenon and are identified in the data by action-oriented verbs. For example:

> *I do empty chair work, I use drawing and clay, and writing.*

Intervening Conditions

These are the broader, structural conditions that act to either facilitate or constrain action/interactional strategies. They help to explain why one person chooses a set of strategies while another person doesn't. For example:

> *You can only take people as far* [in therapy] *as you've been yourself.*

Thus, the counsellor's belief acts as both a constraining variable in terms of continuing with a client and a facilitating variable in referring on.

Consequences

These are the outcomes of action taken in response to a phenomena, but may also be the outcomes of a failure to take action. Also, the consequences of one set of actions may become part of the conditions of another. For example, orientation may be a consequence of a counsellor's personal experience and become a constraining or facilitating factor in terms of their choice of action strategies.

VI RESULTS

In-depth interviews with sexual abuse counsellors were analysed for content using qualitative methods and yielded a number of patterns of repeated relationships between some properties and dimensions. Analysis revealed four categories of phenomena. These were developed in terms of: the conditions that give rise to them and that constrain or facilitate action in relation to them; the action that is taken in response to the phenomena; and the potential consequences for those involved. **Personal experience of abuse** emerged as an intervening condition for all categories, and **orientation** emerged as a causal condition for all categories.

Tables 2 to 5 present the categories along with illustrative interview data (in quotation marks), as well as conditions and properties derived from the literature that seemed important but were not identifiable in the data. For example, the criteria for registration with ACC demand evidence of prerequisite skill in particular areas. Therefore *organizational demands* was included as a causal condition for training. Overall quality of service and outcomes for clients were presumed consequences for all categories, and these are specified only according to their specific presence in the interview data.

Table 2 : TRAINING and DEVELOPMENT

Causal Conditions

Organizational requirements.....	ACC Registration criteria
Peer pressure.....	*"I never refer on to a counsellor who has not done their own work"*
Client's problems.....	*it raised the issue for me of ritual abuse"*
Orientation.....	*"because I am Rogerian I count the people I work with as my major learning source"*
Personal experience of abuse.....	*"my training has been my own journey"*

Context

Intensive self awareness/related work, workshops and seminars (3)
Nursing qualification, related workshops and seminars (1)
Tertiary qualification, related self-awareness work (1)
Professional qualification, related workshops and seminars (3) *(N=8)*

Intervening conditions

Organizational culture.....	*"the Kaupapa is self-awareness"*
Resources.....	*"access to training is difficult in our agency because of the lack of resources*
Motivation.....	*"training is a high priority for me"*
Personal experience of abuse.....	*"my framework comes from my own experience"*
Opportunity.....	*"I haven't been to any training courses because of the pressure of study"*

Action strategies

Informal learning.....	reading, learning from clients, sharing experiences
Self-awareness.....	*"I have been cleaning out my eyes and ears of my own stuff"*
Cultural identification.....	*"what it means to be Maori"*
Specific skills acquisition.....	*"training courses, workshops and seminars"*
Formal learning/professional qualifications	*"something I may do for a framework"*

Consequences

Self-awareness.....	*"you get triggered all the time in this work"*
Confidence.....	*"gives me confidence that what I'm doing is on the right track"*
Competence.....	*"they make the right decision because of the training"*
Flexibility in offering client's choices....	*"if I have choices, that gives my client choices"*
Networking/sharing with colleagues.....	*"it's really important to relate to others"*
Awareness of own limitations.....	*"no-one felt competent to deal with it"*
Willingness to refer on.....	*"there are people out there more skilled to deal with some things"*

Table 3 : KNOWLEDGE of ISSUES, DYNAMICS and EFFECTS of SEXUAL ABUSE

Causal conditions

Clients experiences.....	*"usually they are very weak at controlling children"*
Networking with colleagues.....	*"we share our experiences of working with clients"*
Personal experience of abuse.....	*"my knowledge has come from myself and my own healing"*
Orientation.....	*"a systems orientation...makes me aware of inter-generational patterns of abuse"*
Sexual abuse literature.....	*"I use...what some authors label Rape Trauma Syndrome and Post Traumatic Stress Disorder as a template"*

Context

Ranged from emphasis of a specific cause to articulation of a broad range of causal dynamics including individual, family, social and environmental factors; and

Emphasis on a narrow range of issues and effects to articulation of a broad range including mood disturbances, relationship problems, and difficulties at the various stages of the life-cycle precipitated by prior abuse.

Intervening conditions

Orientation.....	*"abuse...is about how one group of people are able to oppress women in a sexual way in particular"*
Training.....	*"often family boundaries are enmeshed and the child is swapping roles"*
Personal experience of abuse.....	*"when I think about abuse I think about the destruction of the person"*
Knowledge of the literature.....	*"the literature on self-blame and rape myths explains some of the underlying processes"*

Action strategies

"I use Groves' approach, which aims at healing the child within"
"we get to the centre of things very quickly through children as triggers"
"violence is the general focus"
"our work is victim-oriented"
"my approach is led by client needs"

Consequences

Recognizing client needs.....	*"as well as shame, self-blame, anger and especially repressed anger, is an important issue"*
Recognizing boundary issues.....	*"if you just go with your human reactions...you can end up involved in the struggle"*
Recognizing a serious disturbance.....	*"the woman had a multiple personality disorder"*
Recognizing own limitations.....	*"this is an instance where I might refer for specialist help"*

Table 4 : SPECIFIC SKILLS and MODELS THAT INFORM THEM

Causal conditions

Informal learning.....	sharing with colleagues, reading
Training.....	*"in terms of the way I work, I draw alot from the Massey course"*
Learning from clients.....	*"I've evolved a model which I believe is really economical"*
Knowledge of literature.....	*"Haley's 'Ordeal Therapy'...worked for her"*
Personal experience of abuse.....	*"it's basically what I've been through myself and it seemed to work for me"*

Context

Articulation of a broad range of therapeutic interventions and treatment models and expressed a willingness to refer on.
Articulation of a narrower range but expressed a willingness to refer on.
Articulation of a narrower range and expressed reluctance to refer on.

Intervening conditions

Conceptualization of therapeutic tasks.....	*"you can't be effective operating from one approach"*
Training.....	*"without proper training, I think people can do real damage"*
Orientation.....	*"I think Gestalt work is too threatening for most women"*
Appropriateness for particular client.....	*"my approach is led by client needs"*
Knowledge of literature.....	*"I use the Rape Trauma Syndrome/Post Traumatic Stress Disorder framework because it has been well documented"*

Action strategies

Contracting.....	*"having that go-ahead we proceeded"*
Working through the issues.....	*"looking at victim impact issues"*
Conveying hope.....	*"if you can help her see it is possible to heal you are a long way down the track"*
Record-keeping.....	*"measuring, dating and documenting things"*
Referring on.....	*"medication is sometimes indicated as a short-term measure"*
Evaluation.....	*"all clients get an evaluation sheet"*

Consequences

Recognition.....	*"you get a name for doing this sort of work"*
Client choice.....	*"if I have choices, it gives my client choices"*

Table 5 : CONCEPTUALIZATION of THERAPEUTIC TASKS

Causal conditions

Orientation.....	*"what I initially do with women is based in feminist theory"*
Training.....	*"as a psychologist I will be able to comment on the meaning of the way she presents in court"*
Knowledge of effects of abuse.....	*"I don't differentiate physical and sexual abuse"*
Personal experience of abuse.....	*"healing comes with a synthesis of knowing and remembering"*

Context

Articulation of a broad range of tasks including initial and ongoing assessment, tasks specific to recovery from trauma and evaluation;
Articulation of a range of tasks specific to recovery from trauma; and
Tasks not articulated apart from general counselling model and own orientation.

Intervening conditions

Orientation.....	*"our work is victim-oriented"*
Training.....	*"I use structured assessment instruments that have set reliability and validity"*
Knowledge of dynamics, issues, effects.....	*"my approach is led by clients' needs"*
Knowledge of literature.....	*"the 'Courage to Heal' depicts the process that I believe happens"*

Action strategies

"I see my role as helping them to access the memory yet remove the emotional sting"
"I see myself as a midwife to pain"
"I take on a lot of roles to help people work through things"
"as well as doing the healing work [I also do] *ongoing assessment with a court appearance in mind"*
"I think stopping the abuse is the most important thing, but so is healing, for men as well as women"
"the model for my work...looks at the things we learn from painful experiences that shape our lives"
"to me just believing women is the most important thing"
"often all they want to do is talk about it and my role is just to listen"

Consequences

Therapist/client match.....	*"we explored whether I was the right therapist for her"*
Willingness to refer.....	*"if a client outgrows me, or if we get stuck"*
Choice of intervention strategies.....	*"I'd make sure she had support from the group"*

Four themes emerged that may offer further understanding of the variables involved in sexual abuse counselling and the relationship between them. These were the counsellor's orientation, their training, their own experience of abuse, and their knowledge of the dynamics, issues and effects of sexual abuse.

Data is presented here as a narrative account; as a description of the individual themes with illustrative interview excerpts.

ORIENTATION

Two counsellors identified a feminist perspective as their primary orientation. A third qualified her commitment to a feminist orientation - "*You've got to have a strong feminist grounding to work at the centre, so what I initially do with women is based in feminist theory*". While she said she agrees with the basic tenets of a feminist approach to sexual abuse counselling she added - "*I don't agree with it totally ... and I differ from a lot of the people in the centre in that I see individual causes (of sexual abuse) as well as structural and social causes*". In terms of her work with women, a feminist perspective means "*we're less concerned about the perpetrator and the offence than we are about the victim*".

The other two described their meaning of a feminist perspective in terms of the power differential that exists between the sexes.

For one - *"its about what society does to women's self-esteem";* and in terms of her work with survivors of *sexual* abuse - *"just believing them is the most important thing";* for the other - *"my goal working with* women *is to convey that perspective of how abuse sometimes happens. I do a lot of education in my work about how the world is, belief systems, and roles and expectations, power and political issues as well. We talk a lot about empowerment".*

A fourth counsellor described a client-centred approach to counselling. While she based this within a sociological/feminist perspective, her primary focus was a cultural, rather than gender, empowering model - *"we have a strong belief that for Maoridom to move forward we have to heal as we go ... as a Maori women's organizatlon we are motoring ahead and leaving our men behind in terms of growth ... our next stage is to put some training together for men".*

Another described a psychosocial framework and an eclectic approach. *"I take what works for me, along with a real awareness of what works for a particular client, and operate somewhere in between. I use hypnosis as an adjunct ... it allows you to deal in a psychotherapeutic way with issues that may otherwise remain hidden. It also shortens the time you need to intervene in the person's life".*

Another described a client-centred, Rogerian approach - *"Rogerian thinking is in my bones"*. In her work, this means that "to *be an observer is probably the most important thing ... watching for very small signs of disturbance like a change of colour, or change of voice*". The Rogerian concept of unconditional positive regard was reflected in her expression *"I love the women I work with"* and in her emphasis on empathy and identification with people - *"I count myself as an abusing mother. We don't call people clients"*.

An eclectic approach underpinned by biblical theory was described by one counsellor as *"my 'model' for counselling to which I add other techniques. I did a year-long counselling course, which wasn't specifically for sexual abuse counselling, but it was very sound counselling training. That really formed the basis for the way I work. I think counsellors need to understand the dynamics and issues* [of *sexual* abuse] *and the stages of healing, but I don't think you have to necessarily change your whole style of counselling. There is a danger of stigmatizing clients as special cases because they've been abused rather than treating them as people first"*.

Another described a systems orientation which provides a framework for a range of assessment and intervention techniques - "I *have a template in my mind in terms of the meaning of some of these symptoms and in terms of what some authors label Rape Trauma Syndrome or Post Traumatic Stress Disorder ... I keep in*

mind a Grief model and the stages that occur when one is grieving ... the other model that informs my work is a developmental growth and self-actualization model".

TRAINING AND DEVELOPMENT

Three of the counsellors emphasized intensive self-awareness work over a number of years as the basis of their training. This work related in varying degrees to their own healing from the effects of sexual abuse. Training was described as *"my own journey"* and *"my own self-work"*. Each talked about adding relevant courses and workshops as an adjunct - "I *consider my training to be experiential, my own work primarily, and then I add pieces which are useful for my work ... I've done some family therapy training this year ... I have also just completed a Parentline training course".*

Three reported a professional qualification related to therapy and counselling - in clinical psychology, social work, and counselling and psychotherapy respectively. One reported a nursing qualification. The last reported an undergraduate qualification in psychology.

PERSONAL EXPERIENCE OF ABUSE

Four counsellors referred to personal experience of abuse. Initially, this had been included as an area for exploration. During

the first interview the counsellor volunteered that *as far as she knew*, she had not been sexually abused. The interviewer decided that personal experience of abuse was an issue that should be raised by counsellors themselves. The validity of this decision was highlighted by one of the counsellors - *"people may or may not know if they have been abused. If they know, they may or may not tell you"*. The other four counsellors spoke about believing that they were not necessarily less effective because they had not shared the same experience as their clients. As one of them said - "We *all need to address issues of sexuality, powerlessness and anger, and the key is self-awareness and working on those issues that come up for you"*.

KNOWLEDGE OF THE DYNAMICS, ISSUES AND EFFECTS OF SEXUAL ABUSE

Beliefs about the causes of sexual abuse ranged in terms of their complexity. Four explanations related specifically to abuse being intergenerationally transmitted in families, for example - *"abuse causes abuse"; "it's generational, it's our whakapapa"; "sexual abuse often runs in families"*; and *"abused people set themselves up with abusers and start the cycle again"*.

Others included economic and social causes - *"like both parents working and lack of supervision"*. Two counsellors talked about a complex interaction of a number of causal factors - *"there is an interaction between some of the environmental factors and*

preceding factors like abuse, and some things that are within the adaptive strategies of the person themselves ... combined with unemployment and hopelessness and the increasingly violent values which are reflected in society ... all these things interact to contribute to the perpetuation of a context in which abuse occurs". The other saw - "*a number of things ... power ... anger ... and sometimes its just sex. I also see it being born out of frustration and men not being able to deal with things. It often results from stress ... because of unemployment and benefit cuts and the accompanying hopelessness and helplessness ... sometimes it can just happen without a reason*".

VII DISCUSSION

Four themes emerged in relationship to the way counsellor's conceptualized the therapeutic tasks and process in healing from the effects of sexual abuse. These were: (1) therapeutic orientation, (2) training, (3) knowledge about the dynamics, issues and effects of abuse, and (4) personal experience of abuse. The themes are discussed in terms of the significance of the relationships between them, and in the light of what is currently known about the healing process. For example, the differences in the way counsellors conceptualized the tasks and process of therapy was related more closely to their orientation than to their training. The following discussion of the relationships reflects the significance of those relationships according to the data. Illustrative data are presented only to clarify meaning and to illuminate these relationships.

ORIENTATION AND CONCEPTUALIZATION OF THE TASKS AND PROCESS OF THERAPY

Two counsellors who identified a feminist perspective as their primary orientation articulated their meaning in terms of "*empowering*" clients - "*...my goal working with women is to convey* [that] *perspective of how abuse sometimes happens. I do a lot of education in my work about how the world is, belief*

systems and roles and expectations, power and political issues as well, particularly in the groups. We talk a lot about empowerment".

This counsellor's meaning of empowerment is couched in terms of educating women. As well as working at the individual level, she attempts to raise awareness among her clients of the broader social influences in their lives. Another meaning embodied the notion of self-responsibility - *"I don't race around looking after my clients and they know that - that I expect them to look after themselves".*

She contracts with people about the work they want to do and reminds them of their goals if they avoid doing the work they have agreed to do. In terms of the healing process *"...I work in the here-and-now, from dreams, flashbacks, and feelings ...you go with what you know inside, with your intuition, and you encourage the client to do the same and they will virtually heal themselves".* She does *"grounding work"* to foster feelings of safety and self-control, *"body work"* and *"memory-recovery work".* She said she doesn't refer on very much at all - *"In terms of referring for psychiatric treatment or medication, I don't believe they help".*

Her approach to the case vignette involved dealing with the alcohol addiction, which she sees as a way of avoiding or coping, and identifying the need this was meeting. She would do

"*...grounding exercises, like discovering ways she looks after herself other than the drinking. I might get her to draw a life journey and then look at the feelings about that. She would have to work on the abuse, and her relationship with her mother and her father, and the violence in the family*". She would consider a contract with the woman if she thought she was at risk of self-harm.

For the other who identified a feminist perspective, "*...just believing women is the most important thing*". She would not try to take the problem away from the client but "*...empower her to deal with it*". In terms of how she might do this, she emphasized the need to find out what clients want from counselling and for a collaborative approach to setting goals and objectives. She tells clients if she has not used a particular intervention before, in order to give them a choice about proceeding. Thus empowerment primarily means validating women by believing their subjective experiences and joining with them to find their own solutions to their problems.

She believes "*...Freud did a lot of damage with his theories and although it is old stuff psychiatrists still stick to it*". She finds Freud's theory about dreams relevant however, and believes that "*...counsellors, in order to be effective, need to realise that women push things down into the unconscious and deny their experiences of abuse in order to cope*". She said she reads a lot - "*...you can learn a lot from books, but not psychiatric ones*" - and

articulated a broad range of effects of sexual abuse, from Post Traumatic Stress responses and dissociation, to hypervigilance, physical symptoms, psychosomatic disorders, and parenting problems. She described using expressive techniques such as clay-work, drawing and writing.

Her approach to the vignette involved empathic listening and a contract to ensure safety if the woman was suicidal. She would consider referral for medication if the depression seemed severe but did not elaborate on how she would assess this. She said she might try some '*empty chair work*', and would give the woman a written list of practical things to do to enable her to cope with feelings of desperation.

Another counsellor's eclectic approach is derived from her training as a clinical psychologist. She emphasized a systems orientation, which was reflected in her consideration of the effects of abuse on different aspects of clients' functioning. She believes that a feminist perspective is important in contributing to an understanding of the dynamics and issues involved in abuse but that the level of anger at the extreme end of the feminist continuum can be counter-productive if people impose their views on clients.

As well as "*...helping clients through the trauma of abuse*", she described "*...measuring, dating and documenting things very carefully...so that...even if she presents quite well in court, I'll*

have documented evidence all along the way of what she was like when I first saw her and throughout the process". Thus, her perception of her tasks reflects specific functions she may be asked to perform as a psychologist on behalf of clients. As well as these specific tasks, she emphasized the importance of education and prevention: "*As well as working through her issues, we had to do some prevention work and give her some understanding of the multi-generational transmission of abuse*".

Her approach to the case vignette included an assessment of the likelihood of self-harm and the severity of depression. She would consider using the Beck Depression Inventory (BDI) for this purpose, a contract for safety if depression was severe, and focus on lifting the depression before starting work on the underlying issues. She would assess whether the woman's behaviour was indicative of agoraphobia, which could be maintaining the depression.

She might use a genogram to enable the client to understand the family context in which the abuse took place - "*...how it is part of her social system and empowering her within that*". She would encourage contact with other women in the family. This "*...not only provides support but sometimes reveals an overlay of multiple abuses*". The support that women can provide each other can help to lift the depression " *...because they start to build up power through their links as women in the family*". The result is often a "*safety network*" that protects the next generation.

Another counsellor's eclectic approach draws from a similar theoretical framework derived from a post-graduate course in psychology she is currently completing. She finds that "*...a structured psychological approach allows me to recognize and label processes and to almost predict what will happen next*". She finds a cognitive-behavioural approach useful in her work, and may set tasks for clients to achieve particular goals, for example to increase activity level and positive interactions in the case of depression. She has tried hypnosis with a client to "*...assist her to remember the details of abuse for evidential purposes*", but "*...it didn't work because she couldn't relax*".

Her approach to the vignette included an initial assessment of the woman's safety and the severity of depression. She would consider using a structured assessment instrument such as the BDI for this purpose. Use of medication, family commitments, and available social supports were other areas for assessment. She would ascertain the woman's own priorities for intervention. She thought the drinking could be dealt with in conjunction with sexual abuse counselling and would focus on assisting the woman to *control* the drinking rather than trying to stop during the current crisis.

Another counsellor described an eclectic approach based on her social work training. She works from a Christian perspective. For her this means that the focus of therapy: "*...is not so much a*

cathartic thing that takes people back to re-experience the pain. Rather, it looks at the things we learn out of painful experiences that shape our lives". She believes that in conceptualizing sexual abuse as different from other healing processes, *"...there is a danger of stigmatizing clients as special cases because they have been abused rather than treating them as people first".* She said she had changed her approach as she gained experience working with clients, and tends now to *"...stay very much with the person I'm working with, where she is at in the process".* She said that at one time she might have imposed her own view of the stages of healing.

Her approach to the case vignette involved assessing the woman's perception of the issues and exploring how the abuse is affecting her life. She saw safety as a priority and would assess the support available to her. She believes people do not need to remember the details to deal with the effects of abuse, and that there is a danger of dismantling people's coping mechanisms before they are ready, for example with hypnosis. She would therefore explore what remembering the blocked details of the abuse might mean for the woman before proceeding.

Another counsellor based an eclectic approach to his work on his training in psychotherapy and counselling and a post-graduate psychology course. He described coming to sexual abuse counselling specifically through hypnotherapy: *"A number of women were coming with relationship and intimacy problems.*

Using hypnotherapy, I was struck by the frequency of sexual abuse that had occurred at a very young age and who had dealt with it by blocking it out but which was now causing distress. I find it an extremely effective tool because it ...allows you to deal in a psychotherapeutic way with issues that may otherwise remain hidden. It also shortens the time you need to intervene in the person's life".

He also uses the metaphorical representations that people have for the traumatic experience to assist them to *"...get to the trauma and to move beyond it in order to heal"*. This approach does not aim to remove the pain of trauma, but to *"...access the memory yet remove the emotional sting that has been tied to it for so long".*

His approach to the case-study would begin with trying to locate the client's inner hurt child by listening closely to her language. *"It may come as a direct comment or as a metaphoric statement...we may not even talk about the uncle or the father"*. His goal would be to foster a sense of hope - *"...if people are not free of the past, at least they need to know they can be"* - to enhance feelings of control, and to assist the woman to identify alternatives to alcohol for coping. He would consider referrals for more specialized help, both for her drinking and for short-term medication for the depression.

The counsellor working from a client-centred, Rogerian orientation believes healing from sexual abuse is "*...no different to any other healing journey* ", and that too often it is seen as a different therapeutic process, "*...as esoteric or exotic*". She is strongly opposed to people imposing their own reality by "*...helping people through stages that are really counsellors' agendas*". She believes that the human psyche is capable of healing itself in the same way the body heals itself from physical injury, and that "*...professionals actually mostly get in the way of that healing*".

While a feminist analysis provides a context for understanding sexual abuse, she believes its' focus on men's violence can lead to blaming rather than healing and contributes to society's denial of women's violence. From her experiences with clients, she has devised a model for her work that enables her to quickly identify the focus for counselling. She believes that dysfunctional parenting is a representation of some aspect of the individual that is trying to heal, and that children very often trigger parenting behaviour that is linked with an abusive past experience. By helping the client to identify the trigger for the unwanted behaviour, the trigger is often traced to the experience or issue that is in need of resolution. This issue then becomes the focus of therapy.

Her approach to the case vignette involved focusing on establishing a therapeutic relationship. She would "*...follow the*

disturbance as a starting place" rather than having an agenda or "*...a set of things to do*" and would trust that the issues would evolve as the woman was ready to talk about them. She would be alert to the feelings of guilt, knowing that "*...a few layers down will be pleasure, and unless that's found she won't be free or be able to forgive herself*". In terms of the alcohol addiction, she believes that it would have to be dealt with before working on the sexual abuse, because the energy needed for healing is being diverted: "*I think of myself as a midwife to pain, helping people to get the pain out, and there isn't time for detours*".

A second counsellor with a client-centred approach to counselling emphasized a socio-cultural framework for her work. While her focus is on understanding women's experiences of being Maori, she also expressed the need for a holistic approach to the problem of violence as it relates to both men and women -"*...we need to work together, to really see each other. We need to address the basis of our culture and how we feel about ourselves individually*".

Her approach to the case vignette involved establishing trust and a feeling of safety and "*...starting where the woman is at herself*". She stressed the importance of moving through the issues at the woman's pace "*...I would be really concerned not to push her over the top, so I'd be very gentle with her*". She would link the woman into a group she runs "*...which is a very strong source of support*". She finds the group particularly effective for

women who are at risk of harming themselves as "*...the whole group reaches out to them*".

Summary

Regardless of orientation, counsellors shared a number of similar perceptions about the tasks and process of therapy. In various ways, they talked about *empowering* their clients - by encouraging and supporting them to take control of the process of their own healing; by providing education and information; by validating their experiences; and by facilitating understanding of the context in which the abuse took place. Others, while not talking directly about empowering clients, emphasized encouraging independence and linking clients with their own natural support networks.

All counsellors talked about *contracting* - collaborating with clients about the goals and issues for therapy, and for safety. The notion of *working at the client's pace* was also universal. However one counsellor who noted the importance of *timing* said that a client with whom she had tried hypnosis without producing the expected result "*...changed to another counsellor, then soon after left counselling*". After further discussion she concluded "*...I maybe went a little fast for her and she wasn't ready to face what happened*".

Six counsellors talked about *reviewing with clients* their progress toward the therapeutic goals. One described a process

for *evaluation* which provides clients with an opportunity to give feedback about their perceptions of the usefulness of therapy on termination of their contact with the counsellor.

There were also a number of differences. Three of the eight counsellors talked about *assessment* as a task before proceeding with therapy. Two of these would consider using structured instruments, for example to assess the severity of depression.

Consideration of an underlying or severe disorder seemed related to this difference in emphasis on assessment. One counsellor said she would explore the possibility of agoraphobia in conjunction with an assessment of the severity of the depression. Those counsellors who did not elaborate on the clients' depressive symptoms in terms of their possible severity, also did not consider *referring on.*

Counsellors had differing perceptions about the parameters of the counselling role and the effectiveness of more specialized intervention. Three counsellors expressed reservations about the usefulness of psychiatry, for instance. One said that in spite of this reservation, mainly for cultural reasons, she thought *all* perspectives were necessary to provide clients with the range of interventions they were entitled to. Another expressed her reservations in terms of the potential for stigmatizing people but said that sometimes labels like multiple personality disorder enable people to communicate about a client's problem. The third

believes "*...the whole psychiatric system is really abusive and into controlling people*".

Therapists' orientations seem to influence the way they conceptualize the tasks and process of therapy. Those describing an eclectic approach rather than a particular perspective also described a broader range of tasks, involving assessment, ensuring a therapist/client match, and evaluation, as well as working through the issues. Those describing a feminist perspective emphasized *empowerment* of clients but did not differ from other counsellors in the extent to which they actually go about doing this. One counsellor who emphasized empowerment was in fact less willing to offer clients choices in terms of access to services that do not reflect her orientation.

Lather (1988) warns that reproducing the conceptual map of the teacher in the mind of the student disempowers through reification. This metaphor applied to the therapeutic relationship raises issues of imposition and the importance of understanding what happens in the name of empowering. As one counsellor put it: "*...the interface between politicizing the client and striving to convert them to your religion, versus trying to help them to achieve the greatest level of healing that they can within the context they choose to operate, is the issue here.*"

TRAINING AND CONCEPTUALIZATION OF THE TASKS AND PROCESS OF THERAPY

Counsellor's conceptualizations about the process of therapy varied. Those counsellors who emphasized their own self-awareness as their training for sexual abuse counselling, did not conceptualize the process of healing as unique. One said she does not differentiate between physical and sexual abuse and sees the processes as similar. Rather, she makes a distinction between physical and emotional abuse.

Another sees healing from the effects of sexual abuse as "*...no different to any other healing journey*". However she explained this in terms of the danger of counsellors imposing their ideas about a process onto their clients rather than in terms of the effects of abuse.

Another believes that the effects of abuse just compound existing feelings of powerlessness, shame and alienation among many Maori women - "*...I think one of the most difficult issues is coming to terms initially with what it means to be Maori*".

Counsellors reporting professional qualifications and training tended to see the process as having similarities to other forms of victimization experiences but as having particular characteristics. One warned of the danger of "*...seeing sexual abuse as such a separate thing*". She explained her meaning in terms of counsellors needing to understand the dynamics, issues,

and stages of healing, but not necessarily adopting a different counselling style. However, she saw the process of accommodation to the abuse as a distinguishing characteristic.

Counsellors also differed in terms of the degree of structure they attach to the process of therapy. One said - "*You go with what you know inside, with your intuition, and you encourage* [the client] *to do the same and they will virtually heal themselves ... the relationship between the therapist and client is important, not what happens in between*".

Another described a process that included initial assessment using structured instruments as well as client-centred interviewing, working through the issues, planning for termination, and a formal evaluation. An illustration of the differences between these conceptualizations of the tasks and processes involved in therapy relates to termination. One counsellor talked about the importance of a mutual agreement to terminate - "*When I become aware that we've reached some sort of barrier ... the signs are usually that I see resistance developing in the client ... rather than getting angry and thinking this client is manipulative and not really wanting to work forward, I will make the covert overt and look at it with the client in terms of an inner struggle ... then she can make an informed decision ...* [otherwise] *she will move onto another therapist and reach the same point and the pattern of blaming the therapist will occur ... this doesn't allow her to understand the*

meaning of that struggle ... if you are not aware of that, if you just go with your human reactions, some of the things the client does may generate reactions in you that get you feeling angry and frustrated and you end up involved in the struggle".

The other counsellor also talked about premature termination as avoidance - *"If they get angry with me and take off somewhere else, then they are going to be avoiding the work they need to do".* She expects people to take responsibility for themselves and confronts people who she thinks are avoiding the issues - *"I think I am a fairly confrontational therapist ... but I balance that with love and caring, which is the basis of my work. The only time I would refer on is if someone is mucking around and wanted a therapist who would let them do that" .*

According to Meyer (1987, cited in the Report of the Advisory Committee, 1988) therapists need an understanding of the process and management of transference and counter-transference issues in order to avoid personalizing projected aggressive and impulsive behaviour. If counsellors do not recognize displaced aggression as transference and deal with it in a way that gives the client insight into her behaviour, the behaviour of non-protective parents may be replicated by the therapist and experienced by the client as neglect and abandonment.

Differences in the ways that counsellors conceptualize the tasks and process involved in healing from the effects of sexual abuse may be partially explained by differences in training. Those counsellors who described their training in terms of self-awareness did not see the tasks or process as unique to sexual abuse healing. They justified their use of particular techniques in terms of their own experiences - what had worked for them in their own healing process, and the changes they see in their clients.

Counsellors reporting professional qualifications tended to see the treatment of sexual abuse as having unique properties and characteristics. They justified their use of particular techniques according to theory and the evidence of their efficacy in the literature.

TRAINING AND PERSONAL EXPERIENCE OF ABUSE

It was not an intended aim of the present study to include counsellors who had themselves experienced sexual abuse. However, personal experience of abuse emerged as a differentiating factor. Type of training was closely related to personal experience of abuse, with three of the four counsellors who reported personal experience of abuse describing their training as experiential (their own recovery process) and intensive self-awareness work. The other saw her current post-graduate psychology course as her main training source,

supplemented by that initially provided by the voluntary agency she works for. Of the four counsellors who indicated they had not shared the experience of their clients (no personal experience of abuse), three had completed a professional qualification.

The concept of *'triggering'* was used by most (six) to describe how personal issues are raised in the context of working through the client's issues. The meaning of this concept was expressed in similar ways regardless of personal experience of abuse. They included - "*...it's easy to be seduced by content and deal with your own thing and not the client's*" and "*...if you're in this work there is a tendency to regurgitate your own stuff*". Most (seven) counsellors mentioned the importance of supervision for dealing with these issues.

Counsellors were unanimous about the crucial nature of counsellor self-awareness as a prerequisite for working with sexually abused clients. Three of the four who reported personal experience of abuse equated self-awareness with training - "*...the training **is** self-awareness*" - while those who did not, saw it as a necessary counsellor characteristic, related to training and to issues other than just sexual abuse.

KNOWLEDGE OF THE ISSUES, DYNAMICS, AND EFFECTS OF ABUSE

A therapist working with sexual abuse survivors must first have a clear understanding of the issues and dynamics involved in sexual abuse in order to understand its effects. As well, perceptions about the *'cause'* of sexual abuse influence approaches to treatment.

Most (six) counsellors discussed the causes of abuse in terms of an interaction between a number of factors. Two described the causes in terms of patriarchy and the differential power that exists between men and women in society.

All counsellors discussed a range of effects of abuse. However, there were differences in opinions about the nature, severity, and extent of the effects. Some counsellors mentioned factors that mediate the effects of abuse, such as the type of abuse, the relationship between the perpetrator and victim, and the duration of the abuse.

Some saw the effects of abuse as either completely pervasive - *"...when I think about abuse I think about the destruction of the person really"*, or permanent - *"I think it's actually a rare thing to find someone who has completely dealt with the effects of sexual abuse"*.

These perceptions may reflect these counsellors' own experiences of abuse. One also talked about feelings that seem to relate to hypervigilance, which function as survival skills - "*...when you have been abused there are things that you know, that you see - in people's eyes, the way their bodies are - because you learn that. It's part of the skill of survival. You learn to pick out who to go for or who not to go for. You know these things. I don't know if there is something in our genes but those patterns go right back*".

For the other this vigilance related to being able to identify other victims - "*I think there is a victim orientation - women you can pick in a group - and if I can pick them, so can men*".

The normative and social structure of our society contributes to, but is not the only reason there is sexual abuse. If the male dominance argument is carried to its logical conclusion, all men would be abusers, which clearly they are not. Faller (1988) notes increased reports of sexual abuse at a time of unprecedented social concern for, and awareness of, the rights of women and children and a diminishing belief in male dominance. In most cases the dynamics of sexual abuse are complex. While abusers appear to share important characteristics such as sexual attraction to children and a willingness to act on that attraction (Faller, 1988), cultural, environmental, individual, and family factors contribute to abuse. Ignoring the range of factors also

ignores the variation of their influence and impact from case to case.

One counsellor believes that maternal violence is a hidden causal aspect of sexual abuse - "*...we can see men's violence because they act in the public world ... we're all players, and we're all involved, and we just simply pass it on*".

Her meaning was expressed in terms of the cyclical nature of abuse, and the fact that many abusers were themselves abused, often by their mothers.

As well as knowledge of the effects of abuse, an understanding of the dynamics and conditions that contribute to the occurrence of abuse enables the therapist to help the client understand the manipulative means by which the perpetrator exploited and seduced her. This may empower her by enabling her to see the potential to avoid future situations of victimization. Explanations that put the experience completely beyond the client's control may serve to maintain her perception of self as potential victim.

Three counsellors emphasized the processes by which children are manipulated into sexual activity by a powerful adult and by which they adapt emotionally in order to survive. Three referred specifically to the process of *accommodation*. Another, herself a survivor, said "*I don't differentiate physical from sexual abuse ...*

the processes are similar in terms of what happens to people. Either its physical or emotional abuse".

Feminist theory has contributed to unprecedented advances in current understanding of sexual abuse. The feminist literature however, often fails to take cognizance of research relating to victimization from events other than sexual abuse. Such research has been shown to be relevant to the experience of abuse. This is particularly so with regard to the issues of self-blame and searching for meaning. The danger of disempowering by failing to empathize and countering too strongly women's subjective experience has been noted previously. As one counsellor put it: *"...if you counter too aggressively the person's view of reality or the attributions they are making about what happened and their part in it, you can in fact deny their reality ... without giving them a chance to achieve some sense of power and control ... from within themselves".*

CONCEPTUALIZATION OF THE TASKS AND PROCESS OF THERAPY AND PERSONAL EXPERIENCE OF ABUSE

While counsellors shared a number of perceptions about the tasks and process of therapy, there were differences in the techniques they use.

Those counsellors who reported personal experience of abuse also reported using more experiential/cathartic techniques.

Three mentioned bioenergetics and body work. This was described by one as grounding work. Another described it as body/feeling work aimed at integrating the cognitive, emotional and physical aspects of the person to facilitate reintegration of the traumatic experience.

The expression "*...you can only go with clients as far as you've been yourself*" was used by three counsellors. Two expressed their meaning in terms of the need for people to deal with the effects of their own abuse before attempting to help others. The third said that because she is toward the end of her own healing process she "*...may be in a position to take people right the way through*". This seems to mean that people who have not shared their client's experience are not able to do that. The implication that personal experience of abuse is a prerequisite for doing sexual abuse counselling is highlighted in the ACCs pilot study to establish competency guidelines:

> *Counsellors were queried both about what they thought made them competent and how they would assess another's competence.* ***The most frequent responses have been included in the guidelines.*** [Author's emphasis]... *Many counsellors listed their own experience of abuse as a factor in competence.*
> (Martin et al, 1989, p.44).

There is an issue of reification in the above. Frequency of response to subjective opinions about competency provides information about characteristics of counsellors. In the absence of established and verifiable criteria these characteristics cannot be presumed to indicate competency. There is no evidence in the literature that counsellors who have been abused themselves are more effective (that is, competent) than those who have not. There is evidence that having shared a similar experience to clients makes people more empathic and insightful. However empathy and insight could be seen as necessary but not sufficient conditions for competence. This point is highlighted by the experience of a counsellor who sought help from an agency providing counselling by sexual abuse survivors - "*...they would say I know just how you feel and stop you* [from recounting your own story]. *In my experience the very people who were supposed to be there to help actually made me feel beyond help*".

VIII IMPLICATIONS

The aim of the present study was to attempt to identify relationships among factors associated with the process of sexual abuse counselling. Some implications relating to these factors are proposed for consideration.

Summit (1983) cautioned that the explosion of interest in sexual abuse has the potential for creating new hazards for victims in that it increases the likelihood of disclosure but fails to protect the survivors of sexual abuse from further victimization by an inconsistent intervention system. Trauma can arise as much from how the system reacts to disclosures of sexual abuse as from the experience itself.

In New Zealand, the Accident Compensation Corporation employs in excess of four hundred counsellors to provide a counselling service for a growing number of sexual abuse survivors. The present study indicates that while there are similarities in the way counsellors talk about their work, there are considerable differences in the way they conceptualize sexual abuse, both in relation to its dynamics and effects, and the healing process. These differences seem to relate to counsellor's orientation, training, and personal experience of abuse.

While the complex network of effects of sexual abuse means that a range of perspectives, treatment approaches and specific skills is needed to ensure that client needs are able to be met, the absence of a shared conceptual framework with regard to the dynamics, issues and effects of sexual abuse mitigates against an integrated approach to sexual abuse counselling.

The ACCs Pilot Study acknowledged the need for counsellor diversity. However there is no mention of a process for matching the skill of a particular counsellor with the needs of a particular client. The diversity of service providers with regard to their knowledge and skills means that outcomes for clients - in terms of the appropriateness of the treatment they receive - are dependent on the luck of the draw as much as on a systematic process to ensure consistency of service.

Counsellors were most clearly differentiated with regard to both training and personal experience of abuse. While this difference is an important aspect of diversity, improved communication among counsellors and opportunities for sharing of their respective viewpoints could lead to an improved service to clients. As well as the knowledge derived from experience, there is a growing body of literature written by clinicians which provides additional information about treatment approaches. While research does not necessarily provide the answers, it is a way of sharing information derived from a number of disciplines and perspectives and thus complements the knowledge derived

from experience. Familiarity with the current literature not only provides this additional perspective but provides an additional route to establishing guidelines for therapists. Such guidelines are needed to promote the development of treatment approaches that adequately reflect existing knowledge about sexual abuse, and to ensure a more consistent service to clients.

It may be that experiential client-centred counselling, without additional *specialized* intervention, *is* the most effective treatment for the effects of sexual abuse. That can only be determined by clients. However, the findings of the present study indicate that without reference to a broader conceptual framework, less attention is given to a systematic assessment of clients' presenting problems. One of the more serious implications is that the probability of counsellors detecting an underlying disorder is decreased. Counsellors who did not include assessment as a disinct therapeutic task were also less likely to refer on for more specialized help.

The need for improved communication was highlighted in the ACC Pilot Study (Martin et al, 1989) following counsellors' expressions of concerns about other counsellors' training. In the present study, a general feeling expressed by those counsellors with no direct association with the disciplines of psychology and psychiatry was a lack of faith in these professions to provide appropriate healing from the effects of sexual abuse. The multi-disciplinary nature of the sexual abuse field requires

participation by individuals with a number of perspectives. More opportunities for shared communication among counsellors from different backgrounds and disciplines would serve to dispel concerns about each others competency.

While there is little doubt that some professionals consider abuse from their professional perspective only, the present study indicates that mental health workers with other perspectives can be similarly biased. Except for the obvious health risks, the impact of sexual abuse *is* essentially psychological. The inadequacies of many training institutions in preparing professionals for working with sexual abuse survivors has been noted by members of professional groups as well as by related mental health workers. While graduates of these training programmes may not *intend* to work with survivors of sexual abuse, the reality is that a considerable proportion of their future clients *will* have experienced sexual abuse. As well as an institutional responsibility, mental health professionals need to assume greater individual responsibility to acquire the same level of competency that is required of therapists specifically choosing to work in the area of sexual abuse counselling.

The present study did not begin with a hypothesis to prove. Rather, the author explored with counsellors their experiences of doing the work of sexual abuse counselling. By collaborating about the meanings of these experiences, perceptions of what is

relevant to sexual abuse counselling from this joint perspective have emerged.

While the current study represents a small sample of sexual abuse counsellors, the emergent themes offer direction for future research. Research that continues to employ qualitative methodology with other samples may help access other variables in the area of sexual abuse counselling that are difficult to quantify. Future research needs to go beyond therapist's own accounts of what they do. One possibility is to evaluate client's perceptions of the effectiveness of treatment using qualitative methods. Rather than further victimizing sexual abuse survivors (a crticism of research using quantitative methods that the author became sensitized to while conducting the present study), clients may experience the opportunity to contribute to knowledge in the area as empowering. In any case, they should be given the opportunity to decide for themselves.

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Appendix A

INTERVIEW SCHEDULE 1

Demographic Information

1 Gender:

2 Cultural background:

3 Agency:

4 Length of experience: (sexual abuse counselling)

5 Other counselling experience:

6 Training:

7 Qualifications:

8 Number of client contacts per month:

9 Personal experience of sexual abuse: (yes/no).

Therapeutic Process Information:

(theoretical Orientation)

Which therapeutic school do you most identify with? (eg psychodynamic, cognitive-behavioural, family systems, eclectic)

Which theories about the causes of sexual abuse inform your understanding of how/why sexual abuse occurs? (eg psychodynamic, sociological/structural, feminist perspective)

Apart from a main therapeutic orientation, which theories or methods of treatment do you think sexual abuse counsellors need to have an understanding of to inform their work? (eg victimisation/traumatic stress, self-development, feminist theory)

What have you found to be the most important treatment issues in your work with sexual abuse survivors? (eg self-concept, sexual identity, relationship difficuties, isolation and stigma, physical symptoms)

Case Vignettes:

Similar demographic, psychosocial, social support, problem severity and diagnostic range backgrounds.

Crisis versus non-crisis presentation
Presence/absence of related problem (substance/alcohol abuse)
Symbolic and direct communications
Conscious versus unconscious processes (defence mechanisms)
Self-blame statements (behavioural and characterological)
Searching for meaning statements

At designated points, subjects are asked to respond to queries about their conceptualisation of the case and process, on their interpretations of unconscious material, on recommended interventions at that time, and on recommended feasible treatment goals and services.

Case Conceptualisation:
Speculate briefly about factors that may represent significant causal determinants in the client's presenting problems.

Briefly describe the process you would use to identify treatment/intervention goals. (initial contract)

How would you prioritise the treatment goals? (eg. accompanying crisis and client safety, related issues such as alcohol/substance abuse, social supports)

What role would you take in the execution/attainment of the treatment goals? (directiveness, willingness to refer)

What role would you expect the client to take?

Which treatment modalities would you adopt and why? (individual counselling, group work, family work)

Briefly describe any specific techniques you might consider using.

What steps would you take?

Appendix B

INTERVIEW SCHEDULE 2

1 DEMOGRAPHIC AND BACKGROUND INFORMATION

Tell me something about yourself

Cues:

* Cultural background
* Agency
* Length of experience as sexual abuse counsellor
* Other counselling experience
* Training/Qualifications
* Number of client contacts per month
* Personal experience of sexual abuse

---

2 THERAPEUTIC PROCESS INFORMATION

Tell me something about your theoretical orientation

Cues:

* Therapeutic school identify with - *psychodynamic, cognitive-behavioural, family systems, eclectic*

* Theories about causes of sexual abuse which inform understanding of how/why sexual abuse occurs - *psychodynamic, sociological/structural, feminist perspective*

* Other than main therapeutic orientation, theories or methods of treatment that sexual abuse counsellors need to have an understanding of to inform their work - *victimisation/traumatic stress, self-development, feminist theory*

* Most important treatment issues in work with sexual abuse survivors - *self-concept, sexual identity, relationship difficuties, isolation and stigma, physical symptoms*

---

3 CASE VIGNETTES

Please read the following and tell me how you would respond

Cues:

* Factors that may represent significant causal determinants in the client's presenting problems

* The process used to identify treatment/intervention goals - initial contract

* Prioritising treatment goals - *accompanying crisis and client safety, related issues such as alcohol/substance abuse, social supports*

* Role taken in the execution/attainment of the treatment goals - *directiveness, willingness to refer*

* Role the client would be expected to take

* Treatment modalities adopted and why - *individual counselling, group work, family work*

Appendix C

LETTER TO RESEARCH PARTICIPANTS 1

Dear

I am writing to you to seek your assistance with a research project I am undertaking for a Master's thesis. My aim for this study is to explore with counsellors their experiences of working with adults who were sexually abused as children and to attempt to understand how these experiences might contribute to knowledge about sexual abuse.

My interest in sexual abuse counselling stems from my experience as a social worker working with institutionalised young women, the majority of whom had been abused as children. This experience led to an awareness that expertise in sexual abuse counselling is largely gained from doing the work and sharing experiences with others.

Because strategies and techniques have largely developed in a 'trial-and-error' fashion, and because of the lack of empirical research in this area, much of the available literature on sexual abuse has been criticised for drawing conclusions from 'unscientific' data. An objective of the proposed study is to examine if what the literature says *is* effective, can be validated with what counsellors *actually* find to be effective.

I envisage interviewing a small number of counsellors, probably for a period of between one to two hours, and I would be extremely grateful if you would agree to participate. I will contact you in the next few days to discuss this possibility. Thank you very much in anticipation.

Yours sincerely

Sue Stevens.

Appendix D

CASE VIGNETTE

Anne is 31 years old and has been referred by her G.P. who has been treating her for depression. Her relationship with her partner of 8 years recently ended, largely due to her excessive drinking.

Anne has experienced bouts of depression since her teenage years. When she was 13 she swallowed 'Handy Andy' and a few years later cut her wrists. Recently she has experienced a revival of feelings of wanting to harm herself, and taken to staying inside with the curtains closed and avoiding people.

Between the ages of 11-15, Anne was molested by her uncle on more than 50 occasions. She complied because she had been taught to please and help adults and she desperately wanted the approval of someone outside her home. She felt very guilty at the time, and feels guilty now. She believes she must have permitted sex because she wasn't forced into it.

She describes feeling close to her mother but fearful of her father who was physically violent toward his wife and children and not at all affectionate. Anne remembers as a child constantly wishing he would go away and trying to persuade her mother to leave. She can't remember any specific abuse by her father, but has a feeling there might have been some sexual involvement with him.

Appendix E

LETTER TO RESEARCH PARTICIPANTS 2

Dear

I am enclosing an edited transcript of our recent conversation about your work as a sexual abuse counsellor.

I hope you find it an accurate reflection of your thoughts and opinions. For reasons of brevity, I have edited out my contribution to the discussion but I hope I have preserved the context, which is certainly the objective for the final document. With this in mind, if there are any changes at all you would like to make (amendments or additions), I would really like you to let me know. It is important to me, and for my research, that you have this opportunity to ensure that your views have been captured faithfully.

I really enjoyed meeting you and feel privileged to have shared some of your experiences.

Kind regards

Sue Stevens

Appendix F

LIST OF CATEGORIES AND CONCEPTS I

1	Referral Source
2	Presenting Problems
3	Intergenerational Transmission
4	Working through issues
5	Prevention work
6	Looking at victim impact issues
7	Rape trauma counselling
8	Helping through trauma of abuse
9	Preparing her for giving evidence
10	People at different stages
11	Police awareness of Psychologists' expertise
12	Giving evidence
13	Increasing conviction rates
14	Evaluating degree of trauma at outset
15	Evaluating changes throughout process
16	Documenting evidence
17	Measure, date and document
18	Specific assessment instruments
19	Expert opinion
20	Documentation for comparative measurement of trauma
21	Ongoing assessment with legal process in mind
22	Conceptual framework
23	Systematic recording
24	Working empathetically
25	Working sensitively
26	Providing information for self-monitoring
27	Countering discouragement
28	Justification for using certain frameworks
29	Quoting and citing literature
30	Keep in mind grief model
31	Recognizing stages of grief
32	Awareness of personal boundaries/transference
33	Developmental growth and self-actualization model
34	Individual treatment plan
35	Fitting combinations of approaches to particular client's needs
36	Developing relationship with client
37	Bicultural awareness
38	Recognition of limitations of own knowledge
39	Exploration of fit between therapist/client
40	Allowing client to choose to continue with particular counsellor
41	Contract/mandate to proceed
42	Allowing client to keep their own construction of reality
43	Awareness of client's degree of comfort that issue will remain confidential
44	Recognition of and using client's communication style
45	Hypnosis
46	Linking together with client

47 Collaborating with client in healing
48 Learning from each other/mutuality
49 Opportunity for evaluating counsellor
50 Using feedback to improve service to clients
51 Conceptualising why abuse occurs
52 Systems orientation
53 Therapists awareness of patterns of abuse
54 Merging healing with preventative work
55 Differential impact
56 Feminist research
57 Acknowledgement of mens' powerlessness
58 Feminist focus on women as victims
59 Transcending gender
60 Identifying with the dilemmas of being a male therapist
61 Awareness for the need for middle ground
62 Politicising client toward belief system
63 Client may want to remain in family
64 Client goal versus therapist goal, knowing to differentiate
65 Making changes in the family
66 Respecting client's wishes
67 Creating a context where needs can be met
68 Being non-judgemental
69 Making modifications to maps
70 Moving at client's pace
71 Awareness of and overcoming resistance
72 Making the covert, overt
73 Helping client to make informed opinion
74 Contracting for termination
75 Recognising when termination's appropriate
76 Over-involvement
77 Making sense of transference
78 Objectivity
79 Enabling
80 Psychoanalytic concepts
81 Experience as victim being prerequisite
82 Counsellor's unresolved personal issues
83 Power over clients
84 Efects of abuse
85 Presented with clients not able to connect symptoms with cause(s)
86 Phobias, depression, psychosomatic disorders
87 Relationship problems
88 Sexual dysfunction
89 Conscious awareness
90 Anger
91 Unresolved grief
92 Agoraphobia
93 Nausea & vomiting
94 Eating disorders
95 Understanding of mediating factors
96 Dealing with abuse in supportive manner
97 Flight into madness
98 Attribution of blame
99 Empowering
100 Imposing framework versus leading to awareness

101 Give clients reading material
102 Understanding they weren't to blame
103 Awareness of underlying processes and functional aspects of self-blame
104 Awareness of rape mythology
105 Educative role
106 Attribution theory
107 Victimisation theory
108 Using techniques blindly without filtering process
109 Systemic view of where therapist fits into cognitive process
110 In tune with what your feelings are telling you too/Intuition
111 Need for supervision/consultation with colleagues
112 Denial of this not good practice
113 Flexible structure of initial interview
114 Expressions of feeling
115 Here and now stuff
116 Assessing safety/risk
117 Depression screen, BDI
118 Distorted thinking
119 Contract to keep safe
120 Liaison with GP re medication
121 Recognition of causal factors of depression
122 Support systems?
123 Eating correctly?
124 Isolation?
125 Co-variation of symptoms
126 Not dismantling defences too quickly
127 Conceptualizing the abuse in its context
128 Make connections
129 Use of genogram
130 Identifying family support
131 Identifying potential victims
132 Developing bonds between female members of family
133 Setting up safety network as preventative measures
134 Understanding the meaning of abuse in her life
135 How abuse is part of social system
136 Referring on

Appendix G

LIST OF CATEGORIES AND CONCEPTS II

Categories sorting

A Attribution of blame
A Attribution theory
A Awareness of rape mythology
A Awareness of underlying processes and functional aspects of self-blame
A Understanding they weren't to blame
A Victimisation theory

C Conceptualisation of why abuse occurs
C Intergenerational Transmission
C Therapists awareness of patterns of abuse

D Demographic
D Police awareness of Psychologists' expertise
D Presented with clients not able to connect symptoms with cause(s)
D Referral Source

F Conceptual framework
F Acknowledgement of differential impact of abuse
F Acknowledgement of mens' powerlessness
F Attribution theory
F Awareness of rape mythology
F Awareness of the need for middle ground
F Client goal versus therapist goal, knowing to differentiate
F Client may want to remain in family
F Conceptualizing the abuse in its context
F Counsellor's unresolved personal issues
F Developmental growth and self-actualization model
F Experience as victim being prerequisite
F Feminist focus on women as victims
F Feminist research
F Fitting combinations of approaches to particular client's needs
F How abuse is part of social system
F Identifying with the dilemmas of being a male therapist
F Imposing framework versus leading to awareness
F Justification for using certain frameworks
F Keep in mind grief model
F Making changes in the family
F Making sense of transference
F Politicising client toward belief system
F Psychoanalytic concepts
F Quoting and citing literature
F Recognition of causal factors of depression
F Recognizing stages of grief
F Respecting client's wishes
F Systemic view of where therapist fits into cognitive process

F Systems orientation
F Transcending gender
F Understanding of mediating factors
F Using techniques blindly without filtering process
F Victimisation theory

G Goals for therapy
G Prevention work

H Healing process
H Documentation for comparative measurement of trauma
H Evaluating changes throughout process
H Evaluating degree of trauma at outset
H Expressions of feeling
H Here and now stuff
H Merging healing with preventative work
H Moving at client's pace
H People at different stages
H Referring on
H Working through issues

I Issues for survivors
I Agoraphobia
I Anger
I Conscious awareness
I Distorted thinking
I Eating disorders
I Effects of abuse
I Flight into madness
I Nausea & vomiting
I Phobias, depression, psychosomatic disorders
I Presenting problems
I Relationship problems
I Sexual dysfunction
I Unresolved grief

J Joint tasks
J Developing bonds between female members of family
J Identifying family support
J Identifying potential victims
J Setting up safety network as preventative measures
J Understanding the meaning of abuse in her life

S Supervision/Evaluation
S Need for supervision/consultation with colleagues
S Providing opportunity for evaluation of counsellor

T The Therapeutic task
T Allowing client to choose to continue with particular counsellor
T Allowing client to keep their own construction of reality
T Assessing safety/risk
T Collaborating with client in healing
T Contract to keep safe
T Contract/mandate to proceed

T Contracting for termination
T Countering discouragement
T Creating a context where needs can be met
T Dealing with abuse in supportive manner
T Developing relationship with client
T Documentation for comparative measurement of trauma
T Documenting evidence
T Eating correctly?
T Educative role
T Evaluating changes throughout process
T Evaluating degree of trauma at outset
T Exploration of fit between therapist/client
T Flexible structure of initial interview
T Give clients reading material
T Giving evidence
T Helping client to make informed opinion
T Helping through trauma of abuse
T Increasing conviction rates
T Individual treatment plan
T Isolation?
T Learning from each other/mutuality
T Liaison with GP re medication
T Linking together with client
T Looking at victim impact issues
T Making modifications to maps
T Measure, date and document
T Ongoing assessment with legal process in mind
T Preparing her for giving evidence
T Prevention work
T Providing information for self-monitoring
T Quoting and citing literature
T Rape trauma counselling
T Support systems?
T Systematic recording

X Specific skills and therapist attributes
X Awareness of and overcoming resistance
X Awareness of client's degree of comfort that issue will remain confidential
X Awareness of personal boundaries/transference
X Being non-judgemental
X Bicultural awareness
X Client goal versus therapist goal, knowing to differentiate
X Co-variation of symptoms
X Depression screen, BDI
X Empowering
X Enabling
X Expert opinion
X Hypnosis
X In tune with what your feelings are telling you too/Intuition
X Making sense of transference
X Making the covert, overt
X Moving at client's pace
X Not dismantling defences too quickly

X Objectivity
X Over-involvement
X Power over clients
X Recognising when termination's appropriate
X Recognition of and using client's communication style
X Recognition of limitations of own knowledge
X Referring on
X Respecting client's wishes
X Specific assessment instruments
X Use of genogram
X Using feedback to improve service to clients
X Working empathetically
X Working sensitively

Appendix H

LIST OF CATEGORIES AND CONCEPTS III

A AA Attribution of blame

A Attribution theory

A Awareness of rape mythology

A Awareness of underlying processes and functional aspects of self-blame

A Protective mechanism

A Reattribution of blame

A Reframing

A Understanding they weren't to blame

A Victimisation theory

C AA Conceptualisation of why abuse occurs

C Intergenerational Transmission

C Therapists awareness of patterns of abuse

D AA Demographic

D Police awareness of Psychologists' expertise

D Presented with clients not able to connect symptoms with cause(s)

D Referral Source

F AA Conceptual framework

F Acknowledgement of differential impact of abuse

F Acknowledgement of mens' powerlessness

F Attribution theory

F Awareness of rape mythology

F Awareness of the need for middle ground

F Client goal versus therapist goal, knowing to differentiate

F Client may want to remain in family

F Conceptualizing the abuse in its context

F Counsellor's unresolved personal issues

F Developmental growth and self-actualization model

F Don't differentiate from other counselling work

F Experience as victim being prerequisite
F Feminist focus on women as victims
F Feminist model not healing one (blaming)
F Feminist research
F Fitting combinations of approaches to particular client's needs
F Focus on women as victims
F How abuse is part of social system
F Identifying with the dilemmas of being a male therapist
F Imposing framework versus leading to awareness
F Justification for using certain frameworks
F Keep in mind grief model
F Learning theory
F Limits to any model
F Making changes in the family
F Making sense of transference
F Politicising client toward belief system
F Psychoanalytic concepts
F Psychodynamic
F Quoting and citing literature
F Recognition of causal factors of depression
F Recognizing stages of grief
F Respecting client's wishes
F Rogerian
F Self-healing of the psyche
F Static aspect to parenting
F Systemic view of where therapist fits into cognitive process
F Systems orientation
F Transcending gender
F Understanding of mediating factors
F Using techniques blindly without filtering process
F Victimisation theory

G AA Goals for therapy
G Prevention work

H AA Healing process

H A lot of listening at start
H Blocking
H Claims of successful healing
H Deal with addictive behaviours first
H Documentation for comparative measurement of trauma
H Dreams
H Establishing trust
H Evaluating changes throughout process
H Evaluating degree of trauma at outset
H Expressions of feeling
H Healing just happens and is forever
H Here and now stuff
H Integrating cognitive and the emotional
H Layers of abuse
H Merging healing with preventative work
H Moving at client's pace
H People at different stages
H Professionals get in the way of healing
H Re-experiencing the trauma
H Referring on
H Self-forgiveness
H Stages are counsellor's agendas
H Ventilation
H Working through issues

I AA Issues for survivors

I Affected sexuality
I Affects ability to parent
I Agoraphobia
I Amnesia
I Anger
I Conscious awareness
I Denial of womens' violence
I Distorted thinking
I Eating disorders
I Effects of abuse

I Flight into madness
I Misdirecting sexuality
I Mothers as abusers/cyclic nature
I Nausea & vomiting
I Phobias, depression, psychosomatic disorders
I Pleasure as double bind/stigma
I Presenting problems
I Relationship problems
I Response to abuse as damaging
I Revictimisation
I Safety of child
I Self-blame
I Sexual dysfunction
I Unresolved grief

J AA Joint tasks
J Developing bonds between female members of family
J Identifying family support
J Identifying potential victims
J Setting up safety network as preventative measures
J Understanding the meaning of abuse in her life

M AA Searching for Meaning
M Self-blame

S AA Supervision/Evaluation
S Need for supervision/consultation with colleagues
S Providing opportunity for evaluation of counsellor

T AA The Therapeutic task
T Allowing client to choose to continue with particular counsellor
T Allowing client to keep their own construction of reality
T Assessing safety/risk
T Collaborating with client in healing
T Contract to keep safe
T Contract/mandate to proceed

T Contracting for termination
T Countering discouragement
T Creating a context where needs can be met
T Dealing with abuse in supportive manner
T Developing relationship with client
T Documentation for comparative measurement of trauma
T Documenting evidence
T Eating correctly?
T Educative role
T Evaluating changes throughout process
T Evaluating degree of trauma at outset
T Exploration of fit between therapist/client
T Flexible structure of initial interview
T Give clients reading material
T Giving evidence
T Helping client to make informed opinion
T Helping through trauma of abuse
T Hypnotic trance work
T Increasing conviction rates
T Individual treatment plan
T Isolation?
T Learning from each other/mutuality
T Liaison with GP re medication
T Linking <u>together</u> with client
T Looking at victim impact issues
T Making modifications to maps
T Measure, date and document
T Ongoing assessment with legal process in mind
T Preparing her for giving evidence
T Prevention work
T Providing information for self-monitoring
T Quoting and citing literature
T Rape trauma counselling
T Support systems?
T Systematic recording

X AA Specific skills and therapist attributes

X Asking the right questions

X Awareness of and overcoming resistance

X Awareness of client's degree of comfort that issue will remain confidential

X Awareness of personal boundaries/transference

X Being non-judgemental

X Bicultural awareness

X Bioenergetics

X Clearing out personal agendas

X Client goal versus therapist goal, knowing to differentiate

X Co-variation of symptoms

X Depression screen, BDI

X Empowering

X Enabling

X Expert opinion

X Gestalt

X Hypersensitivity to abuse

X Hypnosis

X Importance of observing minutae

X In tune with what your feelings are telling you too/Intuition

X Making sense of transference

X Making the covert, overt

X Monitoring safety

X Moving at client's pace

X Not dismantling defences too quickly

X Objectivity

X Over-involvement

X Power over clients

X Putting aside bias

X Recognising when termination's appropriate

X Recognition of and using client's communication style

X Recognition of limitations of own knowledge

X Referring on

X Respecting client's wishes

X Specific assessment instruments

X Use of genogram

X Use of metaphor/symbolism
X Using feedback to improve service to clients
X Working empathetically
X Working sensitively
Y Awareness of motivation

Y AA Competency/Accountability

Y Own healing as prerequisite

Z AA Training and Background Experience

Z Clients as teachers
Z My own journey
Z Parenting
Z Self-awareness
Z Specific avoidance of formal training

Appendix I

LIST OF CATEGORIES AND CONCEPTS IV

CATEGORIES AND SUB-CATEGORIES

From abstract to increasingly more concrete and specific concepts

SEXUAL ABUSE KNOWLEDGE BASE

Knowledge of conceptual frameworks other than main therapeutic orientation

Attribution theory - awareness of underlying processes and functional aspects of self-blame

Rape/sexual abuse mythology

Normal/abnormal growth and development

Self-actualization model

Bicultural awareness

Learning theory

Family systems

Psychodynamic theory

Conceptualization of why and how abuse occurs

Intergenerational transmission

Knowledge of issues, dynamics and effects of sexual abuse

Family systems theory

Rape trauma syndrome

Psychosocial development theory

Accomodation syndrome

Grief and loss

Differential impact and mediating factors

Victimization theory

Feminist theory

THERAPIST ATTRIBUTES

Relationship qualities

Empathy

Genuineness
Sensitivity
Unconditional positive regard
Flexibility and creativity
Non-judgemental
Bicultural awareness

Self-awareness

Awareness of personal boundary system and maintaining this
Awareness of motivation to do work and personal agendas
Differentiating own goals from client goals

COMMON ISSUES FOR SURVIVORS

Self-destructive behaviour
Substance abuse
Intimacy/trust (reframe)
Overvaluing men
Powerlessness
Dissociation
Agoraphobia
Amnesia/blocking
Anger
Depression/helplessness
Distorted thinking
Eating disorders
Flight into madness
Nausea and vomiting
Phobias/fears
Psychosomatic disorders
Physical symptoms
Self-concept/body image
Sexual dysfunction
Sexual identity/sexuality
Relationship problems - ambivalence about power
Isolation and stigma
Unresolved grief

Parenting
Self-blame
Searching for meaning

CONCEPTUALIZATION OF HEALING PROCESS

Understanding stages of recovery

Disclosing the secret
- acknowleging abuse, breaking through denial (dangerous if not at client's pace)

Relinquishing guilt, self-blame
- reattribution of blame (often onto mother)
- reframing

Catharsis
- psychodrama, Gestalt, expressive techniques; reintegration techniques

Orphanisation
- attempts to transform family
- giving up hope of affecting change and grieving loss of fantasy of perfect family

Reintegration of child within who has been dissociated

Confronting family members
- metaphorically
- linking with others for support
- establishing relationships elsewhere

Rebuilding a new self
- seeing self and world from new perspective
- victim to survivor; developing sense of autonomy

KNOWLEDGE AND METHODS OF TREATMENT

Assessment skills

- active listening skills
- observation skills
- intuition*
- monitoring safety
- documenting*
- evaluating changes throughout healing process*
- knowing when to refer on

Counselling skills

- developing relationship and establishing trust

- creating counsellor/client 'match'

Teaching skills

- parenting
- decision making
- problem solving
- communication
- assertiveness
- relaxation
- self-defence

teaching and modelling healthy interactions

TRAINING AND DEVELOPMENT

Informal training

- experiential learning; fom clients, life experience, parenting
- experiential training; own self work
- sharing experiences with colleagues
- reading

Formal training

- academic qualifications
- professional qualifications
- attendance at workshops, seminars, training courses

Accountability and Supervision

- consultation with colleagues
- providing opportunity for client evaluation
- using feedback to improve service

Shame and its ramifications

as theoretical construct

- type (quality)
- intensity (quantity)