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A Grounded Theory of the Role of Family in Recovery
and Healing from Child Sexual Abuse

A thesis presented in partial fulfilment of the requirements
for a degree of Master of Arts in Psychology
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Lana Jane Morrison
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ABSTRACT

This thesis presents an exploration of therapist perceptions of the role of family in recovery and healing from Child Sexual Abuse (CSA). Consistent with the individualistic focus of Western society, the international body of literature tends to focus on intrapsychic effects and processes of CSA rather than emphasising the ecological and systemic influences which interact with CSA events. Consistent with the New Zealand Ministry of Health's calls to be more inclusive of family in mental health issues, this investigation attempted to provide new understandings of CSA from an ecological and systemic perspective.

A grounded theory methodology was utilised. This incorporated the analysis of therapist data collected from a combination of focus groups, key informant interviews and a national survey.

The core social process which emerged was "Belonging, Estrangement and Reintegration". This model of recovery and healing in sexually abused families recognises the impact that abuse and neglect has across generations of a family, the evolving nature of their relationships before, during and after the sexual abuse event(s), and the impact these relationships have on the healing journey.

Parallel to the core social process were a number of contextual variables which interacted with therapist practices. These factors influenced how practitioners conceptualise and work with sexually abused families. For the most part, these variables were barriers to including family in the recovery process.

It is hoped that the themes which emerged from this investigation will further inform practice in the field by identifying ways in which therapists can successfully incorporate and address contextual family factors to facilitate recovery and healing. It is also hoped that this investigation will alert organisations to the ecological barriers which therapists encounter and which hinder their ability to incorporate family factors in their practice.

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PART ONE
INTRODUCTION AND LITERATURE REVIEW

CHAPTER ONE: INTRODUCTION

New Zealand leads the world in providing free assessment and treatment for mental injury in survivors of sexual abuse. A wide range of service providers and treatment modalities operating within strict guidelines are currently offered. However with increasing numbers of individuals accessing these services, it is vital that these individuals are able to access services which are in line with the latest understandings of best practice and which are most suited to the New Zealand environment and lifestyles.

A great deal of international literature regarding sexual abuse now exists. However, there is currently little empirical evidence to confirm whether overseas understandings transfer to New Zealand culture. Additionally, despite sexual abuse being an event and an experience, not a psychiatric diagnosis, the majority of literature available focuses on psychopathology of the individual, with little regard to the ecological and systemic factors involved. Quantitative data is emerging regarding interpersonal and family factors relating to sexual abuse (Roberts, O'Connor, Dunn, Golding, & ALSPAC Study Team, 2004; Rumstein-McKean & Hunsley, 2001). However, a number of investigations have produced contradictory results and do little to inform practitioners in the field how to best incorporate family in an intervention.

What is known is that family is a major risk factor in a child becoming sexually abused (Lambie, 1997; Putnam, 2003). A dysfunctional environment makes children vulnerable in that they are not well protected or resourced to firstly arm themselves against sexual offenders and secondly to cope once abuse has occurred. Once abuse has been disclosed, family functionality, low parental distress and overall family support has been demonstrated to assist recovery and promote better treatment outcomes in certain cases (Cohen & Mannarino, 1998, 2000). However, the driving mechanisms behind these factors are not understood. Attachment relationships (Alexander, 1992; Cole & Putnam, 1992) along with environmental transactions (Spaccarelli, 1994) and family processes (Bentovim, 1992; Friedrich, 2002) have been suggested.

Additionally it is debated as to whether it is growing up in a dysfunctional family environment rather than the sexual abuse per se that causes long term problems in individuals (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Nurcombe, 2000). While developmental research has focused a great deal of attention on the importance of a nurturing and loving environment for the development of children, we know little of

the importance of the family for adults generally, let alone sexual abuse survivors. Evidence regarding the intergenerational transmission of sexual abuse and parenting behaviours and family functionality is conflicted also.

Empirical evidence to support the efficacy and effectiveness of family systems based interventions is non-existent. Presently practitioners must rely on case studies and protocols based on treatment pilot schemes which have demonstrated promise in clinical practice (Saunders, Berliner, & Hanson, 2004).

The purpose of this study was to describe the role of the family in recovery and healing from child sexual abuse (CSA). It is hoped this will further understandings which may inform practice by identifying ways in which therapists could successfully incorporate and address family factors in order to facilitate reintegration in families of survivors of CSA.

For a number of reasons, this is a very timely investigation. In practice, therapists have reported their desire to incorporate more systemic approaches when working with sexual abuse survivors (Waldegrave, 1998). Currently, a variety of policies and systems, along with a lack of empirical evidence constrain their actions, but at the same time places therapists in a dilemma, as to deny systemic work with children in particular forces therapists to work in a manner which they perceive to be breaching their professional codes of practice.

New Zealand is a multicultural society and services must cater to those with world views which take a more systemic, holistic perspective to mental health in comparison to traditional psychological approaches which have focused on the individual in isolation (Durie, 1994; Lui, 2006; Waldegrave, 1998). Individuals regardless of ethnicity have the right to receive services which share a more holistic vision.

Finally, this study comes at a time when the New Zealand Ministry of Health is calling for mental health practitioners to include family in assessment, treatment and recovery as a matter of course and not as an exception which is standard current practice (Ministry of Health, 2000). Despite the publication of a guide by the Ministry to assist practitioners in including family, recent reports have indicated that very few health boards have implemented the recommended protocols (Whiteside & Steinberg, 2003).

It is hoped that this investigation, based on clinical practice in New Zealand, will highlight and reinforce the New Zealand Ministry of Health's message about the critical necessity to understand and include family in mental health service provision. It is also

hoped that based on the findings of this investigation, organisations which provide or have a direct impact on mental health services will begin to address logistical and organisational barriers which may be impeding clinicians from taking a more systemic approach to their work.

CHAPTER TWO: INDIVIDUALS AND FAMILIES: THEORETICAL UNDERSTANDINGS

Major contemporary theories of individual and family development are presented in this chapter. The contribution of healthy and competent parenting to the functionality of the family and wellbeing of individual family members is detailed. Family systems theory is presented along with an explanation of how family patterns and processes also contribute to individual health. Finally, it is demonstrated how targeting interventions at a systemic level can be beneficial when individual members present for treatment.

Developmental Psychology

The Traditional Approach

The field of human development explores how humans change over the lifespan. It is believed that throughout the life span, progression through commonly recognised developmental stages occurs in a fairly standardised fashion. For every recognised stage, there are biological, cognitive and social tasks that must be successfully negotiated for psychological health to be realised. Where tasks of a certain developmental stage are not achieved, future development is understood to be compromised and psychopathology could occur as a result (Drewery & Bird, 2004; Hanna & Hargrave, 1997; Simeonsson & Rosenthal, 2001).

Early developmental theories focused on isolated, subcategories of development such as cognitive or social and emotional development alone. These are useful in that they highlight specific tasks one would expect an individual of a certain age to achieve and serve to alert others to complications or difficulties that have arisen when the tasks have not been successfully negotiated. This allows for corrective interventions which will allow interrupted development to resume (Drewery & Bird, 2004; Simeonsson & Rosenthal, 2001).

However, early theories paid little attention to the context in which development occurs which simultaneously impacts individual processes (Drewery & Bird, 2004). They also placed little emphasis on the processes and milestones in the second half of the lifespan (Baltes, 1987; Papalia, Sterns, Feldman, & Camp, 2002) and finally, they

were based on perspectives embedded within Western culture which idealises the individual and the philosophy of autonomy and self realisation (Almeida, Woods, Messineo, & Font, 1998; Durie, 2001a; Waldegrave, 1998).

Contemporary Developmental Perspectives

An entire lifespan perspective is taken in Baltes' (1987) model of development. By investigating developmental processes in old age, development has come to be regarded as less deterministic. Development is viewed as a lifelong process with many potential pathways and outcomes and a process which involves gains, losses and compensations. This model also highlights the influence of the context in which one exists on developmental processes.

Bronfenbrenner's Ecological perspective (1979) describes interlocking structures in one's environment and how development occurs within this context of reciprocal interaction. According to this model, there are four levels of environmental structures which can impact individual development and adaptation. The "Microsystem" consists of an individual's immediate environment. This entails all face to face interactions between the individual and others such as those occurring in the home with family or at work. Extended beyond this level of interaction, are connections which concern the individual, yet require less of one's direct input, if at all. At the most distant level is the "Macrosystem" which describes the culture, along with the belief systems and ideology underlying the overall culture within which one exists. Ecological Systems theory provides a model from which we can conceptualise how an individual is impacted by units, systems and cultures beyond oneself.

Individualistic, Western scientific perspectives have dominated psychological thinking. However, coinciding with the recent emergence of postmodernist thinking, has been an acknowledgement of the legitimacy of knowledge and ways of thinking from more collectivist cultures such as New Zealand Maori and nations of the Pacific Islands (Waldegrave, 1998).

A number of Maori and Pacific Islands frameworks have been proposed which conceptualise people, development and health in an integrated, relational and holistic way. For example, Whare Tapa Wha and Te Wheke (Durie, 1994) reflect Maori perspectives. The Fonofale Model is a general Pacific Island model of health for use in the New Zealand context and the Soifua Maolloina Model as conceptualised by David Lui, is a Samoan specific model of health for those living in New Zealand (Lui, 2006).

Common to these models is the emphasis that psychological and physical health is an interaction of factors beyond individual biology, cognition and emotion. Each essential element of health such as, cultural heritage, a sense of belonging and family relationships, must be present and in balance with the others (Durie, 1994; Lui, 2006).

Maori models, enjoying wider publication and acknowledgment than Pacific Islands models, have received criticism despite convergence with internationally acclaimed systems theory and family psychotherapy on a number of issues. Whilst these models share an appreciation of the interconnectedness of the individual and family, Maori models have also been attacked for being too broad and impractical, lacking in empirical validation and dangerous if individual issues are ignored (Durie, 2001b).

Development within the Family Context

Regardless of the model or combinations of developmental models one supports and is drawn to, it is understood that successful development and psychological well being depends on a complex interaction of the individual and the environment. It also follows, that the family context can be considered one of the most significant, direct and enduring contexts of development and influence across the lifespan (Carter & McGoldrick, 1999).

There is no one correct definition of “family”. Families vary across societies and cultures. For example, whilst Western cultures may tend to idealise notions of the nuclear family as typical, more communal cultures like Maori and those from amongst the Pacific Islands may focus more on the extended family and whanau as typical (Carter & McGoldrick, 1999; Durie, 2001a). Regardless of cultural differences, emotional closeness and acknowledgement of being part of a common household through past and present attachments are common to most family units. Equally, each family unit will serve a combination of economic, physical, social and emotional functions (Gladding, 2002; Strong, DeVault, & Cohen, 2005).

Parenting. Children in particular and by their very nature, are dependent on others. Children require stability, emotional closeness and nurturing from supportive adults within the environment in order to allow their full genetic potential to express itself. Within the parent-child dyad, it is understood that each party exerts a reciprocal influence on the other. The parent’s own developmental history and personality greatly influences the amount of responsiveness and sensitivity provided to the child (Jackson & Leonetti, 2001). Additionally, level of knowledge about child development

determines parent ability to make age appropriate demands and to provide appropriate levels of support (Jackson & Leonetti, 2001).

The health and stability of the family environment is largely influenced by and the responsibility of the adults in the family. This is a huge responsibility given that the family has been identified as one of the three major variables which contribute to the child's resilience to adverse events. Developmental theorists believe the emotional ties and socialisation processes within the unit which instil trust, independence and resourcefulness in the child, act as buffers to adversity experienced (Vernberg & Jacobs, 2001).

Family Development: The Family Life Cycle

The Family Life Cycle (FLC) (Carter & McGoldrick, 1999) attempts to capture how a family typically grows and develops. The lifecycle is likely to pass through three general phases; coupling, expanding (having and raising children) and contracting when children leave home (Gerson, 1995; Gladding, 2002). Each phase has practical, emotional and relational challenges along with potential crises should it fail to cope with these challenges (Gerson, 1995). Transitions between developmental stages are potentially stressful as it requires the whole system to rebalance, redefine and realign their relationships (Carter & McGoldrick, 1999). These activities bring out either creative responses or a stalling of growth for family members (Carter & McGoldrick, 1999; Shields, King, & Wynne, 1995) Any unresolved issues resulting from transitions are considered to be potential obstacles in future family activities and development until they are resolved (Carter & McGoldrick, 1999).

Family and individual lifecycles are not always complementary (Gladding, 2002). Therapists working with families must consider how the individual and the family lifecycle mesh and the ways in which they clash. It is then important to find a way for these interacting life stages to be mutually enhancing (Shields et al., 1995).

The FLC model is a useful conceptual tool for clinicians in that it provides a guide to what a family may be going through at a systemic level according to the phase they find themselves in (Gladding, 2002). It also highlights how family tasks required at each stage may clash with what is occurring to individuals and the community within which the family interacts. The model is also useful in that through examining how the family copes with and handles each developmental transition, much can be learned about a family's coping strategies and functionality (Gerson, 1995).

However, this model is limited in that it is based on the concept of a family being an intact middle class, nuclear family (Gladding, 2002), which potentially limits its applicability to the range of diverse families existing within contemporary society. However, in their defence, Carter and McGoldrick warn against assuming universality of their model (Gerson, 1995).

Development across the Entire Lifespan

Just as individual development in the second half of adulthood had received little attention until recently, family developmental processes in the second half of life have also been neglected (Carter & McGoldrick, 1999; King & Wynne, 2004). The FLC places its emphasis on families rearing children, not on what occurs within the family system in later years. However, slowly emerging is the acknowledgement that family plays a central role in multigenerational relationships in later life and in individual emotional and physical well being in later years (Fingerman & Bermann, 2000; King & Wynne, 2004). Family relationships continue to be important throughout later life for most. Families tend to provide the most direct caregiving assistance, psychological support and social interaction for elderly loved ones. Equally, the importance of sibling relationships can increase over adulthood (Carter & McGoldrick, 1999). “Family integrity” is a concept that has been recently introduced. It highlights the importance of many aspects of family life for older adults. This concept is envisaged to be a normal developmental challenge fundamental to both individual and family life cycles (King & Wynne, 2004) and demonstrates the necessity of exploring family life and its role in later years.

Families as Systems

Family systems theories (FST) are about the collective family unit, rather than individual members (Fingerman & Bermann, 2000). According to FST, members of a family are mutually dependent. When change occurs in either a member or in circumstances that impact the overall system, all aspects of the family and its wellbeing are potentially affected (Gladding, 2002; Strong et al., 2005). The family systems modality differs from traditional individually oriented therapeutic approaches in that the focus is on circular and interactive causation, rather than linear causality and pathology (Sporakowski, 1995). The effect of any action by one person can be magnified or

decreased by the way others respond to it. In either case a circular pattern of causality develops (Gladding, 2002; MacDonald, Lambie, & Simmonds, 1995).

FST views the family as a structure of related parts or subsystems. Each part carries out certain functions, any combination of family members may be regarded as a subsystem, such as the spousal subsystem (the strength of the family unit) or the parent child dyad. An important task of these subsystems is to maintain their boundaries. When the boundaries of separate subsystems blur, the family becomes dysfunctional (Strong et al., 2005). The dynamics of the collective family unit are analysed according to process-oriented and functional activities (Sporakowski, 1995). Patterns in communication, roles, beliefs and rules of the family are explored to understand the processes and activities within the system (Fingerman & Bermann, 2000; Gladding, 2002; Strong et al., 2005).

Despite the potential fluidity and flexibility of the approach, researchers have difficulty agreeing about what FST's principal concepts are. Additionally, FST has been criticised for being too abstract and consequently meaningless for practical application. It is also currently unclear whether family systems premises and insights, despite successful application with dysfunctional families, apply to healthy families as well (Strong et al., 2005).

Family Functioning

There is no agreed upon definition of the ideal, healthy family. Rather the focus in FST research has been on identifying and understanding functional family behaviours. Functional behaviours are expected to vary across the family lifespan depending on the stage, transition experienced and the demands they bring with them. Thus, achieving family health should be viewed as a developmental, situational process (Gladding, 2002)

Homeostasis. In most cases, the goal of the family is to achieve continuity and to remain intact; it seeks equilibrium. Families are resistant to change as it threatens patterns and habits that it is accustomed to and which have previously been effective (Fingerman & Bermann, 2000; Gladding, 2002; Skynner, 1987; Strong et al., 2005). Given the dynamic environment within which a family exists, change is inevitable. A major task of all families is to maintain balance between change and stability. This requires constant effort (Gladding, 2002). Healthy systems are open and self regulating. They use feedback from outside to govern and correct them in order to balance

continuity and change. Dysfunction occurs when feedback loops stop working (Gladding, 2002).

Coping strategies used by the family, impact how it will respond to stress. The Check Mark model describes the process a family goes through in adjusting to a crisis (McCubbin & Patterson, 1983). At the start, when the crisis is active, the family becomes disorganised and functions poorly. Once the crisis has ended, the initial chaos ends also. How well a family recovers depends on the resources they have available and how well they use them. Families that are unable to adjust to new circumstances tend not to make the needed systemic changes to manage. Instead, they become stuck or exacerbate symptoms by repeatedly using the same solutions or by increasing non-productive behaviours (McCubbin & Patterson, 1983).

Family life stressors. Family crises often arise during times of major life cycle transitions (Gerson, 1995). The timing and type of stress encountered can greatly impact the family's ability to handle their current situation. Vertical stressors are historical and passed down from preceding generations. These include, family secrets, such as Uncle Bob sexually abusing your mother, and family attitudes, such as distrust of outsiders. Horizontal stressors are developmental and include what is occurring currently. This may include predictable life cycle transitions, such as having a baby. Others are unpredictable and off time, such as discovering your child has been sexually abused (Carter & McGoldrick, 1999).

A family's ability to respond to stressors is impacted by how it is structured and how well members interact. There is no one ideal family structure or level of functioning. This depends on the stage and task at hand. An appropriate structure and organisation is generally one which allows growth and development of individuals and the family as a whole (Gladding, 2002).

The FST literature describes a number of family structures and the likely outcomes should they be faced with change and/ or challenges. Understanding these dynamics helps the therapist to determine what is happening and what needs to be targeted in an intervention in order to bring about positive change.

Symmetrical and complementary family organisation describes the way in which the heads of the family operate. Problems are likely to occur if these structures are too rigid. A more flexible and adaptable parallel relationship between partners is likely to stand up better to stressors (Gladding, 2002). Centripetal and Centrifugal families (Combrinck-Graham, 1985) looks at families across three generations and places then

on a continuum from being centre focused (centripetal) to the opposite end as disengaged or isolated (centrifugal). In this model, changes in individual and family life cycle stages will call for a pull in one direction or the other in order to cope with the transition(s). It is only when extremes in any style are maintained for a prolonged period that poor family health is likely to result (Gladding, 2002).

The Circumplex Model of family systems (Maynard & Olson, 1987) describes the likely outcomes associated with varying degrees of emotional bonding (cohesion) and flexibility within family structures. Overall, achieving a balance of structure and flexibility along with a balance of separation and connectedness between members appears to enable families to function optimally. Both disengaged (or disconnected) and enmeshed (or overinvolved) families are equally likely to become stressed when faced with challenges, especially if they are at the same time either rigidly or chaotically structured.

However, for all the models described, there are ranges of variability in what is viewed as optimal functioning. This is likely to be influenced by cultural norms (Gladding, 2002).

Family Systems Theory and Child Sexual Abuse

The major implication of systems thinking for sexual abuse is the importance of involving family in the healing of one of the members following sexual abuse. Abuse affects the whole family, and the family's response in turn has a major effect on the person who was abused (MacDonald et al., 1995). This implies that for children who have been sexually abused, concurrent work with their family is essential. For adults, even if they choose not to involve family directly, exploration of family responses to the abuse and how that has affected them is essential. Additionally, consideration must be given to other ways of responding to their family's influence where it has not been helpful (MacDonald et al., 1995).

Systems perspectives also provide an understanding of sub-systems and interactions within the family. Awareness of family subsystems is useful in assessing a client's situation and particular needs such as where the individual gets support, who is closest to whom and where the power lies (MacDonald et al., 1995).

In the past, the notion of circular causality has been misused to suggest that abuse is a two way process in which the survivor shares responsibility. However, using the concept to explain the occurrence of the abuse fails to acknowledge the unequal

power relationship between the survivor and offender and is inappropriate. The principle of circular causality should hence only be used in dealing with the effects of abuse and not for explaining the abuse itself (Geffner, Barrett, & Rossman, 1995; MacDonald et al., 1995).

Summary

An individual evolves and develops through time. An awareness of developmental tasks and phases can help inform interventions especially where difficulty has arisen. Individuals do not exist in a vacuum and their development depends on a complex intermingling of a number of elements such as genetic makeup and immediate environment. Of equal importance is an understanding of what came before and the context in which one has and does exist. Consequently, in the case of CSA, a potentially disruptive experience to healthy development, the family which is interconnected to the self in an integral manner, must be considered to impact the healing process.

Currently, little is empirically known about the role of family for older adults and indeed exploration into the developmental aspects of the adult life cycle is relatively recent.

Family systems theory guides understandings of how families operate and how they become dysfunctional or stuck when facing developmental challenges and life stressors. The FLC model assists those dealing with families to conceptualise some of the challenges a family may be experiencing at the systemic level and can be used to help family members understand the tensions between individual and family tasks.

Families are homeostatic, despite their constantly changing nature. Whilst there are no agreed upon definitions of family health, attention has been given to how functional the family unit is in response to crises and stressful events. Families which are flexible, self regulating and responsive to feedback tend to do better at adjusting to their ever changing realities. Regardless of the stressor, a cohesive family which can access resources in times of stress tends to be able to overcome hurdles with greater ease than a more rigid family structure.

CHAPTER THREE: CHILD SEXUAL ABUSE RESEARCH

Much research has focused on describing the intrapsychic effects of sexual abuse. Given the family focus of this enquiry, this chapter takes a closer look at the less understood and less acknowledged interpersonal impact of CSA. Implications for interpersonal and family relations are then discussed along with the risk factors increasing child vulnerability to CSA. Notably, familial variables have been identified as the greatest contributors to this risk. A discussion will then follow of the protective familial factors which have been identified as assisting in decreasing the negative effects of CSA. In considering the heterogeneity of pathways and outcomes in cases of CSA, caveats regarding conclusions regarding the role of family in CSA, drawn from the research regarding the effects, risk and protective factors are presented. This chapter identifies some of the major difficulties and concerns in capturing the family role in the onset and healing from CSA. The chapter ends with an exploration and critique of some of the hypothesised processes believed to be underlying the phenomenon of CSA.

Interpersonal Effects of Child Sexual Abuse

Little attention has been paid to the specific effects of CSA on interpersonal relationships and the family (Roberts et al., 2004; Rumstein-McKean & Hunsley, 2001). Due to a lack of consistently sound research in this area, it is difficult to come to any definitive conclusions about the effect of CSA on these relationships. However, reliable evidence has emerged indicating that certain interpersonal patterns may result from experiencing CSA (Rumstein-McKean & Hunsley, 2001).

The Couple Relationship

The most convincing evidence of a negative impact of CSA on interpersonal relationships is within the domain of couple relationships. CSA survivors tend to experience more relationship problems generally. These include trust issues and low relationship satisfaction, problems in sexual and marital functioning, and attachment (Cherlin, Burton, Hurt, & Purvin, 2004; Pistorello & Follette, 1998; Rumstein-McKean & Hunsley, 2001). CSA survivors are less likely to be in stable marriages or cohabiting

relationships and instead are more likely to experience a greater number of transitory unions (Cherlin et al., 2004; Roberts et al., 2004). CSA survivors also have a greater likelihood of being revictimised in adulthood (Cherlin et al., 2004; Messman-Moore & Long, 2003; Roodman & Clum, 2001).

Despite reports from clinical case studies, such as Maltas and Shay (1995), of the phenomenon of secondary trauma in partners of CSA victims, there is not yet enough empirical evidence to confirm its existence (Rumstein-McKean & Hunsley, 2001).

The Parent-Child Relationship

The issue of the impact of CSA on parent-child relationships lacks sound research, in that often no comparison groups are used and samples are limited to clinical populations (Rumstein-McKean & Hunsley, 2001). However, certain trends regarding impaired parenting in victims have emerged which require further examination. Mothers are documented to be more likely to neglect their children, have a negative view of themselves as parents, use physical punishment and to have less emotional control in parenting situations (Roberts et al., 2004; Rumstein-McKean & Hunsley, 2001). By implication, this could lead to adjustment problems in off spring (Roberts et al., 2004). Schuetze and Das Eiden (2005) recently demonstrated two potential pathways to increased risk for compromised parenting in CSA survivors. In their investigation negative perceptions of parenting and higher levels of punitive discipline were associated with higher levels of survivor depression and the experience of high levels of current partner violence.

Commentators such as Putnam (2003) and Rumstein-McKean and Hunsley (2001) argue that anecdotal reports of the intergenerational transmission of CSA based on clinical practice are likely to be higher than they actually are. Current empirical research has the rate of intergenerational transmission of abuse generally, as occurring in one third of abused children (Putnam, 2003). Far less is known about rates of transmission of CSA specifically, due to the frequent combining of all forms of abuse and maltreatment into single calculations (Putnam, 2003; Rumstein-McKean & Hunsley, 2001). Possibly transmission may vary between genders, with fathers more likely to abuse their offspring and mothers more likely to fail to protect them (Putnam, 2003).

Implications

Poorly developed and challenging interpersonal behaviours impact others around the individual and are likely to elicit negative responses where the limited or challenging behaviour is not understood. Those particularly close to such individuals, such as partners and children have to adjust and cope with new and challenging elements of the individual's presentation. In accordance with systemic thinking, and the principle of circular causality, the trauma of abuse can be either compounded (a vicious cycle) or minimised (a virtuous cycle) by the reactions of others (MacDonald et al., 1995). By implication, therapeutic interventions must look beyond diagnostic criteria and pathological categories and consider the greater relational and systemic consequences which can occur and interfere with the healing process from CSA.

Family Risk Factors increasing Child Vulnerability for experiencing Child Sexual Abuse

An abundance of empirical evidence exists which consistently identifies familial factors as significantly contributing to a child's risk for experiencing both intra and extra familial CSA (Brock, Mintz, & Good, 1997; Lambie, 1997).

Risk factors include, living in a family situation where there is a single parent. (Avery, Hutchinson, & Whitaker, 2002; Kellogg, 2002; Lambie, 1997; Putnam, 2003) Step fathers are consistently cited as far more likely to abuse than biological fathers (Kellogg, 2002; Lambie, 1997).

Living in a family situation where parent(s) have poor physical and psychological health has been implicated also. A mother's mental health in particular has been cited as a high risk, along with parental substance abuse (Kellogg, 2002; Lambie, 1997; Paredes, Leifer, & Kilbane, 2001; Putnam, 2003; Svedin, Back, & Soderback, 2002; Swanston et al., 2003). An emotionally distant parent, (especially a mother) increases risk for CSA (Avery et al., 2002; Kellogg, 2002; Lambie, 1997). A poor and/ or conflictual relationship between parents, as well as having a difficult relationship with parent(s) also increases a child's risk (Lambie, 1997; Putnam, 2003; Svedin et al., 2002). Additionally, experiencing physical abuse in the family environment is a significant predictor of CSA for both intra and extra familial abuse (Lambie, 1997).

Risk factors are understood to have a cumulative effect. Every extra risk factor the child is exposed to, increases their likelihood of being abused by between 10-20%

(Kellogg, 2002). Family risk factors must therefore be targeted in interventions to ensure abuse does not continue or spread to other family members.

Family Risk Factors increasing Child Psychopathology after Disclosure

Maternal Support

Low maternal support has been associated with cases where the mother is close to the perpetrator. This is most commonly seen in cases of incest (Hecht & Hansen, 2001; Paine & Hansen, 2002). Past or present substance abuse, along with a distant relationship with parents have also been implicated in cases of low maternal support (Paredes et al., 2001).

Parental Distress

High levels of parental distress after the abuse have also been identified as impeding child recovery. The role of “mother” carries with it expectations that she will protect her children and disclosure often leads to maternal feelings of guilt and inadequacy (Hecht & Hansen, 2001; Massat & Lundy, 1998). The more distressed the parent is after disclosure, the less emotionally available they are to the child (Cohen & Mannarino, 1998; Hecht & Hansen, 2001; Paredes et al., 2001). The child’s abuse can also cause distress in a parent who has a history of unresolved trauma relating to past sexual assault (Paredes et al., 2001).

Major Stressors after Disclosure

A number of major stressors and changes for the family unit occur after the public disclosure of CSA, particularly in cases of intrafamilial CSA (Hecht & Hansen, 2001; Massat & Lundy, 1998; Putnam, 2003).

In cases of incest, the mother frequently loses her intimate partner and the stigma of incest disrupts relationships with friends and family for all family members (Massat & Lundy, 1998) as well as increasing family conflict or straining family relationships (Hecht & Hansen, 2001). Where abuse has occurred outside of the family, but the abuser is known to the family, adults have reported having difficulty with trusting others afterwards (Hecht & Hansen, 2001).

Losses of income and gains in additional expenses relating to the associated official processes of CSA investigation and treatment, increases the vulnerability of the

family and stressors placed on it. This in turn impacts the physical and emotional state of the parent who is now required to deal with the situation without a partner (Hecht & Hansen, 2001; Massat & Lundy, 1998). This makes the mother less available to the child(ren), further exacerbating the situation.

Protective Family Factors decreasing Child Vulnerability to the negative effects of Child Sexual Abuse

Family related variables are also implicated in decreasing child vulnerability to the negative effects of CSA and in positively influencing child adjustment after an abuse disclosure. A cohesive, functional family unit with high levels of support and an encouraging parental reaction to disclosure appears to assist in an individual's recovery from CSA (Avery et al., 2002; Hecht & Hansen, 2001; Merrill et al., 2001; Tremblay, Hébert, & Piché, 1999).

A functional family environment has the capacity to build and enhance a child's resilience to later negative life events, this has been proven to have long term effects on adjustment, whether or not the child encounters stressors like CSA (Merrill et al., 2001; Ray & Jackson, 1997; Tremblay et al., 1999). A warm and comforting relationship with a significant parental figure (most commonly only the mother has been examined) appears to have a positive impact on victim adjustment whether or not they have experienced abuse (Paredes et al., 2001; Tremblay et al., 1999). Treatment outcomes for children who have been sexually abused and experiencing PTSD symptoms have been demonstrated to be mediated by levels of family cohesion and adaptability, parental support and levels of parental distress regarding the child's abuse (Cohen & Mannarino, 1998, 2000). Lynskey and Fergusson's (1997) longitudinal study identified lack of parental support in particular as a predictor of psychological symptomatology in 18 year olds who had been sexually abused during childhood.

Methodological Issues in Child Sexual Abuse Research

Interpretations of the implications of identified risk and protective factors must proceed with caution as the area of CSA research is fraught with a number of methodological issues, particularly with regard to identifying the role of the family.

Data collection and assessment of the family environment mostly occurs after CSA is disclosed, hence it is reliant on retrospective reports. Recollections can be distorted either by the amount of time that has elapsed and events that have occurred in between. Confusion and/ or blurring can also occur between the distress and dysfunction that occurred as a result of the CSA (Hecht & Hansen, 2001; Massat & Lundy, 1998), with pre-existing distress occurring as a result of family dysfunction prior to CSA.

CSA has been found to frequently co-occur with other forms of child abuse and maltreatment, in particular, physical abuse (Dong, Anda, Dube, Giles, & Felitti, 2003; Hecht & Hansen, 2001; Higgins & McCabe, 2003; Howes, Cicchetti, Toth, & Rogosch, 2000; Friedrich, 1998; Rosenman & Rodgers, 2004). There is every likelihood that these co-occurring events interact and that neither can be seen as solely responsible for later psychopathology (Hecht & Hansen, 2001; Friedrich, 1998; Merrill et al., 2001; Nurcombe, 2000). Equally, the meaningfulness of conclusions from investigations where CSA alone is researched, despite the child experiencing multiple forms of dysfunction simultaneously, must be questioned (Higgins & McCabe, 2003; Rosenman & Rodgers, 2004).

Additionally, efforts using statistical analysis to determine whether growing up in a dysfunctional family or the sexual abuse per se accounts for later psychological problems in survivors has resulted in conflicting findings, depending on the statistical technique utilised. There is evidence supporting CSA as a causal variable in later dysfunction, such as Fergusson, Horwood and Lynskey (1996), but equally there is evidence supporting family dysfunction as having a causal role in later dysfunction (Gold, Hyman, & Andres-Hyman, 2004; Nash, Husley, Sexton, Harralson, & Lambert, 1993). Other commentators argue current evidence is inconclusive and that both factors are likely to be contributing and are equally good predictors of psychological symptoms (Briere & Elliott, 1993; Brock et al., 1997). Additionally it is argued, the process is hindered by the wide range of definitions used for CSA across studies which makes comparisons between them almost impossible (Brock et al., 1997).

Distortion may also occur depending on who is recalling the information (parent or child). Perceptions and accuracy may depend on developmental stage and memory capabilities for children at the time of abuse (Friedrich, 1998). Using parental reports of child behaviours can be problematic also as a number of studies have shown that abusive parents have negative evaluations of their children and hence these reports may

not match other's ratings and observations of their child's behaviour (Hecht & Hansen, 2001).

Data is only collected from those who end up in the system, where official records exist (police files, agency files etc). More often than not this involves struggling families. Abuse in wealthier families and where victims have not gone on to develop symptoms is not well recorded; hence little is known about it (Hecht & Hansen, 2001). Data collected from extreme cases may skew the literature on the effects to more closely represent the experiences of one sector in society.

Process Models

A number of conceptual models, based on diverse theoretical premises have been proposed to explain why CSA and its associated variables affect people in the negative ways they do (Freeman & Morris, 2001; Hecht & Hansen, 2001; Merrill et al., 2001; Nurcombe, 2000; Nurcombe, Wooding, Marrington, Bickman, & Roberts, 2000). It is hoped that by understanding the underlying processes, interventions can directly target the responsible variables (Freeman & Morris, 2001).

Developmental Models

Developmental models are based on theories which suggest CSA interferes with ongoing development in social and self functioning. These models understand the effects of CSA to be determined by systemic and circular processes, thereby implicating the family environment and relationships within it (Freeman & Morris, 2001).

The Attachment Disruption Model (Alexander, 1992) and Developmental Coping Model (Cole & Putnam, 1992) propose that the long term effects of CSA can be understood within the framework of attachment theory. This theory proposes that interactions between child and caregiver in early life result in the development of internal cognitive models and expectancies about future social relationships which later guide the child's social behaviour (Main, 1996).

The Attachment Disruption model. Alexander's (1992) model suggests that disturbed attachment and family dysfunction precede the onset of CSA. Abusive relationships develop within the family structure where there is a history of insecure attachments for either abusive or nonabusive parents. An insecurely attached parent has difficulty meeting his or her own needs, let alone the needs of others. This sets the stage

for the abuse to occur and for the parent's limited ability to seek help to stop the abuse once it has been discovered (Freeman & Morris, 2001). Consequently, interventions based on this model would target the client's important relationships (partner, parenting and family of origin particularly mother) and work to alter working models of them (Alexander, 1992).

The Developmental Coping model. Cole and Putnam (1992) propose that the experience of incest disturbs primary attachments for a child which in turn interferes with their ability to achieve developmental tasks that lead to a healthy sense of self. As a result, the individual experiences deficiencies in adaptive coping skills (Freeman & Morris, 2001). This model stresses the importance of assessing and then targeting the developmental stage that was interrupted at the onset of abuse along with those which were compromised after it. Additionally, consideration of the supportiveness of the familial context in which the development and experience took place would be considered and addressed where perceived to be hindering progress (Cole & Putnam, 1992).

The Transactional model. Transactional Theory of development serves as the foundation for the Transactional model of CSA (Spaccarelli, 1994). According to this theory, development occurs as a result of two way person-environment interactions that can lead to either health or psychopathology, depending on the quality of interactions. In the transactional model, the effects of CSA are viewed as being determined by multiple, reciprocal transactions between the environment and individuals involved. The abuse is also viewed as potentially impacting not only the individual, but one's family and community also (Spaccarelli, 1994). Hence, family problems before and after the abuse which are associated with increased symptoms may worsen the effects of abuse stress or limit a victim's coping options. Conversely, a warm and supportive relationship with a nonoffending parent may protect children from risks associated with the abuse (Spaccarelli, 1994). This model implies increasing support resources and reducing distress of the actual abuse experience along with stresses that arise from the abuse or its disclosure (Spaccarelli, 1994).

Although based on theoretical premises with a strong research base, these sexual abuse specific models themselves lack empirical support (Freeman & Morris, 2001; Merrill et al., 2001; Nurcombe et al., 2000). Currently for example, there is no empirical evidence specifically on the attachment of sexually abused children (Myers et al., 2002; Nurcombe et al., 2000). Until these models have been specifically tested and

evaluated, the appropriateness of utilising them as a guide to CSA interventions will be debated amongst practitioners and researchers alike.

Summary

CSA has the potential to impact not only how one feels about oneself, but also how one relates with and feels about relationships with others. The most conclusive evidence regarding its negative interpersonal impact points to dynamics within couple relationships. There are also indications that healthy relating with offspring has the potential to be affected too. Additionally, evidence has emerged which places the children of survivors at risk for future abuse.

The need for a more systemic approach to dealing with CSA is demonstrated through the identification of critical familial risk and protective factors surrounding the experience of CSA. The structure and interactions of the family environment are involved in the onset of abuse. As family dysfunction escalates, so does a child's risk for abuse. A supportive, functional family environment prior to the experience of abuse can build resilience in a child and this will assist in recovery from CSA, along with continued support and functionality in the environment after the abuse. If abuse exacerbates family problems by introducing new stressors to the family environment, the new stressors need to be addressed and the family needs to be able to access support, help with coping, and may require new skills to rebalance the system according to their new reality. These family related variables must therefore be identified and targeted in prevention campaigns and in treatment programmes where abuse has occurred.

The largely retrospective nature of this area of research, along with the existence of co-occurring events which interact with the experience of abuse, and the often independent yet parallel events occurring at the same time as the abuse, make it difficult to determine what role the family environment has on later psychopathology. Currently researchers have been unable to agree as empirical evidence exists in favour of each argument.

Attachment and transactional theories provide foundations for the major developmental process models of CSA. Whilst little empirical support currently exists for these conceptualisations, their potential usefulness is in guiding treatment interventions which will consequently focus on combinations of individual and family variables to assist in recovery from abuse.

CHAPTER FOUR: CLINICAL PRACTICE; ASSESSMENT AND TREATMENT

This chapter explores interventions used with children, adolescents and adults who have experienced CSA. The interventions discussed are those which take a systemic approach or at least incorporate systemic elements. On the whole, empirical evidence for the interventions described here is very limited. The majority are supported by a combination of theoretical principles and generic theoretical support, case studies and clinical reports. A number of the approaches also demonstrate their potential usefulness through their widespread clinical acceptance. The lack of attention to more systemic approaches with adult clients is noted, particularly with respect to addressing parental behaviours.

Assessment

There are a variety of ways in which a family system can be assessed and evaluated. Often a number of methods will be utilised throughout treatment in order to determine the abilities and quality and style of interaction within and between members. Varied combinations of clinical interviews and observations, genograms and self report instruments like The Family Adaptability and Cohesion Evaluation Scale (FACES IV) based on the Circumplex Model of family functioning, may be used (Heffer, Lane, & Snyder, 2003).

Whilst systems focused interviews and observations, along with the administration of psychometric instruments require specialised training, the utilisation of a genogram does not. Given the diversity of professions and orientations working with CSA in New Zealand, the genogram is most suited to discussion here.

A genogram is a visual diagram of the family system, going back at least three generations. It is a subjective tool which enables an understanding of the family, its history, significant events and relationships to emerge (McGoldrick, Gerson, & Shellenberger, 1999). It enables the therapist to conceptualise clients and their situations systemically. From it, patterns, structures and emotional systems emerge from both past and present perspectives, indicating nodes for further assessment and potential intervention (McGoldrick et al., 1999). Genograms are currently used in a variety of

ways, being able to code whatever features are considered important, such as abuse histories. They enable a lot of information to be collected in a short timeframe, and in a non threatening way (McGoldrick et al., 1999).

However, the utility of the genogram has been debated amongst FST theorists. The Structural and Strategic schools argue it is more important to focus on the family as it is in the present (McGoldrick et al., 1999). In contrast, others argue it is useful because it helps people tell their story and to reveal family patterns and secrets which may be impacting on current distress and dysfunction (McGoldrick et al., 1999).

Interventions for Children and Adolescents: Individualised Treatments with Parental Components

Child focused interventions which have empirically demonstrated the greatest effects are those which have included a non offending caregiver in the intervention. More specifically, those interventions that go beyond mere provision of information and target actual behavioural change and skill building in the parent have produced the most convincing treatment outcomes (Saunders et al., 2004). Whilst these outcomes are evaluated for each participant, not for the family system as a whole, they highlight the critical importance of involving parents in treatment.

Treatments with Empirical Support

Cognitive behavioural treatments (CBT) with an abuse focus and simultaneous parental involvement have received the most empirical support for PTSD symptom relief in sexually abused children (Cohen & Mannarino, 1998, 2000; Deblinger, Lippman, & Steer, 1999; James & Mennen, 2001; King et al., 2003; King et al., 2000; Myers et al., 2002; Putnam, 2003).

Whilst in King et al (2000), parental involvement with children aged 5 to 17 years of age did not improve outcomes beyond individual treatment, others (Deblinger, Lippman, & Steer, 1996; Deblinger et al., 1999), have demonstrated greater treatment effects lasting up to two years after treatment termination in school age children where parents were involved in the protocol. Another investigation demonstrated the superiority of a CBT group intervention for non offending mothers and their school aged children in reducing their distress and their child's sexual behaviour for up to 3 months after treatment (Stauffer & Deblinger, 1996). Equally, a greater effect for up to

12 months following treatment has been demonstrated with pre school children where there was parental involvement (Cohen & Mannarino, 1996, 1997). For African American girls aged 3 to 13 years, from low income families, greater treatment effects were also demonstrated in pre and post assessment where there was parental involvement (Celano, Hazzard, Webb, & McCall, 1996).

Parental involvement in these interventions has occurred parallel to and conjointly with child therapy. The non offending parent is supported in coping with distress relating to the abuse of their child and learns parent management skills which will enable them to be of maximum support to their child (Cohen & Mannarino, 1998; Deblinger et al., 1999; King et al., 2000). Parent-child work is included to practice new skills and facilitate communication between the two in order to carry the therapeutic work over into their home environment (Deblinger et al., 1999).

Treatments with Clinical Acceptance but without Empirical Support

Play therapy is a commonly used treatment approach for children who have experienced CSA, despite its lack of empirical support compared to the abovementioned CBT based programmes. There are however, studies which demonstrate its usefulness generally. A meta analysis of play therapy for those experiencing emotional difficulties demonstrated effect sizes of .66 (LeBlanc & Ritchie, 2001) and .73 (Ray, Bratton, Rhine, & Jones, 2001). Parental involvement is one of the two key factors identified as increasing treatment effectiveness (LeBlanc & Ritchie, 2001; Ray et al., 2001).

Bonner, Walker and Berliner (1999) compared a CBT based treatment for sexually abused children to a dynamic play based intervention. When caregivers were involved, both approaches were found to be equally effective in reducing sexualised behaviour (Bonner, Walker & Berliner, 1999). In this study, parent involvement included education and skill building particularly in child management and child supportiveness techniques (Bonner, Walker & Berliner, 1999).

Other interventions for children are combinations of CBT and play therapy. Whilst there is currently very limited empirical support for this style of intervention, they are demonstrating promise where parental involvement is a treatment component, as in Copping, Warling, Benner and Woodside (2001).

Systems Based Interventions for Children and Adolescents

For complex cases that present with dynamics and issues beyond discrete symptoms often targeted in individually focused interventions, a more systemic and ecological approach is indicated (Berliner & Elliott, 2002). Given the understanding that familial processes contribute to and maintain a child's vulnerability and risk for sexual abuse, it is not surprising that many children (and their family members) present with numerous issues. However, a search of the literature has failed to uncover systems based interventions for CSA victims and their families which enjoy significant empirical support. As outlined earlier, this may be a result of the difficult nature of such research, due to the complex intermingling of individual and family variables before, during and after the abuse.

Treatments with limited Empirical Support

Both Saunders et al (2004) in their revised guidelines for the treatment of child sexual and physical abuse and Myers et al (2002) in the APSAC handbook on child maltreatment outline Friedrich's Trauma-Focused Integrative-Eclectic Therapy (IET) as a potentially useful intervention in complex, multiple issue cases. Despite there being only one treatment outcome evaluation study performed on the intervention with a limited sample (sexually abused boys only), the intervention has substantial theoretical and clinical support and is accepted in clinical practice (Saunders et al, 2004).

This intervention combines individual, group, and family therapy techniques to target attachment relations, behaviour and emotion regulation and self perceptions (Friedrich, 2002). The goals of the intervention are increasing safety in the home environment, improving the parent-child relationship, and helping the child or teen with negative self perceptions and improving coping strategies (Saunders et al., 2004). Parents learn through psychoeducation and a combination of behavioural and cognitive techniques how to understand their children better. They also obtain appropriate parenting and self management skills in order to develop confidence as a parent (Friedrich, 2002; Saunders et al., 2004).

Treatments with some Clinical Acceptance but without Empirical Support

Also available are a small number of clinically based treatment protocols, pilot schemes and case studies describing sexual abuse work with children and families

which take a systemic approach. These interventions are mostly utilised with families where incest has occurred. They generally offer a range of modalities beginning with individual treatments for a variety of members, possibly followed by marital counselling and finally conjoint family work if the abusing parent is willing to take responsibility for the abuse. Simultaneously, family members may also attend groups and receive support services as an adjunct to treatment (Geffner et al., 1995)

Family Resolution Therapy (FRT) has been described as a reasonable intervention which currently has some use in clinical practice and some clinical literature to support its usefulness in cases where sexual or physical abuse has occurred (Saunders et al., 2004). This intervention aims to develop safety for children and where possible, to maintain some type of relationship with their abusive parent(s). These processes occur later in treatment and are comprised of a combination of individual, group and family therapy for all non offending family members and where and when possible a structured and supported protocol around contact between the victim and offender.

FRT has a strong theoretical basis drawing from family systems theory, family and child development, social learning and relapse prevention and has available a treatment manual. However, no treatment outcome studies have been performed using FRT in order to validate it as an appropriate and empirically supported choice of intervention (Saunders et al., 2004).

The “Trauma Organised System” (Bentovim, 1992, 1998) perspective provides a basis for intervening in cases of incest with the whole family requiring attention. This perspective bases its understanding of the onset, maintenance and effects of incest on attachment theory, victimising actions and traumatic sexualisation as it occurs within a broader social context.

In this model, members of the family are organised into self maintaining systems through secrecy, silence, and denial, which has the effect of the abusive events being repeated and reinforced (Bentovim, 1992, 1998). This model understands incest as being an issue bigger than any individual element within the system. The model provides a conceptualisation which enables therapists to target all interacting aspects of the abuse environment, not merely isolated elements. The model indicates that when working with incestuous families one must work with and integrate individuals, groups and families so the trauma organised systems can talk about the previously untalkable

and allow appropriate conversations to develop between family members so they can function on a new and healthier level (Bentovim, 1998).

This model has been utilised in intervention programmes with reported success. Hyde, Bentovim and Monck (1995) describe a study of 47 children ranging in age between 4 to 16 who had been sexually abused by a close family member or resident. Families were randomly assigned to either family treatment alone or family treatment with group treatment for children and their families. Treatment targets were to firstly strengthen relationships between the child and the non offending caregiver and then target individual, marital and family issues. Group work was age and stage appropriate. Clinicians rated pre and 12 month post treatment of achievement of 12 family goals and children and mothers completed standardised measures of behaviour and mental states pre and post intervention also.

The study revealed mixed results. There were no statistically significant differences in outcome between the two groups yet clinical ratings implied that the group work participants made larger gains than those who attended family treatment alone. However, caution must be taken regarding assumptions of the program's effectiveness given the small sample size, the sample bias of participants from predominantly lower socio economic standing, the clinicians awareness of the program type that participants were in, and the lack of immediate post intervention assessment to name but a few limitations (Hyde et al., 1995).

Another multi-modal treatment programme for incest victims and their families is outlined in Bagley and La Chance (2000). Their work was based on Giarretto's (1982) Child Sexual Abuse Treatment Program. This programme targeted adolescent victims, and entailed individual counselling for the victim, mother and offending father, then dyadic counselling for mother and daughter, and group counselling for separate groups of female victims, mothers and father offenders, followed in some cases by dyadic counselling for mothers and fathers and groups containing the whole family when the father was to be reintegrated. Overall it was considered successful, despite the 5% within family reabuse rate of treated victims. Conclusions regarding the effect of the programme are limited due to its quasi experimental nature, high drop out rate and sample bias where the most challenging cases are probably not referred.

Sibling incest

Sibling incest presents additional challenges to therapists in that the question of whether the sibling perpetrator should remain in the family environment is considered in certain cases (Carter & Dalen, 1998). Clinical case studies such as those presented by Carter and Dalen (1998), Haskins (2003) and Price (2004) outline processes for family reunification highlighting family systems frameworks for conceptualising these families and consequent work with them, including methods to determine whether family preservation is likely.

Adolescents

There is an overall trend of lack of well controlled treatment studies for this group. Adolescents tend to be included in studies with children as young as 3 years of age, despite the great developmental differences in individual and family life cycles for these age groups (Friedrich, 1998; Hecht, Chaffin, Bonner, Worley, & Lawson, 2002).

It is argued that as adolescents mature, their symptoms become similar to adults and so abuse focused therapy (AFT) is the dominant treatment approach for adolescents. However, cognitive behavioural treatments with an abuse focus and simultaneous parental involvement such as those described above for the treatment of PTSD for sexually abused children has been helpful for this age group also (Hecht et al., 2002).

Regardless of the treatment modality, one of the best predictors of recovery for adolescents is the belief or support of the nonoffending parents and so where possible should be actively mobilised by the therapist (Hecht et al., 2002). Often it is unclear in cases of incest whether the symptoms in the adolescent are a result of the abuse or of general family pathology and so involving parents assists in determining and resolving these issues (Hecht et al., 2002).

Australasian Perspectives and Techniques

There is a dearth of Australasian research and treatment information with a family focus for treating cases of CSA. Available are occasional case reports highlighting specific techniques based on clinical experience and practice. For example, Foote (1999) provides treatment guidelines for cases of incest from a Milan / Feminist family treatment perspective which highlights the importance of framing individual

recovery within a protective family network for which all family members need to be included. Another example is Miller and Dwyer (1997) who based on clinical experience in New Zealand, outline the importance of enhancing the mother-daughter relationship after the experience of incest.

Love and Whittaker's (1997) edited collection of practice issues for clinical and applied psychologists in New Zealand, provides two chapters on assessment issues relating to child abuse, neglect and CSA. More detailed still is MacDonald, Lambie and Simmonds (1995) clinician's guide for treating sexual abuse. Their recommendations are founded on systems and feminist theory and the structural school of family therapy and clinical experience within the New Zealand context.

Limitations

There is limited empirical data regarding treatment efficacy and effectiveness, whether it be individual treatments with a systemic focus or systemic whole family treatment programmes for these age groups (James & Mennen, 2001). Problems such as inconsistent definitions of abuse, small sample sizes with large age ranges (Friedrich, 1998) and limited follow up make the studies difficult to evaluate (Nurcombe et al., 2000). Equally, even within empirically rigorous studies, exact treatment effects for these populations are difficult to determine given the often complex family context (with multiple abuses and stresses) that precede and occur during and after treatment (Finkelhor & Berliner, 1995; Hyde et al., 1995; Nurcombe et al., 2000). Current investigative techniques are unable to determine and capture these variables.

Treatment for Young, Middle and Older Adults

The majority of initial disclosures of CSA are made in adulthood (Higgins & McCabe, 2003). For many, help seeking is triggered by the transition into a new developmental lifecycle stage, such as having their first child (Trute, Docking, & Hiebert-Murphy, 2001). It is often at this point that individuals, their partners, children and extended family members along with therapists really begin to deal with the long term effects of CSA. There are a number of therapeutic approaches that are currently utilised with these individuals and to a far lesser degree with members of their families. However, the effectiveness of these approaches is not well known or understood.

Individual Treatments

Treatment outcomes for individual abuse focused therapy (AFT) are evaluated at the individual level based on symptom relief. Given the systemic focus of this investigation, only a brief introduction of the most common individual approaches for female adult survivors is outlined.

Treatments for adult survivors is predominantly delivered in individual treatment or group treatment for individuals, with the focus on symptom relief and attending to the sexual abuse as an “individual” issue (Reid, Wampler, & Taylor, 1996). Within the latter stages of an AFT approach, when the individual can cope with facing the trauma and regulate their emotion associated with it, interpersonal / relational work may be incorporated as is outlined in the different abuse focused approaches in Cloitre, Koenen, Cohen, and Han (2002), Linchan (1993) and McGregor (1999).

Marital / Couples Approaches

The couple relationship has been consistently demonstrated to be impacted by CSA (Rumstein-McKean & Hunsley, 2001). Yet, research has paid little attention to how abuse related issues are played out in these relationships and to what role partners can play in recovery and healing (Reid et al., 1996).

Considering the combination of distress of a survivor upon disclosing the abuse to a partner and their potential prior interpersonal and sexual difficulties, the couple relationship is very likely to encounter difficulty. This accentuates the importance of involvement of a partner in some stages of treatment at least (Pistorello & Follette, 1998; Reid et al., 1996; Trute et al., 2001).

In a qualitative investigation regarding their thoughts about therapy for survivors, 17 male partners of sexual abuse survivors argued that they too are affected by the abuse yet they are commonly excluded from treatment modalities provided to their partners and are unsure how to deal with the changes they see in their partners whilst going through therapy (Reid et al., 1996). Commonly raised couple issues included communication patterns, the sexual relationship, physical contact confusion and extended family relationships (Reid et al., 1996).

Commonly seen in clinical practice, dysfunctional patterns from the survivor’s abusive family of origin are carried over into the couple relationship (Trute et al., 2001). Additionally, the partner can inadvertently become the “abuser” through physical and

intimate touch which may trigger flashbacks of the abuse and leave both parties confused and hurt (Maltas & Shay, 1995; Trute et al., 2001). These matters can only be attended to thoroughly with both parties present in therapy.

A small comparative case study analysis with brief conjoint couples therapy for women survivors in addiction recovery with their partners was described in Trute, Docking and Hiebert-Murphy (2001). Improvements were found in communication and mutual problem solving, along with women feeling an increase in support from their male partners, while males experienced a decrease in negative emotional atmosphere in the relationship. Treatment comprised a mix of structural, solution focused, and transgenerational methods which were applied as the therapist thought appropriate to each couple's needs. Assessment, occurring at the beginning of treatment and on average 8 months after treatment, included standardised clinical measures along with client and therapist interviews to determine treatment outcomes. Given the small sample size of 8 couples, the investigation's qualitative nature, and the flexible application of the actual intervention, assumptions about the effects of the treatment programme are indeed limited to this sample alone but do indicate promise.

Secondary traumatisation. Another reason for considering including partners is where the clinically observed phenomenon of secondary traumatisation or "trauma contagion" may be present. This phenomenon can potentially increase confusion and unhappiness in the couple relationship and where possible should be addressed in conjoint work with the survivor (Maltas & Shay, 1995). Through their successful work in an outpatient clinical setting, guidelines for managing and treating such cases have been outlined by Maltas and Shay (1995). However, these guidelines and assumptions are based on a small sample and have not been tested empirically so the transferability of these findings to the greater population are limited.

Parenting

Attachment relationships with children, parenting ability and parenting attitudes have all been implicated theoretically (Alexander, 1992; Cole & Putnam, 1992; Spaccarelli, 1994) and empirically (Putnam, 2003; Roberts et al., 2004; Rumstein-McKean & Hunsley, 2001; Schuetze & Das Eiden, 2005) as being potentially compromised by the experience of CSA and by the context within which it occurred.

Whilst parenting instruction and support groups may be available where one's own child has been abused, for those whose children have not experienced abuse,

parenting may still need to be addressed in order to prevent CSA happening to the next generation. There is no literature available which discusses parenting programmes or modules within an entire treatment package for adult CSA survivors completing individual therapy although generic parenting models have been designed to increase effectiveness of parenting skills in cases of abuse and family violence as described in Jackson and Leonetti (2001), Myers et al (2002) and Saunders et al (2004). An investment in parenting skills for adult survivors may be warranted given the research indicating the negative impact CSA has on parent-child relationships, particularly where survivors are experiencing high levels of psychopathology and partner violence (Roberts et al., 2004; Rumstein-McKean & Hunsley, 2001; Schuetze & Das Eiden 2005).

Family of Origin Work

Family of origin work has been described as a technique which may be used with adult survivors in individual therapy (Pearson, 1994). The goal of this technique is to help individuals gain a better awareness and understanding of their past and present relationships and interactions with family members. These techniques can overlap with family therapy interventions. However, in individual therapy these are used to facilitate individual growth, not growth of their families per se. However, it could be argued that by intervening at an individual level, interactions with others in the system will be altered and could affect change. This technique has only been described in the conceptual literature. There is no evidence to determine whether this specific technique relates to treatment outcomes (Pearson, 1994).

Older Adults

Older adults are a growing sector in Western populations who are increasingly accessing services to deal with their mental health issues. As such it is imperative that therapists become familiar with the needs of the current aged cohort (Carter & McGoldrick, 1999). Little is written about treatments designed for older adults who have experienced CSA, and no empirical research supporting the use of an intervention with older adults was found in the present literature search. Clinical practice, however, informs us that unresolved abuse and associated dysfunction may have overwhelmed the older woman and impacted her relationships for many decades. Spouses, children

and extended family members may have all directly or indirectly felt the effects of the abuse (McInnis-Dittrich, 1996).

An adapted life-review therapy for elderly female survivors of CSA is described in McInnis-Dittrich's (1996) review of four clinical case studies. Particularly salient to this age group is the need to confront members of their family of origin in order to release anger and hurt, to resolve their trauma and to move forward developmentally. This process may include holding a family session for direct confrontation with the perpetrator or silent family members. Where the perpetrator and enablers have passed away, "confrontation" can still occur but in individual treatment (McInnis-Dittrich, 1996).

Summary

Treatments for children and adolescents are frequently examined together, despite stark developmental differences between the ages and differing environmental pressures and requirements on different age groups. Currently CBT abuse focused approaches with the inclusion of the non offending parent appear to demonstrate the greatest efficacy for PTSD symptom relief. Where the individual presents with multiple, complex and interrelated issues the need for a more systemic approach has been indicated, along with the recognition that issues beyond the abuse itself need to be addressed in order to begin the healing process. A great deal is still not known regarding what is the best treatment, for whom, and under what circumstances.

The literature on treating adult survivors of sexual abuse from a systemic perspective is scarce. Family and couples work is hardly mentioned in the literature as a legitimate and helpful means of assisting adult survivor's recovery from CSA. On the one hand, given that symptom relief is obtained in individualised approaches it could be concluded that the role of family in recovery in adulthood is not as important nor as essential as in childhood due to the lesser reliance (physically, emotionally and materially) on family for survival. Conversely, given the lack of emphasis placed on the second half of individual and family lifecycles until recently, perhaps we currently do not know how treatment outcomes could be impacted by more systemic approaches for adults. Equally, given the dominance of the medical model and individually focused approaches in mental health disciplines such as psychiatry, psychology and counselling, it is not surprising that systemic perspectives are rare, or given less consideration, being

perceived to be on the fringes of conventional therapy. Greater sophistication of our understandings is required and will only be gained through future investigations.

PART TWO
METHODOLOGY

CHAPTER FIVE: GROUNDED THEORY

Grounded theory (GT) as a research style will be discussed in this chapter. The section begins with an analysis of the theoretical and paradigmatic underpinnings of the GT approach utilised in this study. Next, a rationale is provided for the choice of method, along with an outline of how the method is typically implemented. The chapter ends with an outline of the criteria used to guide an evaluation of the rigour of a GT investigation.

Grounded Theory as a Methodology

Underlying Assumptions

This study incorporated a modern formulation of GT methodology, which is underpinned by a constructivist research paradigm and guided by the theory of Symbolic Interactionism. The constructivist research paradigm assumes there are multiple, equally valid realities which are constructed by the individual. The researcher is not objective and their subjectivities are part of the end product. The overarching goal of this paradigm is to understand “lived experiences” from the point of view of those who live it (Ponterotto, 2005). Symbolic Interactionism proposes that individuals construct their reality and notions of self through on going social interactions in society and with other human beings (Fassinger, 2005; Jeon, 2004). Attempts to understand people’s lived experience from their own point of view is consequently performed through the analysis of participant action and interaction in their natural, real world context (Jeon, 2004). GT is a qualitative methodology which can be used to achieve such aims.

The goal of GT is to develop a theory based on participant understandings, which explains the underlying processes of their lived experiences regarding the phenomenon of interest (Chamberlain, 1999; Fassinger, 2005; Jeon, 2004; Strauss & Corbin, 1998). The goal of this investigation was to develop a localised theory which could inform practice in the field regarding the ways through which therapists can and do work successfully with families of CSA victims. The decision to use a GT methodology in this investigation was determined firstly by the researcher’s inclination toward a naturalistic research design and discovery oriented investigation. Secondly, the

nature of the research question lent itself toward GT in that the investigation was interested in the lived experience, the thoughts and feelings of therapists who work or have worked in the field of CSA in New Zealand. Currently little localised knowledge about common New Zealand practices, difficulties and successes regarding this phenomenon is recorded. As documented in the literature review, quantitative methods utilised to date have been unable to capture succinctly the role of the family. So it was considered desirable by the researcher to discover an explanatory framework, derived from an alternative paradigm, which would provide clues as to ways to look further. Finally, GT and its underlying assumptions go beyond general psychology's tradition of focusing solely on the individual (Chamberlain, 1999), and incorporate social context in the end product. GT allows for an ecological perspective which is desirable when considering the role of family.

GT has been described as more a style of research with distinct features, than a strict procedure (Chamberlain, 1999; Strauss, 1987). Despite there being no right or wrong way to conduct a GT analysis, there are clear guidelines as to how to conduct an investigation according to the assumptions of the overriding research paradigm. The main features, regardless of paradigm, include theoretical sampling, constant comparative methods, coding, memo writing and theory generation which are interlinked and occur simultaneously (Jeon, 2004; Pidgeon & Henwood, 1997).

Preparing and Collecting Data

Human experience is analysed in GT, and so data is selected on the basis of its ability to provide significant accounts of that experience (Polkinghorne, 2005). Participants are selected purposively on the basis of their ability to facilitate understanding of the experience. Narratives from transcribed interviews, transcriptions of observational data and documents (eg. field notes) are the major sources of data, especially in the initial phases of the investigation (Fassinger, 2005; Polkinghorne, 2005).

The style of sampling used depends on the goals of the study, the question of interest, phase in the investigation and practical limitations of the overall project. Theoretical sampling is a process where after initial accounts are collected and analysed, new and more focused data is collected based on its relevance to the emerging theory (Fassinger, 2005; Pidgeon & Henwood, 1997; Polkinghorne, 2005). Theoretical sampling can range from a structured interview with a new or past participant to

returning to existing data to investigate specific incidents and events. Other sources of data in this process include participant feedback, researcher memos and the existing research literature (Fassinger, 2005). Within GT is it debated when to start using theoretical sampling in the process. Contemporary constructivist approaches to GT start with purposeful sampling (initial data is obtained from information rich participants) and then moves to theoretical sampling as required to verify the emerging underlying process (Fassinger, 2005).

Data Analysis

The GT researcher must dig below the surface of participants' accounts, to bring up the underlying process (Polkinghorne, 2005). This begins with open coding, where initial raw data is broken into meaningful units, concepts, patterns and themes (Fassinger, 2005).

The second level of analysis involves axial coding. Here, relationships among categories are explored, and organised in a way that describes and incorporates interrelationships between smaller, yet related categories (Fassinger, 2005). This is achieved through constant comparative analysis; comparisons are made between the different pieces of data (eg. participants' experiences, existing literature and researcher's reflexive documentation) in order to identify similarities and differences. At this point, tentative hypotheses about the underlying processes may emerge (Pidgeon & Henwood, 1997).

The goal of GT is to create a theory that coherently explains the phenomenon under investigation, given the varied constructs supporting it and the context in which it was derived (Fassinger, 2005). The final step toward achieving this goal is the process of selective coding. Here, the researcher looks for a central or core category that amalgamates all other categories into one explanatory theory (Fassinger, 2005). Like the previous stages, the final theory emerges through constant comparison.

The researcher keeps including and collecting data until "saturation" is reached. This occurs when no new information is being discovered about the categories, their properties or their interrelationships (Fassinger, 2005).

Decisions regarding data collection, coding and theory development are guided by the researcher's introspection and active engagement with the data. This is demonstrated through writing memos, which are completed throughout the entire analysis and become part of the recorded data. Memos can be about anything; lurking

suspicions, assumptions and choices of the researcher for example. Their ultimate purpose is to make the researcher's interpretations obvious to those examining the work (Fassinger, 2005).

Criteria for Evaluation

The standards by which GT should be evaluated have been debated. The result is a variety of recommendations as to what constitutes proper practice. The validity of qualitative research generally is assessed based on the paradigmatic underpinnings of the research and standards of the discipline involved in the research (Morrow, 2005). Variation and debate within grounded theory regarding the goodness and rigour of the research is a reflection of the tensions associated with these two factors.

Where a constructivist paradigm has guided the psychological investigation, Pidgeon and Henwood's (1997) guidelines for evaluating good practice are suited. The following practices will illustrate the ways in which the rigour of the research piece were upheld and maintained.

Documentation spanning the entire research process must be provided. Detail of what was done, why and when should be available in order to be open to an external audit. In particular, documentation, like a researcher's journal, that sheds light on the researcher's values and interests and methodological decisions and rationales will achieve this (Pidgeon & Henwood, 1997). Data regarding the contextual features of the study should be provided to determine how far the findings can be transferred beyond the context of the study (Pidgeon & Henwood, 1997).

The study will produce an end theory with subordinate categories that fit the data provided by participants. The validity of the theory is made visible through writing definitions of key concepts and summarising reasons why phenomena have been labelled in certain ways. Memos are useful in documenting the researcher's connections and abstractions. This transparency allows for an evaluation of the processes by which the data was transformed and how closely it matched the data (Pidgeon & Henwood, 1997). Theoretical sampling is a means of challenging assumptions and categories made by the researcher as coding and analysis proceeds. The use of this technique enables the researcher to modify the emerging theory and prevent closing off other options regarding the theory too soon (Pidgeon & Henwood, 1997).

The end theory needs to be well integrated across the levels of increased abstraction so that each level is clearly related and interlinked. The theory needs to be

abstract and diverse enough to explain the entire problem domain. (Pidgeon & Henwood, 1997). Ultimately, if the theory is judged to be persuasive and believable by those involved in the substantive area, including in some cases participants, this can be used as evidence for the validity of the research (Pidgeon & Henwood, 1997).

Summary

Grounded theory as a methodology was introduced in this chapter. This was considered a suitable methodology for this investigation because of its underlying assumptions which enable rich and naturalistic data to emerge regarding the topic under investigation. The varied and interconnected phases of data collection and analysis were also outlined, along with the criteria by which the emergent core social process should be evaluated.

CHAPTER SIX: THE PRESENT STUDY

This investigation has occurred as part of the larger research programme entitled “Raranga Whatumanawa”, undertaken by Massey School of Psychology. This project was commissioned by New Zealand’s Accident Compensation Corporation (ACC) with the aim to develop practice guidelines for the effective and safe treatment of sexual abuse and/ or sexual assault.

Participants

A diverse group of therapists who either currently or have in the past, provided services to survivors of CSA, voluntarily participated in this study. The therapists varied across types of professional orientation, amount of experience, culture, age, gender, nationality and locality (including rural and urban, North and South Islands).

A total of forty three therapists, from various locations throughout New Zealand, participated in focus groups and key informant interviews. Of those, thirty five therapists participated in focus groups, as described in Table 1 below and eight therapists participated in key informant interviews, as described in Table 2 below. Therapists in the focus groups and key informant interviews primarily had counselling backgrounds, and their theoretical frameworks for sexual abuse arose from training they had independently sought.

Table 1.

Focus Group Participants Location and Topic of Discussion

Location	Number of Therapists	Number of Participant Observers	Topic
Invercargill	5	2	General
Nelson	5	3	General
New Plymouth	4	2	General
Whakatane	5	2	General
Christchurch	3	2	Men
Wellington	4	2	Child & Adolescent
Palmerston North	3	2	Maori
Auckland	6	2	Pacific Islands

Table 2.

Key Informant Interviews Location and Topic of Discussion

Location	Number of Therapists	Topic
Paraparaumu	1	Maori
Palmerston North	1	Child and Adolescents
Palmerston North	2	MH / SA
Palmerston North	1	CAFS
Palmerston North	1	Sex therapy
Whanganui	1	Pakeha working with Maori
Auckland	1	Older Adults and Sexuality

One hundred and sixty six practitioners completed the national survey. Of those that completed the survey, 44.9% identified as Counsellors, 38.5% as Psychotherapists and 6.3% as Psychologists.

Selection Criteria

Participation in the focus groups was open to those who identified as working with sexual abuse survivors currently and/ or in the past. Key informants were selected for interview where it was identified that further information specific to the role of family was available. The survey was completed by participants who were currently registered as an ACC sensitive claims practitioner.

Recruitment

A combination of recruitment methods were employed between the 1st of February to mid November 2005. Initially, public announcements and advertisements describing the project were made. Next, invitations to attend a local road show between the 21st of February to the 10th of March 2005 were issued via email and telephone to ACC registered sensitive claims therapists across the country. The road show was presented by the Massey research team in order to outline the project and answer any questions therapists had about it. This was necessary as the project had information which indicated large numbers of potential participants intended not to complete the survey due to prior dissatisfaction with the lack of release of a previous study commissioned by ACC.

Following the road show, where therapist questions were answered and fears alleviated, the national survey and accompanying information sheet regarding the

survey and project (see Appendices A and B) were sent out exclusively to ACC registered therapists. Then, as well as invitations issued to those who attended the road shows, people filling out the survey were also encouraged to reply and attend focus groups. From there, the project utilised a snowballing technique where word of mouth between road show attendees and their colleagues, along with survey participants, encouraged any other therapists with clinical experience dealing with sexual abuse to become involved. Finally, all focus groups were conducted over the next three months and key informant interviews were conducted as required up until mid November.

Sampling Procedures

Purposive sampling of general focus group transcripts from the greater project was initially implemented where leaders of the groups identified that material regarding the role of family was covered. Next, transcripts from topic specific focus groups identified as relevant to the area of “family” were targeted. The second stage of sampling entailed theoretical sampling by interviewing key informants identified as having further and extended detail specific to the theme of the family role in recovery and healing from CSA. This data was used in order to clarify existing information and to fill in gaps where questions remained. Sampling at each stage continued until “saturation” had been reached, where no new themes or information was felt to emerge.

Materials

Each focus group participant and key informant received an information sheet regarding the research project, its purpose and contact details of the greater project (see Appendix C). In addition, all ACC registered sensitive claims practitioners, received a survey by mail.

An invitation to attend a focus group was issued to road show attendees, along with a form indicating consent to participate (provided in Appendix D) which once read and completed was handed in prior to or on the night of the focus group or interview. Following participation in a focus group or key informant interview, the participant was provided with an annotated bibliography of New Zealand research on sexual abuse as thanks for their time and effort. A small stipend was given to participants to help cover the cost of travel to the groups and interviews. A “thank you” for participating letter,

along with information regarding where to access feedback was also sent to participants (see Appendix E).

Data Collection Procedures

Focus Groups

Semi structured focus groups of a maximum of 10 people, lasting up to approximately 2 hours, were conducted to collect information regarding therapist perspectives of symptoms, assessment and treatment of sexual abuse. Consent forms were signed by all participants before proceeding. A leader and co-leader, of at least one of whom was a registered practitioner conducted the focus groups.

Each group began with introductions, overview of group protocol and aims of the group. Broad subject areas to be covered were introduced before launching into the general discussion. Groups ended with participants being able to ask final questions for clarification and make additional comments regarding areas they felt were important.

Research team guidelines and possible discussion questions covering the broad subject areas to be addressed were issued to each group leader and assistant (refer to Appendix F).

Key Informant Interviews

The key informant interviews were semi structured and loosely followed the focus group protocol described above. Additionally, they were guided by the researcher's aims (to clarify issues from focus group transcripts and to fill in gaps where questions remained unanswered) and the informant's preference (either to be asked specific questions or to offer what information they wanted in any order). This protocol was negotiated throughout the interview with a check at the end that the informant had discussed all they had hoped to.

Transcripts

All data for the focus groups and key informant interviews was collected on tape recorder and transcribed by various independent contractors to the greater project. All transcribers signed confidentiality agreements to protect the integrity of the data. Transcripts included every statement made in the group and interviews. Transcripts were available for review where requested by key informants, but not to focus group

participants as the transcript was the sum product of the group and as such could not be amended by an individual.

To add context to the transcripts, process notes were taken by assistants and leaders in various focus groups. In order to capture the overall process of the focus groups attention was paid to; seating, who and how the group was run, emotional and or debated issues and any problems encountered, wherever possible.

Transcripts and survey data were imported into the computerised software package Qualitative Solutions and Research (QSR) “NVivo” version 2.0. This was utilised to assist in managing and analysing the data body.

Practitioner Survey

Qualitative material from Section B of the national survey of ACC approved Sensitive Claim Practitioners was incorporated. In total, of the 695 surveys issued to practitioners, 166 (24%) returned the surveys. This return rate is within accepted guidelines. The surveys were sent out within three weeks after the road show, in order to maintain the project’s momentum while interest was still high.

Ethics

The structure and content of the practitioner survey, focus groups and key informant interviews, along with matters regarding the confidentiality of data in tapes and transcripts, adhere to and meet the approval of Massey University Ethics Committee and of the New Zealand Psychological Society’s Code of Ethics.

Data Analysis

Data was analysed using a constructivist approach to grounded theory. The rationale for its use in this project is outlined above in Chapter Five. The early stages of the analysis utilised data from general focus groups. The focus of this stage was to identify general patterns and themes. Next, the analysis of focus group and survey data honed in on data specific to the role of family. This data served to further clarify the initial patterns and themes and to identify the broader categories which may overarch them. This was achieved through open and axial coding. Data from key informants was introduced to provide further instances for comparison against earlier data, fill in gaps and cultivate the emerging theory. Memos were used and reviewed throughout the

process. This process assisted the shifting and combining of main categories into a more abstract, core category at the tail end of the overall analysis.

Tightening of categories and themes was also assisted by utilising a series of questions as suggested by Strauss and Corbin (1998) and comparisons with current literature to ensure theoretical sensitivity of the underlying process. Core category emergence also required extensive cross validation checks. Numerous checks against the thematic analyses of data by co-research team members (compromising researchers and therapists) on parallel family related themes were conducted. Additionally a consumer representative was informally interviewed as a cross check to determine face validity of emerging themes from a consumer perspective.

Researcher Participation

Having active knowledge of CSA literature and experience with CSA victims through voluntary work with Womens' Refuge and related organisations, the present researcher had a foundation from which to explore and be sensitive to topics raised by participants.

The present researcher actively participated in the collection and analysis of data. This involved co-leading a road show presentation, two focus groups and by interviewing five key informants. The remaining data analysed by the researcher was collected by a number of other members of the greater research team. The present researcher's active participation varied from asking direct questions, clarifying meaning, adding comments to participant narratives, encouragement of elaboration of issues and communicating interest in topics under discussion.

Summary

In this chapter, the utilisation of a GT methodology as it applied to the goals and purposes of the present investigation was outlined. Participants covered the length of New Zealand and consisted of a broad range of therapists with experience in treating CSA. Data was collected from a range of focus groups, key informant interviews and from a national survey, and was analysed using a constructivist approach to GT.

PART THREE

RESULTS AND DISCUSSION

Introduction

The core social process of recovery and healing in sexually abused families consists of three interacting concepts “Belonging, Estrangement and Reintegration”. This abstracted core process emerged from the substantive codes. The substantive codes are represented by four selective codes which embody the range of family processes that contribute to recovery and healing in sexually abused families. The selective codes include, in temporal sequence, “Vulnerability”, “Relational Interruptions”, “Alienation” and “Reconnection”. Appendix G provides a diagrammatic representation of the relationships between categories and progressive unfolding of substantive, axial and selective codes. The chapters detailing the selective codes support and verify the core social process as the driving force to the events, actions and behaviours described by therapists in the present study.

Despite the extensive body of data available, the core social process regarding family related themes did not emerge easily. Interfering with and running parallel to the emerging family related themes were therapist concerns about the contextual factors which impact their interventions and practice with sexually abused clients. These emerged through spontaneous remarks, comments and therapist reflections and are a departure from our areas of examination laid out within the interview protocols. They reflect therapists’ emotional engagement with systemic issues particular to ACC as a corporation and to other structures and protocols which therapists feel impact on their capacity to practice.

As a result, two processes are outlined and discussed separately. The first involves family related themes entailing the content and processes observed by therapists in their practice with sexually abused families. These examine the role of family in recovery and healing which was the aim of this project. The second process involves therapist related themes regarding contextual factors which influence therapist interventions with sexually abused families in New Zealand (refer to Appendix H for a diagrammatic representation of these themes and their relationships).

CHAPTER SEVEN: VULNERABILITY

In this chapter, the first selective code “Vulnerability” is presented. Therapists were able to identify a number of familial variables which they believed contributed to the processes causing and perpetuating the occurrence of abuse. These are represented by the following axial codes which emerged from the data.

Axial Codes

- Vertical stressors¹
- Horizontal stressors²
- Family organisation and adaptability³

Vertical stressors

- Transmission of attachment style and pathology
- Inheriting legacies, repeating patterns and behaviours
- Cultural history/ forces

Therapists described a cycle of abuse, which often spanned several generations. The intergenerational transmission of dysfunctional attachment styles and psychopathology placed children at risk of neglect, trauma and abuse well before it occurred.

“Another huge impact is on children born to sexually abused parents who then have attachment problems, depressed parents who lack appropriate boundaries and so it passes on to another generation.”

The link between attachment styles and later parenting is articulated in the following quote which highlights the almost unconscious transmission of behaviours and repeating of patterns across the generations in family systems.

¹ Refer to definition of “Vertical stressor” on page 11, in Literature Review.

² Refer to definition of “Horizontal stressor” on page 11, in Literature Review.

³ Refer to pages 11 and 12 in Literature Review for FST terminology and definitions of styles and structures.

"...I think there is a pattern sometimes, unfortunately, of sexual abuse repeating itself in families and that's really sad. I think that one of the issues to be focused on is attachment to try and prevent those cycles from happening again because if you look at attachment across the lifespan you can see for example, my Grandmother parented me that way and now I'm parenting my children this way and I know it's not right but that's what I have had modelled to me."

Inherited stressors due to the wider cultural and political context were also indicated as contributing to making families vulnerable and setting children up for risk, particularly within certain disenfranchised cultural groups.

"You know in our village where we grow up in Samoa we don't share about these things, we just, I don't know we don't have the words, even if we say the words in Samoan it's a shame to say those words so we don't talk about it. We pray, I think we silently pray about it and it will go away, but unfortunately we have to deal with it aye."

"... Oh just that what I'm noticing in our Maori families is that um, its just huge abuse issue //mm// can be right through whole families..."

"... from a Maori perspective we are on the same boat. Historically we are tribal people, we have our maraes, we grew up on our maraes, we had our families we had all the same child, never matter if it was mine, if that child feel out of line or that child sexually abused, we had our ways of dealing with it within that whanau concept, when the Urban move happened we became individualised. I think what's different though is that you have Samoa that you can go back to, but we are here, we are tangata whenua, you know we're here, you know so how do we deal with it you know."

"It's a challenge my sister, it's a challenge, because I'm telling you its taken a 150 years and look at it hasn't even moved much."

"No and we can't say as tangata whenua well lets go back onto our Pas and bring all the families back together because that's not the answer, we've moved,

we're in the year 2005 so we need to find an answer and a common ground where we can deal with these issues in this century rather than in the past."

For these practitioners, the links to the past, inherited legacies and transmission of pathology and/ or attachment styles reflected the vertical stressors which can and do contribute to the creation of vulnerability in at-risk families.

Horizontal stressors

- Co-occurring abuses / parallel events
- Cycle of poverty
- Destructive lifestyles

A combination of developmental familial variables prior to the abuse and familial events running parallel and subsequent to the abuse were recognised as another underlying cause of abuse and vehicle which perpetuated it. The greater the dysfunction in the environment before and after the event, the greater distress and dysfunction was likely to occur as a consequence.

Alongside the occurrence of sexual abuse, therapists were aware of a number of other abuses that may be co-occurring in addition to CSA.

"...Oh it is common. I think emotional abuse, physical abuse and sexual abuse often overlap..."

"There may well be it is a lot of family of origin sort of things not just the sexual abuse but physical abuse the emotional abuse in those sort of families. An alcoholic father and/ or mother, problems with siblings, absentee parents at various times may have been a lot of foster homes and so it is everything else is the problem but the abuse is often the last thing that comes out."

Managing the burden of poverty and/ or psychopathology in sexually abused families frequently entailed drugs, alcohol and physical violence being present in the family environment. The stress associated with financially and/ or emotionally impoverished lifestyles was considered to perpetuate the abuse; parents were unavailable to protect their children and/ or fuelled to abuse them.

"...we're talking about children who um have poverty um maybe neglect or, or certainly their relationships within their family, they don't have a lot of attention there you know they don't get attention even if mum and dad are there, they don't get a lot of attention um, ah there's alcohol, there's drugs, there's, you know, there's a whole lot of stuff ... and I just get the sense that often sexual abuse is just one thing and it may not be the worse thing in their life..."

"...there was alcohol just flowing and people came out of their, from their marae from the rural areas into the towns, saw the big lights and parties and everything, and the children may have been left behind at home, and the beer was taken home, and that was a breeding ground for sexual abuse."

"This issue is just a little bit of the many issues, and this is a bigger problem than, you know, we can say sexual abuse but there's also a lot of things like Domestic Violence, Alcohol & Drugs, all these things happening..."

The therapists did not delineate any one factor as contributing more significantly to the child's vulnerability to the sexual abuse. Rather they understood the causes and impact of it to be more interactive and cumulative in nature. Such a complex picture often left therapists overwhelmed by family variables and questioning whether sexual abuse itself was the worst thing to happen to the child and that a broader contextual perspective needed to be considered when understanding the nature of abuse.

"...and I think looking at the um, the causes, is sometimes multi relationship and sometimes single parents not giving that attention, but to be able to tap into that um why that happened and where it started from, is um, ah, I'm not sure..."

Cross validation with the consumer representative presented a more complex picture of family relating which within a family unit swung between isolated and enmeshed to chaotic and disengaged. The following description illustrates one therapist's experience of a survivor growing up in a chaotic environment.

"And I think because of, um, um, manaakitanga, hospitality, you know there's a lot of different people coming and staying in the house //mmm// umm, things like that, so, children become more vulnerable, parents can't keeping an eye on the situation."

Family organisation and adaptability

- Rigidity and enmeshment
- Power imbalances
- Silence

Therapists infrequently distinguished intrafamilial from extrafamilial abuse. A likely explanation for this is that regardless of the origins of the abuse certain children are more vulnerable and at risk than others due to the family operations and relating being similar in both circumstances. Despite the lack of differentiation, intrafamilial abuse was consistently regarded as more damaging than extrafamilial abuse.

"If it occurred within the family it means betrayal of trust by caregiver/parent and has more major implications."

"Intrafamilial abuse creates added problems with Schema forever warped."

Whilst precise understandings of how intrafamilial abuse has a more severe impact did not emerge, particular styles of family organisation and functioning were more frequently associated with intrafamilial abuse and may provide clues as to how this type of abuse is able to continue undetected for extended periods of time.

"When it's in the family it's more likely to um go on for a long period of time //yep// 'cause the perpetrator has more ready access..."

Rigid, enmeshed family structures were described. These families created vulnerability in their members through being closed to corrective feedback from the wider community. Without feedback, the family is stuck, they continue to repeat unquestioned and unaltered destructive practices.

"... one of my transgender clients actually who was um sexually abused very severely um by his father, right up to the age of sixteen because this family was kept so close at home that he didn't actually know that what was happening was not okay and not what was happening in other families until he started doing small stuff outside the family..."

The absence of outside influence means members must rely on feedback from each other. This too is problematic where there are gross imbalances in the allocation of power as often there were understood to be in incestuous family systems. Through exploiting the inherent power imbalance between adults and children, disturbed members are able to overstep morally and developmentally appropriate boundaries within the family system and force vulnerable members into roles which are pathology inducing.

"Imbalance of power within relationships broken boundaries esp. intrafamilial relationships."

"...It could be the guilt and shame that stops them from talking but it could be 'I don't want to talk about this' it could be 'I tried to talk about this but nobody believes me and you get into even more trouble because I'm lying or whatever or they do believe but they just don't care..."

Regardless of the causes for the abuse, the incestuous family particularly, was described as being silenced, a convenient means for the power holder(s) to avoid corrective feedback. Denying, covering up and sharing in the family secret are specific styles of communication and interaction operating within the family which enable abuse to continue.

"Much abuse is hidden or secret."

"... Isn't there the trail of secrecy and the pattern of covering up and being so strongly in denial, it might well be. I can imagine that too of a generation and also the difference between incestuous families where the abuse happens within the family or from outside. I think that's a huge difference."

Denial, isolation and guilt were understood to be a consequence of the secrecy for both the victim and other family members.

"...you're dealing with people who have had secrets for so long, the secrets that have been so important that quite often are very deeply buried..."

"...Isolation due to secrecy..."

"Person carries the secrecy, shame, blame."

Summary

The interaction of horizontal and vertical stressors on the family system and individuals within it, instils vulnerability in children which places them at risk for abuse. Whilst the exact nature of this interaction is not understood, familial variables are strongly indicated. Specific styles of family organisation, such as rigid, enmeshed and silenced and denying, were highlighted as contributing to the perpetuation of abuse, particularly in incestuous families.

CHAPTER EIGHT: RELATIONAL INTERRUPTIONS

Due to the widespread and variable nature of the reported effects of CSA, therapists took a developmental perspective when trying to understand the complex sequelae of sexual abuse. Not only was there variance of effect between individuals and their families but also variance across their respective lifespans. As outlined below, one of the most consistent effects to emerge from therapist discussions was the interpersonal damage and interruptions to relating between individuals and their families.

"...abuse is an interpersonal experience and so it has to impact on your interpersonal relating."

Axial Codes

- Developing and/ or coping within the family context
- Compounding / interacting issues perpetuating problems

Developing and/ or coping within the family context

- Interrupted development
- Children's dependence on others
- Attachment relationships

Childhood is a time where young people develop a range of skills for life. This process was perceived to be interrupted by the trauma of the abuse.

"... it could be described in terms of injury done during developmental stages where that part of the learning is disrupted and just not being able to be attended to."

"...children who are abused as um, a multi dimensional um person and the abuse may channel into, it may block off a couple of the areas but not everything um yeah so a child may go on developing in some areas but others are just blocked by the abuse..."

The effects of CSA for children were perceived to be more damaging because children by virtue of their lack of years have not developed the skills and abilities to cope with the experience, like an adult victim might.

"Extremely damaging early childhood with client having few resources and little ego strength."

A developmental perspective is also used in adulthood. The earlier interruptions explain why adulthood was thought to be often the earliest they are ready to address the trauma.

"...abuse counselling, because it is so emotionally based and so personal. All those fears and emotions are raised when you are doing that sort of work with adults and surprisingly, I would say probably, a lot of the sexual abuse work does get done with adults because that's only when they are ready to do it."

An outcome of taking a developmental perspective of CSA, is the recognition that individual and family life cycles intersect. As indicated by the therapists, children are dependent on their environment and so this immediately implicates the role of family in the healing process where developmental interruptions have occurred. The younger the child, greater was the therapists perceived need to involve caregivers in treatment.

"...it is very, very different, working with younger children where there is a stronger dependence on the parents and the younger the child the more the parents need to be involved."

"...and the younger the child, obviously, you have to have the mother more involved or whoever is the closest but I think it is quite important to ensure the family work because if that can't happen you actually cannot afford the healing for the young child. Yeah. The counsellor can't actually hold a child through the therapeutic healing process when it is, say, a dysfunctional family. It's just impossible."

By implication, given the mutual influence of individuals within a family system, the constant close physical proximity between family members in childhood and the longevity of their emotional ties across the lifespan, the family serves as a major force in shaping and assisting an individual's recovery.

"...we, we might work with them for an hour, two hours, an hour or two hours a week, they're with them 24/7, they're dealing with all the effects, their behaviour, their grief, whatever the effect it's having on the child but they're also dealing with the effect that it's having on the family system as well..."

Equally, the family was understood to serve as a major force in shaping the degree of intensity and duration of dysfunction after the abuse.

"...I firmly believe that if children are not showing any signs of symptoms in terms of behaviour and everything is fine and going along smoothly but the parents are pushing and are anxious it is actually about the parents issues about how they need to deal with it."

At a practical level therapists believed family is essential to treatment with children simply because children need family to drive them there, be a voice for them when too young to articulate or reflect and to provide contextual information

"...with children it, the parents or the person that brings them in is very important source of information about the situation and what's happened um so that's where, that's where your information is gathered from um ..."

"...I can remember one who wasn't even able to communicate about it um, where the communication had to go through the mother who brought her along yeah..."

"Sometimes a session like that can sort of disclose or reveal a high level of dysfunction with a parent..."

The role of attachment relationships in healthy development was emphasised by therapists and considered pivotal to recovering from the sexual abuse experience. The protective nature of healthy attachments was highlighted in that it was considered by therapists to buffer against further risk of abuse. Frequently, poor attachment relationships prior to the abuse or as a result of the abuse experience were revealed.

"I think it's always useful to look at the attachment of the person to their caregivers when they come in, regardless of whether it's for sexual abuse queries or other issues, simply because I think it is about pulling together the family to support that young person. Even if abuse has happened outside the home I think messages given to the child and relationships within families between parents and children, can either make things a lot worse or make things a lot better..."

Compounding / interacting issues perpetuating problems

- Toxic relating skills
- Dysfunctional intimate relating
- Compromised parenting
- Relations in the family of origin

With great frequency, therapists provided illustrations of the widespread interpersonal toxicity that abuse causes within and across generations of families and how this prevented healthy relating with others outside the family of origin. Therapists reflected that where developmental trajectories and attachments had not been reset on a healthy course after the abuse, interpersonal skills and cognitive understandings of the self and others were increasingly compromised.

"... now if there isn't an intervention as early as possible then they develop their own ways of coping and often in adulthood it's that coping doesn't work anymore for them and that's why they have to come, you know that's why they'll come in for therapy because they're finding that the things that they did when they were kids to cope with the situation don't work anymore..."

In particular, the fundamental requirements for having relationships with others such as the ability to trust, a strong sense of self and ability to establish boundaries were described as being damaged in those who have been sexually abused.

“Major disruption and difficulties in interpersonal relationships. Serious difficulties with trust and boundaries with others.”

“... it sets them on a view of the world that is different from others and their whole sense of self and their whole sense of boundaries and where they are in the world and how they are in relation to people and their environment is shaped by those kinds of experiences and to build a sense of self...”

“We try not put that label on in adolescence but you can see them developing that [personality disorders] because they haven't learnt stability in their relationships, they haven't learnt that close caregivers can be trusted...”

The salience of the intersection of the individual and family lifecycle's is crucial here as the toxicity of poor interpersonal relating was understood as compounding over time and spilling over and spoiling the quality of relationships survivors has with others. This illustrates the principle of circular causality where the other's response can either maximise or minimise dysfunction. This process was identified as particularly so in intimate partner relationships.

“No direct communication, no ownership of needs no expression of feelings, no respect for others needs and feelings, manipulative behaviour, not necessarily because people are deliberately being nastily manipulative but they do not have other ways of communicating things that is an unknown or something shameful.”

“...are likely to be other referenced and so it is very difficult to focus or to function healthily in relationship with someone else if you don't have a good sense of self and an understanding of your own boundaries and respect for other people's boundaries all of the interpersonal skills can be impacted on.”

Toxic interpersonal relating was conceived as contributing to survivors tendencies to be revictimised across adulthood. Examples were provided where survivors repeat the cycle of abuse by becoming involved in abusive, violent relationships which intensify symptoms and threaten recovery.

"...I do see with sexual abuse survivors some repeating of the dynamics of the abuse...Some will come to me because they recognise they have had series of relationships with people who treat them badly sexually they are wanting to break that pattern..."

"Some people have been trained through sexual abuse to be submissive and to use sex as a currency by which they try and please a partner and while they are busy focussing on doing that underneath that are resenting that so are actually doing expressing their resentment in ways that undermine their relationship too. It all gets to be a great mess."

"So then sex can come from a position from closeness rather than any of the old ways that the survivor may have been taught about what sex is for you know to service someone else or keep them happy."

Partners of adult survivors were often described as feeling confused by the messages and interchanges they had, before, during and even after the survivor had sought treatment.

Speaker A: "...sometimes sex is used as a form of currency. Whereby if I give you sex will you go and buy me a pair shoes or will you buy me the latest something or rather CD or something along those lines. It is not something that is thought to be horrendous awful or bad it is just..."

Speaker B: ... that is how their life has been...

Speaker A: it is an exchange system that takes place."

"So that with their partner the partner becomes confused. "I just wanted to put my arms around you and suddenly you go stiff as a board and say 'you want sex'." So it makes it very difficult to maintain comfortable, easy, relationships, couple relationships I think."

"Sometimes they just feel left out you know particularly once the survivor begins to get some good counselling and begins to make the changes they may not want to share those experiences with the partner so they can feel excluded and just not attended to. A number of partners have said to me over the years isn't there a support group for us. So it is really difficult I think and some of them are very very supportive and caring and understanding some get really impatient and fed up some feel horrified or sickened by the abuse stories don't know how to deal with their own feelings about it. So it can be really difficult."

Furthermore, the process of secondary traumatisation in partners was described as being a not too uncommon response in caring partners who hear about the abuses endured by the survivor.

"...they are not deliberately usually but they are made to feel like they are an abuser still because the survivors reaction to them can be as if they are an abuser. The partner may unwittingly trigger flashbacks or you know aversive responses that come from memories and then feel really caught up in that and shamed or feel bad like they have done something bad but also resentful because they know they haven't, but they can get confused."

Being caught up in the cycle of abuse as an adult and lack of partner support were frequently cited as significant client barriers to recovery from sexual abuse. By implication, excluding partners from aspects of therapy is to under utilise a potentially powerful natural resource in the healing process. Should partner issues, intimacy and communicating between partners be addressed, partners would be given the tools to better understand and support the survivor and maximise their journey to recovery. Additionally, where survivors are in abusive and therefore highly unsupportive, partner relationships, therapists must factor into treatment how that relationship may sabotaging a survivor's efforts to get better.

"...I've got one client whose partner, you know, she's just, she's just, beginning, and she's got all this, all the post-traumatic stress disorder symptoms and its like, you know, he persists in telling her she's a nutcase and, you know, and that's not helpful //hmp mmm// and he's been to a session and um, heard about impact but that's just his nature that he's still doing it, you know //mm// (.) so I call that an abusive relationship //yeah mm// ."

"I think people, whatever age, whether it's a five year old or a fifteen year old or an adult, they do need to be in a stable, safe place to do the abuse counselling."

Parenting ability of adult survivors received a great deal of comment also. A number of examples of compromised parenting practices such as lack of parental care and protection, poor role modelling and maintenance of inappropriate boundaries were provided by therapists.

Adult survivors were frequently described as unable to establish a healthy attachment with their children. By implication their ability to understand and respond appropriately to their children has to be questioned. Equally this attachment style is transmitted to their children and impacts their way of relating with others.

"... difficulty bonding with a girl baby infant right through toddlerhood has been really distressing thing to witness as well. Just an avoidance of bonding and on some occasions they just cannot, they identify too strongly."

Survivor interpretations of what is "safe" and consequent parenting decisions and practices regarding boundaries within the family and the role modelling of safe behaviours raised concerns for the physical and mental well being of survivors children. Frequently parental over protection of children leads to enmeshment within the family, whilst under protecting children leads to chaos and disengagement within the family system.

"...and often where, where the parent hasn't dealt with it and that allows them to be unable to keep their child safe because they were never kept safe and it's so complicated psychologically..."

"...I think that is one of the effects that in parenting the parent thinks they are being careful...Now this is a mother who one of her multiple abusers took her off the street and took her to the toilets at a park and abused her at the park and left her there. And she could not see that in actual fact that while she thought she was being safe that she could see the park she could not actually see all the park and nor could she see the toilets... moving into gradually getting her to see that maybe that is not the best possible thing to be allowing the children to do. You know so they can't carry their learning from their scenario often through into their parenting learning..."

"... and not setting good boundaries, not setting good examples to children about how you can look after yourself..."

"continual coping problems incl. children and overprotected or inability to protect them."

Associated with these are the therapist concerns that by failing to model appropriate and adaptive behaviours to the next generation, adult survivors inadvertently increase their children's vulnerability to later dysfunction (often externalising behaviours) and/or abuse themselves.

"...that's right and sort of often the adolescent, rebellious stuff in these families or in this family I'm thinking of, gets very over the top because they are actually really waiting to get out of the family. That constraint. Aren't allowed to go to school camps for fear of and very often this happens when the child reaches the age that they, women was when they were abused. That pattern happens over and over again..."

"...The best one I had was, was a, a boy who was stealing when I worked for social welfare um which is not ACC but he was stealing because his mother was depressed and she, when he stole she got angry and an angry mum was much easier to deal with than and live with than a depressed mum who might commit suicide..."

Members within a survivor's family of origin were also described as being impacted adversely by the toxicity of the abuse. A multitude of stresses and structural changes occurred, particularly after an abuse disclosure, which were described as devastating to a non-abusing parent(s) and fellow siblings.

Brothers and sisters of the victim experience a loss of potentially two major caregivers and important attachment figures as a result of changes in the physical structure of the family after a disclosure.

"...and in other families you will have a mother who will support the father to the detriment of the children and you will have Social Welfare stepping in and saying you are now not a successful mother we will shift the children out. So the children or the family go through a stage where there is another breakup that takes place and that is between mother and children..."

Additionally, siblings of abused victims were in some cases known to be secondarily traumatised by the abuse of the sibling victim.

"...sometimes the sibling will know about it //mmm// because they might have been in the same bedroom or, um (.) I've heard of a person who was traumatised because they knew what was happening a, a, family member was coming and removing the child from the bedroom, and he was just following and keeping and eye on things to see what happened and it had a big impact on him as well //mmm// keeping an eye for sister //right// umm ..."

Therapist accounts indicated that the birth order of siblings could impact how the victim and other children perceived the abuse events and their role in it. Older children were described as having feelings of responsibility and thought they needed to protect younger siblings. As a consequence some older children believed they had to "make themselves available" to the perpetrator in order to save younger / other siblings. The burden felt by the responsible older child, may interfere with healthy sibling relating across the lifespan. Not only do childhood cognitions about their responsibility for the abuse need to be addressed, but the resulting disrupted relating between siblings needs to be attended too also in order to move further along the healing continuum.

"... how destructive it is in family relationships that for every level of the family... I had one client who allowed all sorts of ghastly abuse because she had to protect her younger brother and now that they are adults this relationship with the younger brother has to be worked out and that's so there's all these extra things that are happening in the family and family relationships are hard enough anyway, without having to deal with "My life was spoilt because I was looking after you and then maybe I wasn't I thought I was but actually it happened to me as well."

Non offending parents are frequently highly distressed through learning their child has been sexually abused. By implication this distress can interfere negatively with the recovery of the abused child in that the parent is preoccupied with their own concerns, reducing their availability to the victim and other dependents in the family system.

"...guilt um falling apart, disintegration of, of coping ability so that they're not as competent as they were, that they're questioning themselves, they're feeling shame, um outrage..."

"Well it, it, it raises huge issues about their role as the mother and how they're going to behave with the children which will impact on the child."

"...often I think particularly fathers, that the child's been spoiled um and I didn't protect her and that was my job as a father and, and my little girl's been damaged and she's, she's not as good as she was, those sort of feelings..."

The distress in parents can last beyond that of the child's.

"... I'm working with this huge guilt that those Christian people brought a young boy off the streets into their home who then abused their son, and that's actually finishing the work, the boy's actually grown, he's got a job now after being all over the place and I'm just finishing off the parents..."

Relationships with your value system and the culture from which they were derived can be negatively impacted also.

“And whanau I think is the other aspect that is often really significant for Maori like, especially if the abuse has happened within the whanau, that there can be a lot of repercussions in terms of um, whanau relationships even um, if it's happened, not even if it's happened at home actually, but often there are issues around turangawaewae, peoples ability to feel confident about where they stand and to feel safe, um, within those sort of relationships with whanau yeah.”

Summary

Interrupted relating is a common feature in the sexually abused family. Interrupted relating makes children vulnerable to abuse. The interrupted development experienced as a result of the abuse exacerbates the toxicity of poor relating styles learned in the family. Left unaddressed, this was understood to become incorporated into their everyday life and begins a journey which compounds and perpetuates the abuse experience and dysfunction across adulthood.

CHAPTER NINE: ALIENATION

The response and reorganisation of the family after a sexual abuse disclosure was described as being of critical significance to the recovery and healing process. A sexual abuse disclosure and associated fallout often exposes gross dysfunction within the unit and/ or places enough pressure on it draw out any pre-existing weakness within it. In either case, based on therapist descriptions, the disclosure sends the family off balance for a period of time as it attempts to adjust to their new circumstances. It is the maintenance of the intense and entrenched stress response by the family which was understood to increase the severity and complexity of outcomes for survivors.

"...even if abuse has happened outside the home I think messages given to the child and relationships within families between parents and children, can either make things a lot worse or make things a lot better ..."

Axial Codes

- The I / me focused parent
- Systemic response to stress

The I / me focused parent

- Not believing
- Not protecting / preventing
- Putting parent needs first
- Parental emotional unavailability and pathology

A critical factor to recovery was whether the victim had been believed by their support system when they disclosed the abuse. Not being believed was linked with inaction where the abuse was allowed to continue and the victim was not supported nor protected following disclosure. This was a barrier to recovery in that it exposed the victim to an abusive situation for an unnecessarily extended period.

"...when the um child is believed its when it can be stopped //right// where as if they're not believed that, you know, um is gonna leave the framework there for it to carry on."

Not taking action after a disclosure illustrates how dysfunction within the family environment (whether home of the perpetrator or not) enables the cycle of abuse to continue as the victim is revictimised again by not being supported and left alone to "manage" their situation.

"Behaviour responses by people around can have greater traumatic effect than the actual abuse or vastly increase devastation..."

"There's the abuse experience and there's also the reaction of family which makes it twice as bad..."

"Sexual abuse victims are frequently multiply victimised by their abuser(s), by the responses of family and friends, by the systems that are supposedly there to protect and support them."

Interrupted attachments between mother and child were understood to be one of the underlying processes contributing to the alienation of the child.

"...but that also brings in attachment issues, you know, you often have um a client that felt um that their mother abandoned them and so a lot of the work is around that stuff..."

The mother not believing and in some cases choosing the perpetrator over the child is an illustration of how the mother was emotionally unavailable to the child and unable to protect them from harm. The parent is absorbed in their own issues and past traumas which have not been faced or dealt with adequately.

"...well there are for some, I mean, we were talking about the ones, especially the ones that don't that choose the partner, if it's a partner, over the girl. They are often women who, if they haven't been sexually abused, they have been abused in every other possible way and they need that man desperately ... She's not going to let go of that guy. She's got two other kids with him, younger ones, because she has to pick she will pick him over the girl."

Therapists singled out the level of parent functioning as an accurate gauge of the degree of safety and support experienced by the child within the home environment both before and after the disclosure. A number of therapists were concerned about the emotional unavailability of parents and lack of safety of their children due to parental psychopathology and preoccupation with their own issues and distress possibly stemming from earlier CSA. As such, parent issues are a major barrier to the child's recovery.

"...the other thing is that it's often the mothers who need the counselling not the kids."

"...and having healthy parents so that the parental issues um don't get in the way."

"...I'd rather see the parents, dad as well but generally there is, often there's no dad um and give them some time, give them some sessions as well as the child."

"But there are other people who can't self reflect because it is too frightening for them it is too fearful so we are busy still trying to deal with how they cope with their flashbacks and keeping their safety you know their physical safety you know how they deal with the flashbacks you know how they deal with the children while they are also trying to deal with what's going on their mind..."

"...protecting their children aye, like when this one woman who I just said about the mother, she had these hugely violent images of what she would do to her children, you know, like that's a real warning sign..."

Parental self absorption with their own inner world and personal dramas can still block recovery and healing even when they do take their children to get therapy after being abused.

"... you still get mothers who don't believe the children, I've had a mother bring a child to therapy, [She ask's], "Are you sure anything happened?" and children pick up by osmosis um what's going on and the younger they are the more in tune they are, the older they are they lose that um so if this mother has some doubts about, that's very unsupportive..."

Another block on the road to recovery was high levels of distress in non-offending parents. In some cases the parent and child roles completely reversed; parents were described as using the child for their own support. This is yet another illustration of the interrupted relating present in the families which sexually abused children tend to spring from.

"... if the parents do not get support in this area, that you can block the therapeutic process. I would like to take it that far because, for example, when there is a mother who is only anxious, which is understandable after the situation and carries a lot of guilt because she didn't protect her child, there are major issues and she will act that out in one way or the other and that will have an impact on the child and I have experienced a situation with a child where the child started to look after mother and couldn't do her own work so, you can not separate those two..."

"The guilt, guilt and it's my job to protect my child therefore um that makes me guilty..."

Distress in parents can also stem from cultural values and issues regarding gender and sexuality.

"... if it is boys who have been abused you talked about girls are they going to be nymphomaniacs the boys the first question invariably from dad is will he be gay."

The upshot is that regardless of how or why children arrive at therapy after sexual abuse, parents are, at some level, forced to confront their personal issues which are both uncomfortable and distressing. These issues need to be part of the treatment equation and adequately addressed if the healing journey is to begin for child, parent and family unit alike.

"...very much for children, very much depends on the response of the parents whether um they actually believe them or whether they just disregard and that child is left and so um, and in that, that case sometimes um you know parents will, they'll go along with um their children having um therapy even though it highlights the fact that they weren't able to be there for them yeah."

Systemic response to stress

- Equilibrium restored via silence
- Disengaging and isolating
- Splintering
- Scapegoating

Some families attempt to maintain equilibrium through organising themselves in such a way that they can deny and or remain silent about what has occurred. Silence prevents the healing from beginning as nobody is willing to take responsibility for what has occurred and thereby increases the amount of damage by holding onto pain, secrets and dysfunctional patterns and pathology.

"...and then you get the kids who have disclosed, being believed and nothing's happened and then there's this dreadful silence that descends on the whole family and that's a further trauma for them too. I have just had a client whose done some major work with talking to the whole of her wider family about a silence that happened when she disclosed and she feels just so strong now..."

The public disclosure and consequent exposure of the family's "dirty" secrets were described as impacting both the victim and family by feeling shame and a sense of disconnection from a disapproving community and society.

"...they are being ostracised because the abuser is in the family but she's got a victim in her family as well so that, that um takes it's toll hugely yeah..."

Feeling like outcasts, therapists described situations where families became completely disengaged and alienated from one another, turning against one another and using the victim as a scapegoat for the stress and shame they experienced. Therapists described victims as left to feel totally isolated and disowned by the family. The revictimising nature of family responses, such as blaming, scapegoating, and splitting, were identified as being responsible for this.

"... I would say that we do try and use a family systems approach and say, well okay, lets look whether there's triangulation going on here or whether there's scapegoating in a family and certainly there might be scapegoating with abuse. I could think of a number of different scenarios where one child has been scapegoated because they raised the abuse issue and other children then had to deal with it because they were also abused and that's been a scenario that I have dealt with in a couple of occasions. A lot of the therapy work was family work really, to help that family pull together again."

"...situations where families get split down a loyalty line, those who will disbelieve disclosure and those who wont and that can actually be maintained for a lifetime."

"...a young person I'm working with at the moment where the family blame her because she put her dad and he went to prison and she, she the family apart and it's all her fault and she probably asked for it anyway, um so that child has been alienated from her family..."

"...and she's a Maori child so she's in an absolute bind at the moment and wanting to be with the whanau and, and yet their, they totally betray her on an ongoing basis..."

A consequence of divisions and further interrupted relating within the family is increased survivor anxiety. The survivor feels guilty and responsible for the stress they are “causing” within the family. In turn the victim begins to believe the new family motto that they are somehow damaged, defective and bad.

“One of the common um things with, issues would be the splits and the taking of sides and the, and the wishing to go back to the secret and the silence, you know to pull, to pull the child back into or the adult back into the secrets, broken down and take different, different sides of family telling different stories and people trying to figure out what’s real and what’s not.”

Such unsupportive family reactions and the negative feelings they induce in child victims were provided as an explanation for why some children recant claims of abuse.

“I think one of the other effects it has on families as well is the children when they disclose that it polarises the family, they see the anger and the hurt going on in the family and that’s when they recant and it’s like I just want, I, I’m going to say it didn’t happen because I want things to go back the way they were and it fascinates me how that’s the bit that everybody jumps on, this child is now recanting so now we don’t believe it.”

“... the guilt ... they have been really brave and have told and the person has gone to prison and then they see themselves as being directly responsible for breaking the family up, because that is what perpetrators told them. ‘If you tell they will send me off to prison and you will break the family up and nobody will believe you.’”

“Exacerbated by the fact that this child was abused, the police have come in and taken dad away and the other kids are saying, you dirty little liar, you why, I mean children um tell lies to get out of trouble, what does this give them but xxxxx grief where everybody knows this stuff...”

The strength of attachments within the family system was again provided as an explanation for the consequent maladaptive and unsupportive response of the family to the stress brought about by disclosure. Without strong bonds, closeness and loyalty between members prior to the abuse, the stress of it will serve to further disengage an already fragile and separated family system.

"... I think families go through a lot when they are dealing with their child who has been sexually abused even if it hasn't happened within the family. It can put a big strain on the family and that's where relationship issues if there's not been a strong attachment just falls apart... Often it does work the other way unfortunately. We will see children that get into a great deal of distress and the family breaks down and they leave home and they are unsupported."

Summary

Alienation of the survivor occurs both within the parent-child dyad and within the whole family system. Parents who are absorbed with their own issues tend to be emotionally unavailable to their children and as a result often failed to protect their offspring from abuse. A strong indicator of parental pathology and disturbed parent-child relating was in situations where parents did not believe their child's disclosure and in turn failed to prevent further abuse occurring. The family response to the child's disclosure was also often understood to be as damaging as the abuse itself. Frequently a disclosure highlighted previous dysfunction and weaknesses in family relationships and in their organisational structures. In response to the stress and public exposure, the survivor is blamed and revictimised. Family members in turn disengage and are alienated, leaving the survivor alone and unsupported.

CHAPTER TEN: RECONNECTING

Recovery and healing from CSA was understood to be assisted through the reconnection of family members. Reconnecting in healthy and more functional ways enables parents to be more competent at nurturing and protecting their children and enables the family as a whole to be free of restraints past and present which perpetuate the cycle of abuse.

Axial Codes

- Becoming an I / we responsive parent
- Unbundling restraints

Becoming an I / we responsive parent

- Family centrality to resilience
- Parent-child attachment
- Parenting skills and behavioural management

When therapists prioritised work with child victims, safety issues came before trauma work. A lack of safety and stability within the home environment indicated the child was unsupported and too vulnerable to focus on trauma work.

“I mean, first the safety is in the room and the therapy session but I think that’s not building it in their environment because it doesn’t do any good to do this work if they are going home to a dramatic, unsafe situation and I’ll reinforce, you know, a lot of the things we are going to be talking about aren’t going to work in a dysfunctional situation. You know, it’s not safe to be open and disclosing in an environment that’s not safe so...”

“...they need to be in a safe place physically so we would say care and protection issues for children need to be sorted first and then look at therapy because you can’t put that onto a child.”

Therapists frequently mentioned “resilience” and the role a warm, stable and supportive family environment played in contributing to it. The protective and nurturant family was perceived as a major contributing factor in children’s development of adaptive coping skills and serving as a protective buffer against any adversity experienced by the child. As heads of the family, parents and relations within the parent – child dyad were a central focus for many child therapists.

“I think it also has something to do with the support they get from their families, if you’ve got a really supportive family and I’ll watch it with, with the children, if they’ve got a, um parent, caregiver, extended family whatever that’s there supporting them through the process of the healing um their resilience is much higher than for a child who’s whipped out of home put into a foster home away from all those support systems and expected to just get through it or survive, I think that’s got a lot to do with resilience.”

The level of past and present familial support a child received was viewed as a gauge of the child’s resilience against the trauma and as a predictor of treatment outcomes. Therapists often described using a “genogram” as a means of getting to understanding past and present influences on the client’s current situation. Therapists considered information regarding the client’s family of origin and significant attachments, their childhood and home life at the time of abuse as highly significant to the client’s case, which could be obtained through such a tool.

“... there is one thing I consider essential for me. I do always do with absolutely every client and that is I prepare a Genogram and I work with a genogram over approximately two sessions maybe I get through it in the first session I don’t know but I always front it up by saying that this I turn it into a bit of fun. This is a really good test of your knowledge of the family and this really stops me from asking stupid questions like how is that person related to you all I have to do is look at the genogram. And then they oh this is interesting and then I tell them I get to know a bit about the family secrets. And it is amazing how much information you can get from a genogram and out of a genogram. And often you can have that first report three quarters of the way done by the time you have got to the end of the genogram.”

"... if you do the genogram you'll get a pretty good idea about what the person's been through and what sort of messages they've received throughout their childhood but if the abuse is, say, later on then you're probably dealing with someone who bounces back faster, than you would say a child whose been abused from an early age..."

Attachment within the parent-child dyad was targeted by therapists to engender engagement with, and support of, the child victim. Therapists described that when a parent is bonded with the child, they better understand them and in turn can be more responsive to the child's needs. The importance of healthy attachments to the process of recovery once again demonstrates therapist perceptions of the intergenerational nature of abuse and the influence of family relating on that process.

"...I also talk about that with the mothers so that they're understanding and I, one of the things I do believe, at one level um is that parents will know what to do with their kids if they can understand them, it's when they don't understand them, that they haven't have a clue what to do and I know that's true and not true, yes we could all have used more traps but I mean the first thing is, first understand your child and if, if you don't understand them you've got a major problem..."

"...more time talking about how the parent feels about their children now, how they felt when the child was very young."

"...Helping parents understand why they respond and relate to their kids the way they do and why they have the feelings that they do is important. I think sexual abuse is a very private thing and it raises a lot of worries for parents even if they don't voice them to the child. Once they are aware of abuse, attachment issues come into play whether they have supported the abuser being in the home or whether they haven't picked that there's been abuse or whatever..."

Therapists regarded the purpose of targeting attachments as a means to improve relating and emotional closeness. As a consequence, the family unit as a whole could and would want to work together more cohesively.

"...I think it's always useful to look at the attachment of the person to their caregivers... simply because I think it is about pulling together the family to support that young person."

Parents, as heads of the family system, were identified as needing to be educated about, develop skill and confidence in their parenting. The ability to establish and maintain appropriate boundaries between the children and adults was identified as being essential to facilitating recovery.

"...any work with the child is better to come through the parenting in helping the parents understand the child's behaviour and holding boundaries firmly, still letting the child know they love the child but working with the parent..."

"... specifically with sexual abuse we look at the dynamics and the relationships within families. I guess that's sort of the systems idea, are the parents able to be parents in this situation, are boundaries blurred and often they are.... Often parents find adolescents difficult to manage and then they tend to back off because there has been abuse then they will often be unable to put firm boundaries round the young person and that seems to work against them..."

A parent's ability to respond to their children in developmentally appropriate ways was also highlighted as being critical to recovery. Education about child development and the role family plays in this through supporting and role modelling behaviours is therefore an essential aspect of treatment. In particular understanding the family role in "sexualising" children is especially important work for parents of children who had been sexually abused.

“... a guy who hadn't been able to ejaculate and his mother you know with the see-through nightie and stuff like that now you see, that's another area isn't it because I think there's nothing wrong with nudity and I think when your children are young that's, that there's not a problem with them seeing your parents but I think that parents need to actually respect the changing needs of the child as they get older...”

Even with adult clients, therapists acknowledged there was an issue with potentially compromised parenting in these clients. This was of concern to therapists as it was difficult to know if and how this should be handled in some cases.

“...and sometimes we don't get to hear a voice, even if we enquire about them because most, a lot of our work is one to one. I'm always conscious of a bigger system behind that person but sometimes it takes quite a long time to realise and to even start talking about how the children are being raised and sometimes the description of that is so abnormal and yet it is the norm to that family, a whole new lot of work needs to happen and often it's to do with over protected...”

“...and also if they've got children themselves the parenting stuff and looking at whether this client is emotionally available to her own children...”

Unbundling restraints

- Communication – opening up
- Appropriate roles and boundaries
- Attending to everyone's needs
- Support in the extended environment
- Reconnecting with culture / identity

For therapists working with children outside of the ACC framework, interventions which strengthened families were often considered more essential to recovery than trauma focused work for an individual member.

"...and it's about identifying what the issues are that are going on for this child and for the family as well."

"...I've heard people say regarding sexual abuse, that that's a very specialist kind of area and I'm in two minds about that. I think if you work from a developmental perspective and an attachment perspective, and you are working with the effects of abuse. That might be depression, anxiety, trauma, those sorts of issues. I think that is the work you can do that's really valuable so I don't think specific sexual abuse counselling around helping people talk about their abuse or what happened and being able to process that, is always essential. How you help children at various ages do that may vary. I still think that people that work with children and young people can do that work."

"...Each case is individual and I think that's difficult. I have worked with a couple of young people where they haven't actually had specific sexual abuse counselling, however, they have had a lot of trauma counselling. They may present with a lot of relationship issues. Strengthening family units, providing parenting strategies, those sorts of things, placing supports around the young person. They haven't actually had sexual abuse counselling and they leave the service doing really well."

Families were understood to present with different issues and as a consequence working with and strengthening them can take a number of forms. Previous styles of relating and organisation were never, or may no longer, be adaptive in the wake of a sexual abuse disclosure and were consequently considered appropriate targets in interventions.

Speaker A: "So what sorts of things would you be looking at with regards to strengthening families?"

Speaker B: "I think, first of all, just doing a full assessment of how the family has functioned including a developmental history and an attachment history as well as the current functioning of the family."

By breaking the silence, systems therapists understood that families could begin to open up and relate in an open and honest way. Breaking the silence could facilitate the detection and amelioration of weak spots in relating and organisation.

"...explore taboo territory..."

"They let go of the secrecy..."

"Even to get whanau to acknowledge that some of their own members are perpetrators."

"... if there's abuse within the family, there's often, you know, huge emotions around the person that's raised the issue of the sexual abuse, you know, if it's the young person that's spoken out, I mean, that's often been the scenario that we've had to deal with and that young person has all kinds of feelings their way from anger from parents who now have to deal with it to, you know, some being supportive, others being rejecting. I mean, so strengthening the families would be addressing some of those issues."

Again holding onto or installing appropriate boundaries were considered essential to contributing to the health and wellbeing of its members.

"...Sometimes it is about normalising that the family will go on...So it about encouraging them to hold the same sort of boundaries and work with the behaviours that is what is acceptable. So you are trying to normalise the family life but you are trying to resolve the fears of the mums and dads..."

Speaker A: "What sort of families or dynamics were in those families where it worked?"

Speaker B: "Oh you go and pick a long one then, um where there was open vision and where, where the underlying reasons for the incest were dealt with um and that people took responsibility and that the parents starting setting some clear boundaries and mending boundaries and where there was an acceptance by all ..."

Far less attention was paid by the majority of therapists to partner relationships and what specifically worked to assist in recovery. However, being supported and encouraged by a partner through establishing appropriate communication and relating in order to facilitate understanding and intimacy within the couple dyad / unit was strongly indicated.

"...and then for the sexual abuse survivor and their partner the hardest thing it is difficult to break through those old patterns..."

"Help a couple talk about how the sexual abuse counselling would be impacting on them how the abuse itself and its effects are impacting on the relationship. So looking at things from the relationship perspective and particularly talking openly about how that has impacted on their sex lives and helping them look at how they will deal with the possibility of the lack of sex with changes to what is happening sexually while the individual is undergoing individual counselling. And often that is the first time that people have ever talking about that sort of issue opening so it is important stuff."

Sometimes the attempts to put new and more appropriate boundaries in place can take some adjusting to, especially when other family members are not able to be part of the treatment process. Once again this demonstrates the importance of considering a client's wider ecology in the treatment plan in order to summon support and not have others who are confused and threatened, sabotage the healing process.

"... as the person changes, and becomes more assertive //mm// then more, what ya call uppity, you know, that can be a bit of a shock //mm// for family members, especially partners //mm// you know. For them to adjust to this new person //mm// (.) whose now, um, more assertive then- feeling more powerful //mm// so you know dynamics there, um, it takes an adjusted to //mm// yeah."

Ultimately, the needs of all family members, subsystems and the unit as a whole must be addressed to ensure they are then left with enough emotional resources to contribute to the functioning of the family and its members in healthy and appropriate ways.

"If it was outside the family, it still has a huge impact on families when there has been abuse and it's looking at the impact on other siblings as well and so sometimes we work with other siblings who experienced you know, a lot of anger or anxiety around what's happened. So when I say strengthening families that might be working with all the children and the family might be given family sessions including caregivers and children together, maybe having parent only sessions to strengthen the parent's coping strategies and helping them you know, these things are helpful to reduce your child's distress and if you can deal with the abuse in this way so we do a lot of that sort of work, you know."

Equally, attending to everyone's needs may not always be possible. Therapists described situations where they supported the dissolution of the unit in order to set the client on the road to recovery. This was particularly so where adult partners were abusive.

"...I've had clients who um, or leave an abusive relationship, like say, um, in recovery, and um, gained, regained their power //mm// gained some for the first time sometimes //yeah// and um, learnt to be assertive, and decided, um they're not gonna put up with that anymore //mm// selves- having self esteem, a sense of self worth suddenly you know, 'why am I putting up with this dork' //yeah yeah// and they'll leave an abusive relationship."

Utilising an inclusive definition of what constitutes "family" emerged as being important in family based interventions and was emphasised in discussions about extended family and culture. Therapists recognised that the process of reconnecting could be achieved and assisted by relating with others beyond one's immediate family.

"Support networks either family or friends and encourage the abused person to take someone else into their confidence."

High functioning extended family members were identified as being able to model healthy behaviours and providing support and encouragement for the victim. In addition, family members who themselves had received sexual abuse counselling began to influence the family organisation by breaking the silence and sharing their

experiences. In doing so, they inspire and permit other family members to start their journey to recovery.

“Modelling, learn to model self care and empathy.”

“...I’ve got, I’ve had clients who um, have disclosed, be-been able to disclose for this first time, ... the clients have told, not only like close family, but often tell cousins and you know more extended family... and a sense of satisfaction about doing that.... that person was affected too...Or being role models for recovery, when there is a lot of people in the family affected ... the aunt who had never had any counselling, and who are all, functioning very badly because of their mental injuries...”

In this investigation, it was understood that for Maori and Pacific Island peoples’ particularly, one’s connectedness with family is directly related to one’s cultural identity. As a result, culturally appropriate family based services are likely to achieve a more complete healing with clients who identify strongly with their ethnic culture.

“...I think that cultural identity and resilience have a real strong relationship.... for Māori...just from my own experience, I think there is a very strong relationship there, and that’s why to me, I overtly or not so overtly always work with cultural identity, you know, sometimes it’s, people are very um, very sort of out there with it and other times not so much, but to me I’m always working with it anyway. The people who are, it’s really quite interesting aye, cause some Māori that I’ve worked with they just, they sort of just, it’s like they just come out of themselves suddenly, they’re kind of like, as they start to re-experience the world in a different kind of way, they start to see um, those cultural issues, in a way that they’ve never seen before, and sometimes it’s you know, um, it’s quite intense, you know, and they can get really angry or they can get just such an awareness of what it is now to be a Māori in this world, in this society, and what’s going on politically, and all that kind of stuff starts to emerge, and I find that very exciting actually, I enjoy working with that but yes, resilience is hugely important...”

"Whanau conflict and disconnection."

"... for Maori I think regardless of how young they are sometimes and there might even be um, stresses of loss of identity for starters, and they may have been whangai, and things like this, and ah, and what 'X' mentioned about whakapapa, and making that connection with them and allowing them to feel grounded, and have a sense of belonging from the beginning..."

"I did some work with some maori men for a maori organisation... is that I want them to know that overtly, I believe part of their healing means that they need to reconnect with their identity whether they want to or not and I will be quite overt about..."

"Well I think probably the most um, significant ones are about are around identity, because what I find with Maori that come for counselling is that it can affect their sense of who they are in the world, and I think that's true for pakeha as well, but I think for Maori there's the additional aspect of cultural identity..."

"...so the flip side of that is that those, and I have worked with another man who was sexually abused by a komatua on the marae and so his choice around that was to avoid any cultural experiences at all and to try and deny himself his heritage and part of his healing was to actually go back to the marae and to confront the man that did it who wasn't alive but confronted him by going to his grave and peeing over his grave. His way of choosing to be disrespectful of the komatua but something I necessarily supported (laughs)."

Even when clients are unable to face others or because the others are dead, as can be the case with older adults, therapists were able to address these issues in order to facilitate more healing.

"...they thought their mothers kicked them out of home and discovering from two chair work that it wasn't their mother that did it or whatever and then having conversations after that all the time with the mother and feeling really connected and wonderful so two chair works really good for that."

Summary

The reconnection of family members makes recovery more complete and is a critical factor in the long journey to healing. Strengthening the parent-child dyad ensures the future nurturing and protection of the child, thereby contributing to the increased resilience of the survivor. By unbundling the restraints that kept the family system alienated and stuck, the family can relate in flexible and appropriate ways which provides each member with the adaptive coping skills needed to live enriched and fulfilling lives. New ways of relating prevents further abuse occurring by replacing vulnerability and weakness with adaptive coping and resilience.

CHAPTER ELEVEN: BELONGING, ESTRANGEMENT AND REINTEGRATION: THE CORE SOCIAL PROCESS OF RECOVERY AND HEALING IN SEXUALLY ABUSED FAMILIES

The core social process regarding family related themes which emerged from therapist accounts and understandings consists of three interacting concepts “Belonging, Estrangement and Reintegration”. This model of recovery and healing in sexually abused families recognises the impact that abuse and neglect has across a family’s generational boundaries. It also describes the evolving nature of relationships before, during and after the sexual abuse event(s). This chapter details these processes.

The selection of the overarching process was based on the presence of the following features; being a constant process which accounted for changes over time, variations in conditions and variances between therapist accounts and behaviours. With this piece of research, the core social process accounts for changing needs and issues of clients and their families across the lifespan. It accounts for various types of CSA experienced (i.e. extra and intra familial abuse / current and child client or historical and adult client) and varying levels of severity of impact of the sexual abuse experience. It also accounts for the diversity of interventions provided by therapists of varied disciplines and for the various specialised populations encountered.

The Core Social Process: Overview

Belonging

- Belonging: a multigenerational construct
- Vulnerability from belonging to growth inhibiting systems
- To belong: a lifelong aspiration

Estrangement

- Many faces of estrangement
- An unsupported journey

Reintegration

- Triggers to reconnecting
- Integrating according to new rules and organisation
- Different paces and processes
- Reintegrating for prevention of further vulnerability

Belonging

Belonging to a family is an inescapable aspect of an individual's identity. At birth, individuals become members of a family which has a past, present and future. Family legacies, behaviours and ways of relating are handed down the generations and influence how families respond to current experiences. Therapists reflected their understanding of the multigenerational nature of abuse embedded within the fibre of the family.

"Abuse usually in some form passes from one generation to the next"

"... inter-generational, attachment, relationships and inter-generational sexual abuse and violence carry on down the line."

"... I'm often really aware of the impact, the women that we see or the odd men obviously, the impact that their wounding has on their families..."

When comparing practitioner understandings of the underlying causes of sexual abuse, belonging to a family that did not / could not protect and nurture individuals was problematic. Sexually abused families were described as having vulnerability inducing structures and/ or patterns of relating which increase susceptibility of its members to abuse and perpetuate the cycle of abuse they get caught in.

"...I've worked with clients where sexual abuse was inter generational and also, yeah horizontal and there was an incredible amount of abuse within the family and it, it was, I mean you're dealing with all sorts of things, you're dealing with denial in that situation, um you're dealing with an absolute lack of safety for

children um because of the denial of, of, of parents or mothers, you're dealing with um the children using the resources there like alcohol in order to cope with situations of lack of safety..."

"...these kids are you know, their interests if they had one is survival because we're talking about children who um have poverty um maybe neglect or, or certainly their relationships within their family, they don't have a lot of attention there you know they don't get attention even if mum and dad are there..."

The yearning to belong, feel safe and protected emerged as an aspiration which lasts a lifetime. When this aspiration had not been achieved, as is the case when primary caregivers do / did not believe or support the survivor, it is more the hurt from the isolation and alienation from those people than the perpetrator's actions per se which will disturb the survivor for life.

"...I remember years ago we ran... groups for teenagers who had been sexually abused and probably the most successful and vivid one was girls who had been abused either by fathers, step father or grandfather and talking about the abuser and dealing with that was much easier than talking about the mothers and for all of them they had this thing about how mothers should know and should have recognised and should have protected..."

"...at least two of them I'm seeing now, they are belting up dad for not, not the joker that offended, but dad for not stopping it or believing, you know when he told dad."

Needing to belong, "no matter what", was frequently reflected in the survivor's patterns of interrupted relating and revictimisation across the lifespan. For example, their attempts to connect with and feel loved by their primary caregiver, survivors remain in abusive and victimising relationships with them, well into adulthood.

"...he's had so much negative from his own mother that he still sees, she's eighty three ... and er that negative thing, he's just beginning gradually to see that he's been crushed by it..."

Frequently experiences of revictimisation occurred through survivor's seeking adult relationships which functioned and operated in similar ways as those they were subjected to in childhood.

" I think with all, sexual abuse survivors or not, repeat patterns that is part of human nature and so I do see with sexual abuse survivors some repeating of the dynamics of the abuse... Some will come to me because they recognise they have had series of relationships with people who treat them badly sexually they are wanting to break that pattern..."

"...around their absolute need to be in a relationship to start off because that is the norm that society expects. The fact that we can come out of a relationship today after having been given a really good thumping by somebody and walked out and within a week we are in love with somebody else and we are now into a new relationship and he is the most wonderful thing that god ever put breath into and we have got an extremely lustful sort of relationship and we will continue that until such time that particular person reacts in the same way as the previous one and the previous one before that..."

"You know how its affected on me in relationships and often getting into, having other abusive relationships (.) violent relationships, more abuse, got raped again and again and again, //mmm// you know 'cause of, weak boundaries, lack of assertiveness, just a general lifestyle //yeah// they drift into."

"Well, the tragedy is often that the children of an abused mother will be abused. There's that I think that must be that's the hardest thing sometimes for them to live with and that they come in because they felt that they could put their past behind them but their child has now said something about being abused..."

The fear of not belonging, not being believed or protected could be so strong, that survivors would deny and minimise what had occurred to them for the sake of being loyal to what they knew deep down was a very dysfunctional and unhealthy family that was perpetuating their unwellness. This dynamic would also occur even at the expense and to the detriment of other innocent people.

“... the distortion between normal healthy values and how they are held on in a distorted way and particularly loyalty of how the dilemma between being loyal to the family and being loyal to self disclosing...”

“...and then the other thing ... is the whole notion of minimisation because things were so bad ...Well, she casually, you know, throughout the session said she was abused by her father and three brothers, one of which is in jail and the other one she believes is a paedophile but doesn't feel comfortable disclosing but is very worried about him abusing other children and he has access to children and she felt she has dealt with it because she has read a lot of books, you know, and so that level of, I don't know what you would call it, she sees no connection between that and her rigid body and migraines and the tremendous loyalties with the family. The brother that is in jail, he's a paedophile. She had gone to court to testify on his behalf even though she knew she had been abused and so it's these types of things, you know, it's definitely a consequence and yet how to bring it more consciously out, they need to be worked with.”

For others, therapists described situations where belonging and the capacity to reach out and give was simply too painful, so survivors turned in on themselves and denied (for a time) this need. The experience of male survivors was extremely poignant as illustrated by the following account of a therapist / survivor.

“One of my sons had obsessive-compulsive disorder and he used to have panic attacks and he would want to be held and he was I think about 15/16. I found it extremely hard to hold him, extremely hard and I would have been like a wooden post. He must have felt he was hanging on to a gate post and I didn't know why but I just froze. I didn't make any connection with my own abuse or anything like that but I found it extremely, extremely difficult to offer that, you know, what he wanted, you know, that loving support and that, which a father should be able to give.”

Whatever the coping strategy employed by survivors, the physical and or emotional separation from their families was understood to be a significant hurdle to

overcome in the journey to recovery. Healing cannot occur until the unit of belonging, the family, is adapting and relating in a healthy way.

"... even with older people, you know, inviting perhaps a mother in who wasn't able to protect the daughter you know whose come for sexual abuse counselling. If there can be some healing that can be facilitated. Like sometimes it's too daunting to actually do that, for the daughter to do that with the mother face to face. I am really open to inviting that type of situation, to happen and to facilitate that because I think again, it's a shortcut really. ...A shortcut to working with that person on and on and on until eventually, they either get over the issue whereas if the Mother said "I do love you and I was just not able to be there because I was fucked." You know?"

"...connection and attachment which enables healthy attachment in other relationships..."

Practitioners from communal cultures particularly understood that disconnection and isolation of the individual from the family has long term implications for a victim's identity and sense of cultural and spiritual connection.

" Not being able to talk to them about it, that it's a secret, that its, there a sense of disconnection with some whanau members because of that, um, it might mean that they don't even feel safe to go back home, it might mean that, that they get anxious if they have to go to a tangi or um, you know, there's a lot of, because whanau such a basic part of our lives it can have quite a lot of different effects in terms of the relationships and sense of belonging too, for some people it can really affect their sense of belonging to that whanau as well. I guess that's mostly when it's within the whanau, but even when it's somebody that's connected to the whanau but isn't actually a part of the whanau, I mean it can still have those kinds of effects for people as well."

Estrangement

From the therapist accounts, emerged varying patterns of estrangement between sexually abused family members on their journey towards recovery and healing. The process of estrangement appeared to take many forms, it occurs at different speeds and at various junctures in the abuse experience.

Sexually abused family members were often estranged, felt isolated and disconnected, even when physically living together. As a consequence, therapists observed victims isolating from others in an attempt to cope with their experiences.

"The humiliation in, I suppose of being disowned, you've told mum, mum has said it hasn't happened, so in effect although you've lived with mum, and continue to live with mum they've disowned you, and so you learn to build your shell a bit thicker and a bit harder, um, and move on."

"Now I have no problem... I am able to feel the emotions and things that I couldn't feel then. They were just cut right off. Yeah for me a lot of emotion gets very cut off."

"Loss of safety and support can result in dissociation as a coping mechanism."

Estrangement could also occur due to members being forced apart.

"...and in other families you will have a mother who will support the father to the detriment of the children and you will have Social Welfare stepping in and saying you are now not a successful mother we will shift the children out. So the children or the family go through a stage where there is another breakup that takes place and that is between mother and children..."

Therapist descriptions also reflected on estrangement occurring as survivors drifted away from family connectedness over time.

"...they also suffer degrees of shame because now suddenly they are the pariahs in society ...so they try to distance themselves from the person..."

Estrangement further exacerbates the interrupted relating that was present prior to the abuse experience. Prolonged periods of estrangement after the abuse experience increases the intensity and duration of symptomatology experienced.

"...however if you're a child and it happens in your childhood and then it's not addressed, then you're going to be carrying that trauma with you, and that then affects the way that you operate in the world and of your life, and then it just kind of all starts to pile up on top of each other I think..."

"Well it [having supportive family environment] meant that their recovery will have been a lot quicker and that they will have coped with it a lot better."

Therapists understood the impact of being estranged from family, as increasing survivor vulnerability. Unsupported, survivors have to carry the burden of the abuse and all its mitigating circumstances alone. Survivors were often described as unable to summon functional support due to either isolative tendencies or disruptive and challenging interpersonal relating styles. As a consequence, therapists placed great emphasis on the importance of external support, virtually all therapists sought to ascertain the extent of estrangement and degree of external support available to assist the individual in their recovery.

"... for me it's having to bear in mind all the time that it's not just me and this person... so it's a bit of a relief when I remind myself that there are other people around but also that acknowledging there needs to be a safety net around the person and that's a big part of the safety..."

"What support do they have now and is it functional support."

"...part of the healing is in fact, to enable you to be open and free with your support networks and your systems..."

The process of estrangement limits healing potential in individuals. As one therapist remarked;

"Ultimately until their individual changes are integrated into the ways that they relate to others I don't think the work is complete."

Reintegration

Unless family issues are addressed, the underlying mechanisms for the onset and enabling of abuse (vulnerability, interrupted relating and alienation), project onto future generations, perpetuating the cycle of abuse and neglect. The reintegration of families in new, growth promoting ways was perceived to benefit survivors and their families as the loss associated with estrangement could be healed.

"... in terms of working from a family assistance perspective, that the ability for people to move on and to be supported in a new journey and a new way of dealing with it, you need to be able to involve those external agents in it as well.."

Reintegration can be a lifelong journey which entails recovering the sense of belonging and connection. This was understood to be achieved through relationships with supportive partners and children.

"...I had an adult person last week who was saying to me "Here I am in my mid thirties and I didn't realise what it had done to me all my life and now it's crunched up my adolescence, I became an absolute mess for a while and then later I sort of saw the light and wanted to partner somebody who had a bit more sense and got some children' but it's only now, in her thirties, that she's able to even begin to think about working on it."

Facing significant developmental milestones and the consequent changes in the mix of family members (new babies, partners entering or leaving, death and other losses) frequently precedes the onset of the period of reintegration. It is often then, the

traversing of new developmental stages at any point in adulthood that sexual abuse is disclosed for the first time and treatment sought.

"The beginning of committed relationships, marriages, birth of a child, loss, grief, any kind of grief actually. The loss of a loved one..."

"...you're dealing with the child and mum for the first time burst into tears and talks about her abuse and nana comes along to support mum and talks to for the first time about her abuse..."

"...And that's often why they come ay, I mean it's not for themselves but it's like "Ohh, I've just realised I was doing this. I don't want to be a mother like her this time."

Reintegration could occur through a therapeutic intervention. When discussing what occurred in therapy and how therapists treated sexual abuse survivors, a process of reconnecting the individual to others (deliberately or not) was articulated. The means of achieving the reconnection varied according to age of client and model of practice of therapist.

In accord with communal cultures' models of health, reintegration could occur from targeting the whole system first.

"...where possible I always try and keep the whanau intact, because we're going to move on, we're going to go, but your whanau are always going to be there, that's who you should always be relying on."

"With children its hugely important... and this is true for adults...at the end of the day its their whanau that are going to be, that are going to be looking after them and supporting them and working with them, I mean, they may not see themselves formally working with their children but they do, they do it all the time... we're there I think, to give that really, not just to the child but to the whanau, to the family as well, so that they can take that away and continue to work with them, and they very much need to be included in that process."

Reintegration for children can only occur by working with the family.

"... I think it is quite important to ensure the family work because if that can't happen you actually cannot afford the healing for the young child."

Reintegration can occur by bringing a partner and survivor together and working on issues that are relevant to how the abuse impacts their relationship.

"...yeah about five couples talking about their experiences, their impact on their relationship //mm// and how their partners in healing, they got back to being sexually intimate again //mm// and how you know through that, the partner going 'ew no, no don't touch me' its like the partner becomes a victim too //mm// it's affecting, its impacting on them. //mm, yeah// to help them to understand that."

Reintegration can occur by bringing in significant others from the survivor's family of origin.

"... I've had this woman whose been acting out against her mother something chronic, like she's an adult but to see her.... then the other day, her mother said "When I left" because she left and left the children with the abusing father, "When I left it has been the hardest day of my life and it haunts me every night." Finally after six years, this woman got to hear this and it's changed the relationship just like that. Sure, there's still more work to be done but such a lot of good came out of her mother saying that then she felt more validated whereas before she had felt rejected and discarded really. ...for her to say how much she had suffered just changed the whole perception of this mother who was so lacking, you know and to feel loved instead of rejected and discarded. Makes that person much more grounded and more able to love herself, you know.?"

Reintegration could also occur from working with one individual and targeting family issues.

"I have just had a client who's done some major work with talking to the whole of her wider family about a silence that happened when she disclosed and she feels just so strong now ..."

Reintegration can occur by natural processes outside of and parallel to therapy. The process can be slow and evolving.

"...you know and sometimes that has a, you know a ripple on effect that that has, and probably a lot of times, but sometimes that's more obvious that people will talk about it, that ripple on effect it has within their whanau, so you know that sense you're not only working, you may only be working with that individual in the room, but in actual fact you're working with the whole whanau."

"They [survivors] can make a beneficial impact on their families cultures and extended communities."

Additionally, reintegration was considered to be not only a curative factor but a preventative process against abuse in future generations as the new ways of operating decreased offspring's vulnerability through being able to protect and nurture them.

"...just that I think it's an enormously valuable service and you know, it's like supporting young parents. It pays off, in the future and we may not see the benefit now but for every person who has resolved some of this, society's better and we pay less in the future, I think..."

"...because I work with quite a few mothers. It's lovely. It's lovely work to work with mothers who either have just got a baby or they have got small children and they come and do the work so they can actually be mothers. It's lovely."

The desired result, regardless of the speed and manner reintegration is achieved, family members have thrown off old restraints which kept them stuck and vulnerable to abuse. Adults in the family are more responsive and model healthy behaviours to family

members. The whole family becomes organised in a different way and slowly starts to relate in nurturing, supportive and protective ways. Vulnerable individuals now belong to a growth promoting family system.

Family is likely to be a barrier to recovery where members are not functioning well. Should these issues not be addressed, the weaknesses merely serve to place a child at further risk for abuse, and sends them on a less than optimal developmental trajectory. By targeting family deficiencies, the skills and abilities developed for individual recovery in the treatment setting can be transferred to and maintained within the home environment.

Summary

The process of “Belonging, Estrangement and Reintegration” encapsulates therapist understandings of the sexually abused family. Belonging is an inescapable aspect of the human condition. Where family relations are interrupted and dysfunctional, its members are vulnerable to abuse. A lack of care and protection from family members will blight the individual across the lifespan until those wounds are healed. It was understood that sexually abused families tend to be estranged from one another, often before and frequently after the abuse. The recovery and healing journey is arduous when faced alone which was understood to often occur in sexually abused families. Reintegration of family members is needed to allow complete healing to occur and to prevent future vulnerability and risk occurring in future generations of the family unit. Reintegration can and does occur in a variety of ways, therapist intervention being one of them.

CHAPTER TWELVE: CONTEXTUAL FACTORS IMPACTING FAMILY WORK

The following chapter outlines the therapist related themes that emerged as contextual factors which position families within the unique New Zealand environment. These factors run parallel to and intersect with the practices of the therapists. It is these elements which practitioners must fit in with, and work through in their daily practice with sexually abused families.

Axial Codes

- Therapist beliefs and attitudes
- Therapist training and skill base
- Conditions for systemic work
- Conflicting models of practice

Therapist beliefs and attitudes

- Role as therapist
- Positioning systems work
- Professional rivalries

It became clear early on that a great number of therapists working within a Western based model of practice, especially those working with adults, saw systems work as beyond their role and model of practice. For some, involving family was a barrier to recovery for the client because it was a source of toxicity and perceived to hinder not help the process.

“ Inability of clinicians to effectively firm boundaries on what is discussed in Rx i.e. dealing and family issues instead of sexual abuse issues.”

“ Therapist becomes over attached, therapist tries to be the social worker. Therapist becomes enmeshed in the family system.”

Systems work was understood by many to be a separate, specialised style of working that was distinct from traditional individual focused therapy. This attitude is a reflection of the dominant Western cultural values (individualism and autonomy) from which current counselling practices were developed. It is also a reflection of the variation in meanings and understanding that can exist for one particular concept.

"...the role of a counsellor or therapist or psychologist is actually quite limited I think in a way, its very specialised and specific..."

"...I'm, I'm a strong advocate for working with, and it's my social work background as opposed to being a counsellor or a psychologist but I am a very strong advocate for working with the systems..."

Therapists also often portrayed the view that systems work was tricky, tiring and a burden.

"I remember one case, I think it went for about 5 hours, 'X' had, I had the perpetrator and she had the um victim, that was really stray, we set it up and gave them the boundaries, but we had them for a while. But even that, one would go off and have sleep and you'll think, then the family would drop in, oh god, it was messy but not. I think they all walked away looking better than we did, we needed a holiday after that lot, um."

"...when I went to xxxxx a family that we hadn't, we worked with incest families where they wanted the abuser to stay in the family and we had a little team set up to deal, to try and deal with that, it's very, very hard wor...k"

"... you know you can almost fill a clinic with a couple of families and you've got your work cut out."

"...if you've got several children and a mum on her own, who's, who's probably been sexually abused, it's an enormous burden to carry particularly on your own."

A consequence of these attitudes and beliefs, along with the lack of organisational support provided to practice in this way (as discussed under the axial code “Conditions of Systems Work” in this chapter) is a huge disincentive to therapists embracing training in systems work and to practicing in a more ecological manner.

ACC contracts out to a wide variety of health professions. Financial awards for each profession are based on its socially recognised professional status and perceived level of expertise. The variance in recognition and awards between disciplines, along with their often conflicting views regarding what is best practice creates a hostile working environment.

“...what you could charge a poor old counsellor for doing it but you know, but it's those kinds of things which I think probably within the ACC is a lack of recognition actually and the fact, I mean, I don't, as I say I don't mind the peer reviewing and that but I do know that a lot of people were upset about that because they put clinical psychologists in there which I think was a bit of an 'up yours' to the counselling profession. I mean there's one counsellor, BG who does the, you know. So we are lower down the pecking line.”

“...so I suppose the ACC could pay us more. I'm serious about that. They will pay a psychiatrist \$97 an hour. Why? I know more about this actually. I know more about this work than they do... I mean, money's not everything but apart from the support and that, I think it would give acknowledgement and recognition to both the nature of the work and the skills and the training and the experience that we have in that this is different work ...”

The hostility between professionals is exacerbated when they disagree on ways of working with a particular claimant. This occurs because each discipline brings with it a different model of practice which informs interpretations of what is occurring and how it should be addressed.

“...Fundamental differences and my experience of one is almost on bordering with hostility from the part of Mental Health Services for and a lack of acknowledgement about the professional, you know, the whole area of psychotherapy or counselling...”

Particular issues of contention between the varying models of practice which emerged were the targets of treatment for child claimants and the timing of delivering sexual abuse counselling to a victim, as depicted in the following quotes.

"... there are times to do specific sexual abuse counselling and there are times not to and I think that sometimes we have seen young people come in who had some sexual abuse counselling and it hasn't been working and you know, they have deteriorated and its at that point that I'm thinking to myself "I wish they hadn't even started that." It wasn't the right time..."

"So I think we can step in a bit too early sometimes with children and sort of force the counselling when it's really not helpful. I think if we can see their perspective and read the signs and think well maybe this is more about reducing distress and trauma symptoms and supporting families to cope and deal with what's happened and less about talking about the specific abuse incidents or whatever. Just a form of focus I think."

"...yes they do need counselling, but it is a different type of counselling so maybe from the sexual abuse counsellor they can still get some therapy but not dealing specifically with the abuse issues. Not talking about the abuse necessarily, not looking at how its affecting them or how they might feel about the abuse, it may be doing other things like looking at their relationships in general, how they feel about themselves, strengthening their family unit, so they get lots of support, that's the sort of work that they need..."

Another major area of contention surrounds cultural values and models of practice regarding issues of safety for children and how these should best be managed / resolved.

"... But how big, how much can you, how much can you do, do you know what I mean? I mean I will draw your attention to the likes of the Celia Whittaker of little Bella down the line you know, she was a sexually abused child, we kept that in the family, we gave it to a family member, that sexual perpetrator still had access to that child, and that child was abused and that child was

subsequently killed, and that's the danger, you know I'm all for, I'm a Maori, you know I'm all for the family sorting out family issues, but how safe is it to keep that child or the sexual abused victim in that family circle?..."

"...we [Pacific Island peoples in New Zealand] are always challenged by the fact that, how can we really make sure that this child is safe when we leave them, because the very mother that knows that this is going on is the very mother that's still falling in love with the same guy that's come and now touched the children you know, but its good because more and more I'm seeing a lot of the service providers are coming together to see if I'm not there, or can you please go Tuesday, that the child has always got somebody throughout the week, that they are monitoring them but it is true it only takes one hour and that hour could have been the night, and like you said 'X', where's the resources to come together aye, its not like Samoa, like I commented earlier, we have houses that are wide open, they will see somebody that's acting stupid in the middle of the night, and they put things in place to make sure that they suffer the consequences. Over here at least they have time to come back to the community aye, but there, they can go through some heavy penalty aye 'X', and it effects the whole family where as here we've become so isolated in the way that we are placed that we don't have that system, so there's many things that New Zealand as a society needs to address when it comes to this kind of work, because it's a very sensitive area...and part of that is being aware that we have ways that have been foundational in our up-bringing that actually worked..."

This issue also reflects the difficulties which therapists from collective cultures face when attempting to transfer their models of practice to another society and fit them into the nuts and bolts of the dominant Western culture in New Zealand.

"...legally we are always at risk because that we have that's why I said, legally, professionally, culturally we switch around to make sure it fits and always make sure it's safe practice..."

"Its something that we are trying to lobby aye because we cant say to the family people and then do it the pakeha way which is very individual, very individualistic."

This hostility and points of difference between the models of practice can act as a barrier to the multidisciplinary team work which has often been cited as needed to work more systemically (as discussed under the axial code "Conditions of Systems Work" in this chapter).

Therapist training and skill base

- no training in sexual abuse
- need specialised training for child work
- no language to describe & detect phenomenon

Many therapists articulated that they are "self-taught" in sexual abuse work, due to the lack of access to any type of training on the subject.

"Yeah, yeah, I, I have to say that there was very little um content in the masters in regard to sexual abuse..."

"Well I became a trainer before I was trained."

The lack of official training reflects the relative "newness" of the subject area in research. Historically there has not been a sound research base to support training. Even today, it was noted by therapists that the subject area is faced with methodological issues, particularly biased samples, which limits the degree that results can be generalised beyond the populations investigated.

"...there's a lot more girls on than we know about, and it gets covered up but the joke when I was a social worker was that the rich sent their kids to boarding school and the poor sent them to social welfare and there's a lot more proof than that so I think there's a lot of covering up..."

It was identified that there are a lack of therapists trained and or available to work with children. This is a real barrier to delivering optimal services to this client group, as it was recognised that to work this group one must be specially trained. By implication, without that training, practitioners may not appreciate the level of family involvement required to achieve a speedy recovery. Equally, without access to intervention, the child's and the family's distress is prolonged and or intensified in the interim.

"Despite what clinicians say, there are very few who are specifically trained to work with children."

"...that people who are working with children in adolescents are special people and they need special skills and training and that includes their peer reviewers..."

"I think it's a particularly difficult, it is in 'X' anyway, there's very few people working with children in the ACC system so it's really tough."

"There is a dearth of counsellors for children, ACC sexual abused sensitive claims children because there aren't enough people... They had pulled out of ACC work, you know... so that's another problem with treatment."

A number of therapists, even those working with children, were unable to access and provide succinct descriptions of the families they encounter and often appeared overwhelmed when trying to do so. Whilst this reflects that few practitioners operate from a systems based modality, it also implies that without the access to systems based language, therapists cannot or do not always recognise and/ or describe nodes where systemic interventions would be most desirable, as in cases with multiple issues, abuses and neglects occurring at once. The following quote demonstrates how given a cue to discuss the family in systemic language, the therapist responds from a literal position as they have no access to systemic descriptors.

Speaker A: "Do these families look like something compared to others?"

Speaker B: "No, they don't have it written on their forehead, no."

Conditions for Systems Work

- Team work and peer support
- Support at an organisational level

Both therapists currently practicing and those wishing to practice from within a systems framework, were able to identify a number of conditions which need to be present to make this style of work more accessible to therapists and clients alike. A supportive team environment was identified as being crucial to this style of work.

"Yes, it's very much working together. I think we do work across team and within team... we have got individual special skills I guess, within our team as well and we do share that."

"... you need a team, you need, I mean that is so intensive because you need almost somebody for every member in the family and you need multiple, you need individual for the abuser, individual for the victim um parental work, family work, maybe the other siblings because often the other siblings, particularly if it's a father, the other siblings could be very jealous of the relationship that the victim has with the perpetrator and so those dynamics need to be addressed as well..."

Without goodwill and effective communication between practitioners, it was identified that clients were likely to become confused by the varying messages received from the different operators, and organisations they were involved with. In addition, by streamlining the process of teamwork, it would enable the various practitioners to see all pieces of the puzzle and in doing so provide a more effective service.

"Well I think it's just left to the individuals, the counsellors to be able to just pick up the phone and communicate. I think that we try to do that and you know, I have had it work the other way as well where a private counsellor is doing some work and just wants to let me know that It is important that we are on the same wave length or we are not crossing over. You've got a family here that does not want to get mixed messages and particularly for the young person themselves, that they are not actually been given a lot to do or two totally

different kind of approaches. That's not to say that the two approaches aren't equally good but if they are there at the same time, the family or the young person might get quite confused about that and that has happened."

"...and it was fortunate for those twins that the other worker and I happened to know each other and we do get on with each other and we were able to work together but there's heaps and heaps of situations with siblings, with all sorts of situations with boy children as well, who get sexually abused, when there isn't any chance to cooperate between the practitioners because they are private and I think it means that the work is splintered and uncoordinated. It doesn't go well and the recovery is hampered..."

Therapists also recognised that the organisation in which one works, or is contracted to, ultimately determined how well, if at all, a therapist could perform a systems based intervention. These factors were determined through the level of support and resources the organisation allocated for its delivery.

Developing relationships with the members of a family can take time. This is a critical part of the intervention. Therapists pointed out that their organisations needed to be able to allow for this.

"... the time factor, you just allowed them all the time you could. If I knew I was getting a sexual abuse case then I would close off the whole day, you know, and I just wouldn't see anyone else and whatever they talked about that was ok, you know, and they may beat around the bush for bout 4 or 5 hours, and eventually they would know, that they could see that I was with them..."

Requiring ample time to develop relationships, was particularly salient to working with Maori, where discussing tribal differences and histories could be part of the relationship building process.

"...the one thing we recognized there when we are dealing with Maori clients we need to be sure that we had a lot more time to deal with the social work wasn't it, it would take me half an hour to go in and see um, a non Maori person, you get the details, who they'd hurt, the next of kin, this is what's the

matter with you, right, this is what I'll do for you, gone, half an hour and yet you touch base with a Maori, who will go in, Kia ora I'm 'X', I'm 'X', oh right, and you get the blame yeah with your bloody lot that came down and swapped my bloody lot, you know your grandfather ran here..."

"...and you always proved to them, no, that wasn't you, yes I'm not to bad, I can do this and where it took half an hour for non Maori, it could take me a good 4 hours just to get them to open up, and we did..."

Another aspect of systems work that was highlighted as requiring sufficient allocation of time, was liaising with the other professionals and organisations in contact with the client and their family. This allows for the delivery of a more holistic intervention, allowing all aspects of the family ecology to be considered, not just isolated aspects of it.

"Ok, I think one of the things I find very helpful is integration of Services. Like for instance, the Social Worker, the Counsellor, the family, the Pastor, you know the integration network of the community and that's what we have to do, to be able to help this person or these people, and just that communication, like you say, your so right about that, so its just ringing up and say hey I'm going here can you please ... You know it's that connection and you know working together as a team. "

"Right, we would certainly do that with the young person. tapping into the school environment, tapping into home, what other supports do they need. It's surprising how much of our work is liaison work, and facilitating. Although we are seen as a specialist mental health service we are actually doing a lot of that work liaising with various services such as Across Social Services that might have kids in care, and Child, Youth and Family Service, as well as schools."

Therapists were concerned that despite theory and practice based evidence which demonstrates the essential nature of working ecologically with certain populations (eg. children), it was felt that the current ACC system was not supporting

these types of activities. Therapists felt out of pocket if they practiced how they thought they should, because ACC would not pay them for their time.

"...next to including family which is very essential, what we are talking tonight about this also excluding all the work one does naturally with schools, other people involved, extended family and so on and so on and this is all sort of undervalued too."

"Another thing I blame the Government for this kind of thing, I strongly quote that, because we, they give us the mandate to follow and expect us to do, for example, we have to write a report, and they expect us to go visit, see what's happening, come away from it in the report. But that's not the way that we work, and then when we tell them that we need to spend 5, 4-5 hours to work the family they don't believe it..."

"...you feel like you are being greedy because what you are saying is we can't do that because we won't get paid but it's the reality. You could do it on your own time as much as you wanted but perhaps I'm not quite that masochistic. I might have one session in that sort of I'm sure I have over the years, seen people and not charged for it but I certainly couldn't do that over many weeks work."

As a consequence of these organisational restrictions, many therapists believed they are being forced to practice under sub optimal conditions and clients as a result are not receiving a service which constitutes best practice. The likelihood of their ending up in other services down the track was seen as inevitable – costing the government even more money over the long run. The irony of this was not lost on the therapists.

"...so it doesn't add up, it's almost like the Government have the community people and services to fail..."

Conflicting Models of Practice

- medical model vs counselling
- legislative issues
- governmental policies and funding
- social discourse : gender issues

It became clear very early on in the transcripts that the models of practice of service providers were clashing and thereby creating an environment of discord amongst various service providers. ACC, the funder of treatment, operates from a legislative perspective and a medical model of health. In contrast, the majority of therapists, the deliverers of treatment, operate from a range of non medical, mental health models whose conceptualisations of events and aspirations for treatment diverge often greatly from that of ACC's.

"...I hate all the terminology, all the terminology is medical and I hate it, and I think it's really inappropriate, that's something I haven't said, and most counsellors I think would say the same thing, we don't work from a medical model, but ACC does so we got a bit of a clash you know of world views if you like, and I'm not quite sure how that might be resolved..."

"...to use that sort of diagnostic labelling is really akin, it goes against my spirit, because I'd rather view people as they yeah able to cope with things and not judge them by symptoms that are then categorised and labelled."

A consequence of this seeming incompatibility between providers, is that therapists are being forced to deliver a mental health service within a physical health framework. Whilst there are overlaps between the physical and mental health of an individual, therapists point out that mental health services are far less prescriptive than those for physical health, requiring a more holistic relational perspective of the presenting issues.

"I think what we are hoping is to get away from a medical model, DSM or kind of stuff ... is that they had to bring um the sensitive claims into the legislation

that covered the whole lot so that they were trying to make it fit into what was meant for the physical stuff.”

“... the categories and labelling, how ACC are pushing that perspective to have very - particular diagnosis to treat discreet symptoms, not necessarily connecting them to kind of, drug and alcohol issues, family issues, these other effects that influence and interact, the current model conceptualisation of counselling is not taken into consideration, the need to address those issues...”

“... part of the healing is in fact, to enable you to be open and free with your support networks and your systems and if that means family work, that means work with children and with adults and the openness and things, now that's not really therapeutic work in the eyes of ACC...”

A significant and frequently voiced concern, particularly amongst those working with children, was that therapists are unable to secure funding to include others in treatment beyond one identified victim. This is of grave concern to the therapists as the family and its dynamics can block the therapeutic process because they are often perceived to be part of the “victim’s” situation and problems. Without being able to address family issues where indicated, therapists are faced with ethical and moral dilemmas, in that they are forced into providing sub optimal, contra indicated services. Legislative constraints have been held responsible for this phenomenon by ACC. Therapists did report variations in how closely individual case managers followed the legislation on this matter. However, the inconsistent approach taken by ACC merely serves to increase therapist frustrations and decrease their faith in the merits of the ACC system.

“...but of course ACC do not pay for that they will only pay for the child. They have said to me when I have challenged them historically they have said to me ‘Well of course we don’t actually know whether you are seeing the child or not’ But my own ethics will not allow me to see the parents and not the child, so sometimes it is about bringing the child into the first part and an aunt or somebody take the child away...”

“...including the system that the child lives with which of course is, part of what's going to help with the healing. If there is going to be any healing at all, we have to actually have consultation with parents or with the care givers or with somebody who the child is actually trusting so for me it's really a worry that ACC continues to work with children in isolation like this and doesn't include the family as a matter of course and the systems around the child, like the schools, as a matter of course.”

“They hide behind the Act because Act and I have not read it, I must own up, but the Act says I think that it must be the individual and so they hide behind that and that is most frustrating.”

Other populations identified as negatively impacted by the symptom based perspective of ACC are older adults. The following example demonstrates how ACC staff, without a working knowledge of mental health issues, have difficulty understanding the complexities of the effects of sexual abuse across the lifespan beyond a specific DSM diagnosis and the making of a direct link to mental injury.

“...that's all right because I was just going to add the interesting thing is about people who come in at an older age I have two one at 68 and one at 75 and because they have basically coped or adapted their life to their abuse ACC have struggled both times to allow those people to have hours granted to them and it has been interesting having the argument on behalf of the client with ACC about whether they are entitled to hours, what's the mental health problem as such. The fact that they are depressed that they are on antidepressants is not necessarily seen as a mental health problem and because they have modified their lives and accepted this for so long there is a perception by whoever is making a judgement call over the ACC 290 that these people probably don't need it in actual fact.”

Adherence to a symptom based model also created issues for therapists who deliver cultural services. Many of the counsellors had chosen to work outside the ACC system because of its restrictions. As a consequence, not enough culturally appropriate

practitioners are available under the scheme and so their people are unable to access vital and necessary services which would be most appropriate.

"I mean I, the problem is the lack of culturally appropriate counsellors, you know if we had Maori counsellors male and female available I'm sure that they would, that access issue would be lessened you know..."

At a more distal level, therapists understood that responsibility for the way they were being forced to work with clients, lay in the hands of the government. Governmental legislation, policy and funding were ultimately seen as driving service provision for children and families in New Zealand.

"...you know we have government ministers who, government ministers who um talk about family values um and talk about you know the political side of, of families and that sort of thing but at the end of the day they don't do anything about protecting the rights of the children of this country..."

The low priority given by the government to children and families resulted in what therapists considered to be a lack of services available for children and families generally.

" We really did have the most wonderful play room in Wellington, I reckon. And they lost the whole thing, partly because of Management's change of policy, change of direction. Now they are into they are more in social services directions rather than actually working with children and families as such so, yeah, it's hard to get any help for people unless they can pay for it and that's not fair either, to the child who is the client, you know."

Despite these criticisms therapists acknowledged that without the ACC system, many troubled families would not be able to access any sort of intervention.

"I think that, that, that is important to is that at least some kids are being seen that otherwise, if ACC wasn't there. At least we've got something as opposed to nothing."

Cultural discourse on matters regarding gender were also identified as contributing to problems with the positioning of children and families in the New Zealand context.

“...and so that’s the big thing is how do we get to a situation where boys are allowed to come forward and disclose that they have been sexually abused. So it’s a cultural change. To me it’s like a major vision in the whole country, that it is up there, that our children are precious to us; let’s have a look at why we are allowing the sexual abuse to continue...”

“...but I do bring a feminist analysis to the work that I do, and I do think um, that women, what women have to live with is um, different in the sense that we, we live within a rape culture if you like, and that we have a different sort of status in this society, so, we’re more vulnerable to abuse and um, we don’t necessarily have the same access to power that men do, in terms of, self determination or feeling in charge, or feeling powerful in our own lives, so I think there’s some differences there, not to say that men don’t have a lot of those, I wouldn’t say that men have necessarily any different effects when it comes to that, just a different position I think, that your working from.”

Summary

Systems based interventions were viewed as a demanding and intensive field of work by the therapists. A number of organisational structures were recognised as being barriers to the provision of such work. Therapists described feeling unsupported by both fellow professionals and by the system that they worked within. Additionally, cultural values were recognised as impacting what funding and type of services are made available through the public health system.

The identification and expression of the contextual factors imply that CSA, at every level, is very much an ecological issue. Any work in the field of CSA requires balancing of the various tensions between the therapist, client, community and governmental organisations and the wider social milieu within the unique New Zealand context.

CHAPTER THIRTEEN: DISCUSSION

The purpose of this investigation was to explore the role of family in recovery and healing from CSA, with the aim of further understanding ways therapists can incorporate and address familial factors in the recovery and healing process. The major findings of this investigation were that family has a significant role to play in the onset of abuse and in recovery and healing from it. Specifically, family variables are indicated in placing a child at risk for abuse. Family processes were also understood to either minimise or intensify symptomatology of the victim/ survivor. Additionally, CSA was perceived to impact family relating across the entire lifespan. Finally, children in particular but not exclusively, require family participation in treatment, regardless of the therapeutic modality provided.

The major findings along with the core social process of “Belonging, Estrangement and Reintegration” are discussed below in relation to the international literature on CSA. The present findings both lend support to a variety of areas within the body of literature regarding CSA and provide new insights and understandings of the role of family in the unique New Zealand cultural context.

The Selective Codes

Vulnerability

The findings in this study indicated that certain children are placed at risk for abuse well before it actually occurs. Therapists attribute member vulnerability to a number of dysfunctional family processes that were inherited from previous generations and which interact with current internal and external stressors. These variables are consistent with the literature detailing family related risk factors for increasing child vulnerability to CSA as reported in Brock et al. (1997), Lambie (1997) and Putnam (2003).

The present body of data went further and framed the risk factors within a temporal and systemic context in an attempt to more fully explain their occurrence. This framing of time and space is consistent with both Bronfenbrenner’s (1979) Ecological theory, FST understandings of the intermingling of individual and family lifecycles and

Carter and McGoldrick's (1999) delineation of stressors which may impact the development of a family across the lifespan.

The present study provides clinically based support for a predisposition to the transmission of prior vulnerability into an abuse saturated family lifestyle. The therapists understood that if family related risk factors were not attended to, they would transmit across into future generations, further perpetuating the cycle of abuse. The phenomenon of the intergenerational transmission of abuse generally, not sexual abuse per se, has been previously identified (Putnam, 2003; Rumstein-McKean & Hunsley, 2001).

The therapists' accounts of horizontal stressors, mirror the literature regarding co-occurring abuses in sexually abused families (Dong et al., 2003; Hecht & Hansen, 2001; Higgins & McCabe, 2003; Howes et al., 2000; Friedrich, 1998; Rosenman & Rodgers, 2004). Whilst the technical literature has focused a great deal of attention on determining what specific type of abuse is responsible for later psychopathology as summarised in Merrill et al., (2001) and Nurcombe (2000), present therapists did not attempt to make such a distinction. This trend lends support to the argument of commentators such as Higgins and McCabe (2003) and Rosenman and Rodgers (2004) who question the clinical meaningfulness and credibility of conclusions from studies who claim to have done so.

The combination of vertical and horizontal stressors indicate that sexually abused families often have multiple issues that require addressing. By implication therapists need the ability to perform a transgenerational assessment of overall family functioning, not just whether a mental injury from CSA has occurred.

Therapists articulated understandings of how the cycle of vulnerability perpetuates itself. No one comprehensive account emerged, but rather a number of variables were revealed including attachment relationships, family processes and socio-cultural stressors. Whilst these accounts do not fit with any one developmental process model of CSA, they do instead reflect more the variables which are targeted in multifaceted treatment protocols for complex cases such as those designed by Bentovim (1992) and Friedrich (2002). These programmes acknowledge and target the interacting social, family and individual factors identified as contributing to the onset and maintenance of abuse.

By implication, a transgenerational focus within an intervention is indicated as CSA appears to be impacted by past influences (eg. transmission of attachments,

working models of relating, legacies, secrets, denial etc.), present family dynamics (eg. parent-child relations) and contextual factors (eg. culture) which transmit to the next generation and create future problems if this cycle is not broken.

Relational Interruptions

Both traditional individual and contemporary contextual developmental theories informed therapist understandings of the effects of sexual abuse. Interpersonal and social development particularly was understood to be “interrupted”. These individual interruptions were contextualised within the overall family environment and the relational interruptions occurring within it.

Children’s adaptation was understood to be highly dependent on the adults in the family and by implication, the overall functioning of their family. These themes are consistent with literature on the parent’s role in child development (Jackson & Leonetti, 2001) and role of parenting and family environment in resilience in children (Vernberg & Jacobs, 2001). Equally therapists understood that when parents were healthy, stable and able to support the child in therapy, the child coped better and had a speedier recovery. By implication, these themes provide further support to the importance of including parents in treatment for CSA children as described in (Celano et al., 1996; Cohen & Mannarino, 1996, 1997, 1998, 2000; Deblinger et al., 1996; Deblinger et al., 1999; Stauffer & Deblinger, 1996).

Therapists emphasised the critical significance of the interpersonal effects on a survivor’s recovery and healing. Their descriptions of the relational interruptions in partner relationships are consistent with previous literature (Cherlin et al., 2004; Pistorello & Follette, 1998; Roberts et al., 2004; Rumstein-McKean & Hunsley, 2001). Adult survivor’s experience of revictimisation, entering transient and unfulfilling relationships and being in abusive partner relationships were all common profiles of the clients encountered in the practices of the current sample of therapists.

The literature is conflicted on the issue of the impact of CSA on later parenting (Putnam, 2003; Rumstein-McKean & Hunsley, 2001; Schuetze & Das Eiden, 2005). In contrast, therapist accounts consistently understood parenting to be negatively impacted. This could be compounded by the fact that these therapists were seeing a selected sample of parents whose children were in therapy. Relationships with members of the family of origin, particularly with the mother and other siblings, were also understood by therapists to be negatively impacted by CSA. These findings are particularly

important as CSA literature has not been particularly focused on how family of origin relations are impacted and so these themes provide some new insights. Ignoring family of origin relations, particularly sibling relationships, is common in even the FST literature (Carter & McGoldrick, 1999). Hopefully these findings stress the importance of considering all relationships within the family of origin.

From a systems perspective, the compounding and interacting relational interruptions identified across the lifespan are an example of the principle of circular causality and are a logical consequence given the dysfunctional relating and processes identified as present in many sexually abused families prior to the abuse event itself. This indicates the absolute importance of therapists needing to understand where the interruptions may occur, how they block the healing process and how they can be overcome.

Alienation

The interrupted relating and consequent alienation of a client was considered to be a significant barrier for recovery and healing. Therapists perceived the process of alienation to be as victimising as the abuse experience itself, hence signifying the importance of harnessing family support in the recovery and healing process to ensure the abuse does not occur again.

Therapist discussions of parents of CSA survivor's, frequently demonstrated that they were unavailable to their children, both before and after an abuse disclosure. This was understood to be a result of their absorption with unresolved personal issues and past traumas. These dynamics are consistent with literature on parent related risk factors and the interference of parental psychopathology as reviewed in Jackson and Leonetti (2001), Lambie (1997) and Putnam (2003) and a result of the stress of consequent events after disclosure (Hecht & Hansen, 2001; Massat & Lundy, 1998; Paredes et al., 2001). These themes are also similar to the child treatment literature where parental distress was understood to interfere with positive outcomes as their issues left the parent emotionally unavailable to support the child whilst they faced their own concerns (Cohen & Mannarino, 1998, 2000; Deblinger et al., 1996; Deblinger et al., 1999; Hecht & Hansen, 2001; Massat & Lundy, 1998; Paredes et al., 2001).

According to FST, the way a family is structured and relates influences its ability to respond to the inevitable stresses of life. Therapists identified common responses a disclosure provokes from the family as a whole. Scapegoating, splintering

and isolating actions were identified as directly relating to the alienation and estrangement of the individual client. These family processes and styles of relating, present before and after the abuse disclosure, can be mapped on to Olson's Circumplex Model of family systems (Maynard & Olson, 1987). For example, enmeshed, disengaged, and chaotic families which swing between styles of operating were present within the transcripts. Consistent with therapist descriptions, the mapping of the dynamics of sexually abused families onto this model creates an image of very dysfunctional systems, particularly where the abuse has been intrafamilial.

The family stress response to disclosure appears to be maintained for extended periods in sexually abused families, beyond the initial expected rebalancing period a system would experience after a stressful event (McCubbin & Patterson, 1983). FST describes healthy families as self regulating and open to outside feedback (Gladding, 2002). In comparison, it emerged here that sexually abused families tend not to have functional structures which enable this process to occur. Consistent with the principle of homeostasis, in an attempt to maintain equilibrium after a disclosure and lacking the skills and resources to alter their ways of being, sexually abused families use old patterns of relating. This may keep things the same or may be more likely to exacerbate symptoms. By implication, without intervention, sexually abused families are likely to remain with the status quo, leaving members at continued risk for abuse and / or neglect and greater psychopathology in adulthood.

Reconnecting

Recovery and healing involves reconnecting the sexually abused family. Depending on the therapeutic model, age and culture of the client, reconnection was targeted by therapists in a variety of ways.

Some practitioners target weaknesses and deficiencies in the operations of the system in order to strengthen the family and enable it to support the survivor. A nurturing and supportive family environment has been identified as a significant protective factor decreasing child vulnerability to the negative effects of CSA (Merrill et al., 2001; Ray & Jackson, 1997; Tremblay et al., 1999). A number of multifaceted systems based treatment approaches are described in the literature as outlined in Saunders et al. (2004). Similar approaches were described in this investigation where the therapist worked from a systems based perspective.

Child practitioners tended to target the parent-child dyad. Developmental and attachment theories largely informed their practices. A major goal of their work was to increase parental protection and support to the child. These goals are consistent with the literature on the benefits of parental support as a protective factor against the negative impact of CSA (Cohen & Mannarino, 1998, 2000; Hecht et al., 2002; Lynskey & Fergusson, 1997; Paredes et al., 2001; Tremblay et al., 1999). However, the issue of who, how and when any parental issues blocking this process should be addressed, was contentious and various responses emerged.

Consistent with the individualistic focus of many American and British therapies, interventions offered to adult survivors were mostly one to one. However, there were many exceptions to this. Some therapists identified techniques which could be utilised with adult clients when they could neither tolerate facing their abuser or were unable to confront the perpetrator or enabler(s) due to their untimely death or absence, despite the motivation to do so. These techniques have been outlined in the research on working with sexual abuse survivors in older adult populations (McInnis-Dittrich, 1996). Where partner issues like intimacy and communication were identified as barriers to recovery and healing, some therapists reported including confused yet willing partners in the treatment process. These couple related issues have appeared in the small body of research regarding partner relationships as appropriate interventions for CSA survivors, as reported in Pistorello and Follette (1998), Reid et al. (1996) and Trute et al. (2001).

Whilst therapists demonstrated that there are many routes to reconnection, more importantly they revealed that recovery and healing from CSA is an interpersonal and ecological experience. By implication, family needs to be considered in the assessment and treatment process for all clients, regardless of the age and stage of the client.

The Core Social Process: Belonging, Estrangement and Reintegration

At a more distal level, “Belonging, Estrangement and Reintegration” is the underlying core process behind the themes of “Vulnerability”, “Relational Interruptions”, “Alienation” and “Reconnection”. It emerged that the need to belong is an integral aspect of human identity which is important across the entire lifespan. Furthermore, the feeling and process of estrangement was understood to exacerbate ill health and symptoms and works as a block to recovery and healing. It also emerged that

regardless of how achieved, reintegration with family is necessary for healing to truly occur.

Understanding Differences in Identity and Connection

Whilst belonging was identified as an underlying process, it has been captured and identified by both therapists and literature, in different ways. These differences can be explained as a result of variance in cultural values and experiences.

Models of health derived from communal, collective cultures, such as Whare Tapa Wha (Durie, 1994) and the Soifua Maoloina Model (Lui, 2006) understand belonging to family and culture as an integral feature of the individual. Family is one of the core elements of health within these models (Durie, 1994; Lui, 2006). Estrangement and disconnection implies ill health, until reconnected, dysfunction persists. Furthermore, disconnection from family was understood to disrupt relating with one's culture, a further blow to one's sense of belonging and identity and hence the stress placed on reconnecting with family and culture in communal culture models of practice.

Practitioners operating from these models have access to specific language, concepts and phrases which describes family relating and relationships. As a result, in this body of data, therapists from communal cultures immediately spoke of family when discussing CSA and had a clear appreciation and understanding of the family role and the disruptions to connection and belonging that occur as a result.

In comparison, practitioners operating from Western models of health, articulated belonging as an adjunct, or separate process to the autonomous and self actualising individual. This can be understood given that these models have emerged from a traditionally patriarchal society which values consumerism, secularism and individualism (Almeida et al., 1998; Waldegrave, 1998; Whiteside & Steinberg, 2003). Within these models, families were considered toxic and a source of stress to clients. This led to the belief and emergence of practice which privileged work with the individual client (Whiteside & Steinberg, 2003). Families were perceived as the cause of superficial problems which should be dealt with by "lesser" professions, such as community workers and support agencies (Whiteside & Steinberg, 2003). These sentiments were reflected in responses by some participating practitioners, but not all.

The emergence of the postmodernist movement has challenged the underlying assumptions and values espoused by traditional Western theories and dominant governing institutions, thereby calling for models of practice and actions to reflect

realities of today (Waldegrave, 1998). Indeed, recent models have attempted to capture the interplay between the individual and the environment, and relationships between people, their history and land (Almeida et al., 1998). Attachment and FST theories have done much toward increasing understandings of how our identity is connected to others past and present. But, in the case of FST, the focus is turned to mechanical and systematic processes. Presently, caregivers may be considered more for physical and material assistance, rather than to fulfil a spiritual connectedness between family members, as may be the case in models and practices derived from more collectivist cultures. However, with the evolution of attitudes to women and children, and the role of marriage and family within Western cultures (Carter & McGoldrick, 1999), a broader focus may eventually occur.

Furthermore, the interplay of family variables is difficult to capture empirically. Without empirical support to justify and guide practice, practitioners are unlikely to be supported in their pursuit of a family based approach. Communal cultural models have not relied so much on empirical justifications but rather experiential understandings; as a consequence, the family is well understood. But, incorporating this style of knowing into practice, has encountered resistance from funding agencies due to the lack of empirical justification (Durie, 1994). This difficulty reflects a broader unresolved debate about how outcomes are measured and particularly regarding the applicability of scientific method to social sciences (Lambert, Garfield, & Bergin, 2004).

If organisations and practitioners in New Zealand are committed to providing best practice empirically and culturally, an appreciation and wider acceptance of collectivist culture's models of development and health is required. What emerged in this investigation is that these models have additional dimensions and different understandings of human relatedness which are derived from their cultural realities and experiences. These must be respected and allowed to be expressed in interventions with those who identify with collective cultures. This body of data hopefully assists in collective cultures' challenge against mainstream policy.

Of particular note, Pacific Island migrants data was expressive of the difficulties they are having operating out of their traditional model of health within the New Zealand culture and environment due to different rules, regulations and lifestyles they live and experience in New Zealand. David Olson has described this phenomenon in the development of his Circumplex Model of family systems (as cited in Gladding, 2002).

This demonstrates that models of therapy are not universal. They are culturally and contextually bound.

Importance of Family Relating in Adulthood

The current body of data serves to support the postmodernist challenge of supposed dominant cultural values in the New Zealand context. What has emerged, is that belonging is essential to the health of individuals and families and the way this is expressed within the New Zealand context varies somewhat between collectivist and individualistic cultures. Therapists understood that family was important across the entire lifespan, despite the severe dysfunction and interruptions which may blight their relating. According to the therapists, the negative interpersonal effects of CSA are profound. It emerged that targeting DSM symptoms alone is not enough, relationships were also significant to healing and where interrupted, healing was understood to be blocked. In a variety of ways, as outlined in “Reconnection”, therapists target client relating in order to undo damage caused by “Alienation”.

Some of the newest and most interesting findings that emerged from within this project are the significance of family relationships for adult clients. This was reflected in the themes which emerged regarding the potentially long term negative impact of CSA on partner relationships, parent-child relationships and sibling relationships. These findings tend to conflict with stereotypical notions of our cultural values which acknowledges vulnerability in children, but has yet to recognise the vulnerability and degree of “need to belong” in adults. What emerged here was the simultaneous autonomy and connectedness in adults. This is consistent with calls from commentators such as (Carter & McGoldrick, 1999; Fingerman & Bermann, 2000; King & Wynne, 2004) who criticise FST for the lack of attention to family role and process, including in the family of origin and extended family, across the second half of the lifespan.

These findings also reflects a gerophobic society that takes a negative perspective of aging and as such until recently has tended to neglect this aspect of human development altogether (Baltes, 1987; Carter & McGoldrick, 1999; Papalia et al., 2002). Indeed, within this project there was a significant absence of discussion on older adults. This absence may be explained by the current aging cohort’s experience of gender roles and attitudes toward help seeking behaviours. However, it emerged that the younger generation’s experience of abuse within a family was increasingly serving as a trigger for help seeking behaviours in older generations. Hence therapists and funding

organisations are likely to encounter the aging cohort more frequently and need to be equipped to address their unique issues.

These themes imply the need for therapists to understand and appreciate how individual and family lifecycles intersect across the entire lifespan, not just in families rearing young children. As a consequence interventions with adults need to consider those significant other family members who are impacting an adult's healing journey.

The Therapeutic Debate

Through the emergence of a diverse range of practices, perspectives and contentious issues, this investigation highlighted the presence of a lively therapeutic debate regarding what works best and for who, when, where and how. It appears that in New Zealand, there are currently a great number of interventions utilised with sexually abused clients. Whilst many practitioners agreed about the causes and contributing factors to CSA and its consequent impact, they often do not agree on what or how these factors should be targeted in therapy. Involvement of a caregiver when working with children was the only area of total agreement. However, therapists still disagreed about how best to involve them. Each clinician believes that for the majority of clients they see, their method works best. This is consistent with research comparing different treatment approaches (individual, group and systems, within and between modalities). Currently it is concluded that no one technique or discipline is superior (Lambert et al., 2004). However, in New Zealand, comparisons of treatment outcomes with CSA survivors have not been empirically examined, particularly with regard to post treatment maintenance of believed gains of the intervention. To determine outcomes, assessment of progress and goals is required.

Many practitioners within this investigation did not view "assessment" as part of their practice. However, this may be more an issue about how "assessment" is defined. With regard to family, a number described utilising a genogram, and indeed within FST, this is deemed an assessment tool. The need to be committed to culturally and empirically based best practice is a requirement to ensure optimum outcomes for clients coming from a wide variety of backgrounds, ages and with differing needs. By implication, various methods of assessment must be utilised.

Utilising Attachment and FST as Conceptual Frameworks

In consideration of the transgenerational transmission of vulnerability and the intervening family processes and relating which were identified, Attachment and Family Systems theories are by implication potentially powerful and highly relevant conceptual frameworks for CSA intervention with clients who identify with European culture. Attachment theory focuses on intergenerational transmission of family relationship quality and individual adaptation, but has ignored the potential role of contextual factors (Cowan, Cohn, Cowan, & Pearson, 1996; Main, 1996; Riggs & Jacobvitz, 2002). Recent attachment research has demonstrated that attachment relations are impacted by contextual factors (Cowan et al., 1996; Riggs & Jacobvitz, 2002). Family systems concepts may add to attachment theory by predicting and understanding member's present adaptation given their family context. At the same time attachment may enrich FST by going beyond observed interpersonal transactions to seeing how internal working models of caregivers enhance understanding of how these patterns may persist across generations (Cowan et al., 1996). However, the need to acknowledge the importance of these theories for clients across the entire lifespan, not just in childhood is paramount.

An Ecological Issue: The Importance of Context to Experience and Practice

Consistent with premises of Bronfenbrenner's (1979) Ecological Model, the current investigation demonstrates that ecological structures impact the wellbeing of CSA survivors. Therapist descriptions contextualised recovery and healing from CSA within the many layers of an individual's ecology, particularly the systems in their immediate environment. More indirectly, as outlined in "Contextual factors", both therapist related issues and broader organisational, governmental and cultural issues impact therapist choices and decisions in how they work and the services which clients receive.

A number of therapist related barriers to family involvement in treatment which emerged in this investigation, have already been identified in New Zealand publications such as those outlined in Whiteside and Steinberg (2003). The identification by therapists of organisational and cultural barriers to working with family can be considered a reflection of the dominant cultural values in our society. Values of autonomy, competition and materialism, shape the organisations and structures within it and in turn determine service provision. Consistent with the themes which emerged

here, Whiteside and Steinberg (2003) noted in their publication regarding family inclusion, that whilst the New Zealand government has publicly acknowledged the need for family involvement, there has been little support, particularly financial support, for this practice. As identified in this investigation and consistent with Whiteside and Steinberg (2003), lack of governmental support filters down to the organisational level; management needs to support clinicians by providing them with adequate training and then the time and resources to do family work.

Implications

The present work has highlighted a number of areas where further work could add to current literature on CSA and the role of family;

Governmental Institutions, Communities and Therapists

Given the transgenerational nature of vulnerability to abuse and pathways identified as perpetuating it, at risk families must be identified and participate in prevention programmes.

Government and ACC

The contextual factors expose barriers and disincentives to including and working with the family despite indications that this is a preferred modality in many cases. Government agencies need to be supported and in turn, support practitioners in this type of practice. Appropriate training in theory and practice of ways to work with family needs to be incorporated into professional training courses and institutions. The bottom line for ACC is that it needs, at a bare minimum, to fund parental involvement in child interventions.

Therapists

Therapists cannot view clients as independent from their families. They need to be open to taking an ecological, systemic and transgenerational perspective towards their client's situation. Therapists need to be open to addressing interpersonal and family issues in treatment.

Child clients. Any work with children must incorporate major caregivers. There is also a need to assess for the health and functionality of the family unit and

caregiver(s) for all child clients, without exception. Treatment can then target and address simultaneously any parental and family issues in order to ensure a safe, supportive home environment for the child.

Any family dynamics contributing to the onset of the abuse must be addressed in order to ensure child safety and protection whilst in treatment and in the future. Equally, siblings of the victim need to be considered. For example, how has the abuse impacted their situation, how are they responding to the victim consequently, are they themselves exposed to familial risk factors which may increase their vulnerability to abuse?

Adult clients. The therapist needs to consider the interpersonal impact of the event and interpersonal context of the client currently. Therapists should consider the involvement of significant parties, such as willing partners, at appropriate stages in the treatment process to complete the recovery process.

Parenting ability in adult clients is a critical yet contentious issue. Therapists have a legislative responsibility to ensure no harm to others at the very least and this needs to be considered in their work with adult survivors.

Researchers

This investigation highlights the necessity to extend investigations of CSA beyond a DSM symptom based perspective. Treatment outcomes must be understood and measured from a relational, as well as symptom relief perspective. By implication, there is a need to utilise methodologies which will enable investigation into and the capturing of family and broader community variables which impact both client experiences and treatment outcomes.

The model of recovery and healing which emerged from therapist accounts should be further validated against consumer perspectives. The resulting model, combining therapist and consumer voices, could then be developed into a psychometric instrument which would have the potential to guide assessment and resulting interventions by identifying family related themes and nodes which are of relevance to CSA clients.

Similar to assessment tools and processes which are available for evaluating levels of cultural identity, the ability to assess for levels of family identity and connection could be useful when working with clients identifying with European derived cultures. Based on findings here, we cannot assume that this population necessarily is as individually focused as traditional models have lead us to believe.

Through this style of assessment, the actual importance of family to clients can be determined and provides an interpersonal framework to work within.

Empirical evaluations of the various modalities of intervention with CSA consumers also needs to be performed in future investigations.

Limitations and Suggestions for Future Research

The goal of grounded theory is to produce a localised theory of a core social process. Grounded theory does not offer a complete universal interpretation and process. Rather, it raises awareness of a local perspective which may inform and challenge a number of previously taken for granted assumptions. As such, the current study does have limitations to the transferability of findings to other populations.

This study included voluntary participants which may not represent the full range and variance of practitioners experienced in working with CSA. However, participants were both ACC and non ACC therapists, and were representative of a wide range of disciplines working with the issues. They also included practitioners from rural and urban centres and were taken from a nationwide sample spanning from as north as Whangarei to Invercargill in the south.

The nature of focus groups is also such that participants may focus on a specific topic and follow that when other information could have been provided. Social processes and pressures such as not wanting to outwardly disagree with fellow professionals may be an explanation for this. Other limitations of the focus group format include that often participants talked about different types of sexual abuse, different age groups and different cultures without delineating it. Another limitation was that some participants saw the focus group as an opportunity to complain about the ACC system, articulating their own agendas beyond the purpose of the investigation. However, in an attempt to overcome some of these limitations, data collection also entailed targeting key informant interviews which solicited views from professionals with known expertise in the field which would fill gaps by providing greater detail and insight to areas which lacked clarity after the completion of the focus groups.

The time required to complete the survey questionnaire was in many ways prohibitive. Participants reported they became tired and bored with it and that it was difficult to put into the written word what it was that they do in practice. As a result many did not complete the survey. Despite it being long and involved, the goal was to

obtain rich data and indeed, for those who did complete it, detailed scenarios provided an overview which assisted in examining how clinicians conceptualised cases. Fortunately a sufficient number of practitioners did complete the survey which provided a viable sample size (n= 166) for analysis.

The core social process and underlying associated themes derived here are therapist perceptions. Whilst a cross-validation with the consumer advisory group member was obtained, a better balance and ability to generalise the core social process would be achieved through obtaining a greater number of consumer perspectives. As part of the greater project, consumer focus groups have been held. However, due to the practical restraints of resourcing, they are, at the present time, to be analysed separately and not with respect to family related themes. This would be a useful step to take in future research. This information could provide additional perspectives to incorporate into an intervention which would ensure the effectiveness of family based approaches while at the same time defusing some of the dangers inherent for consumers in taking such an approach.

Summary

The core social process of “Belonging, Estrangement and Reintegration” is based on processes involving family which emerged from the data body and are consistent with literature on CSA, contemporary developmental and FST theory and postmodernist discourse regarding culture and values.

This investigation provides further evidence to an already well established body of literature regarding children and the integral part that family plays in their wellbeing. Family was identified as both contributing to the onset of distress and in supporting recovery when they encounter distress. It also provided insights to how important family can be to treatment outcomes and the healing process for adult survivors and the importance of understanding the role of family of origin and procreation beyond the child rearing years. Additionally, it accentuates the point that family has been neglected and brushed over in Western culture. This body of data provides evidence for the importance and value of considering and incorporating family in interventions. Instead of ignoring family toxicity, it needs to be addressed so future toxicity does not spread. By implication, an Ecological, Family Systems and Attachment focus appears to be highly applicable to conceptualising the recovery and healing process in CSA.

Overall, the findings reflect that a solely individual based approach to healing may not be the most optimal as running parallel to and intermingling with individual issues are family related issues which impact healing across the entire lifespan.

The findings also add credence to the New Zealand Ministry of Health's call to include family in assessment and treatment. Additionally though, the need for support from governmental organisations to implement the very changes they ask for emerged through the themes underlying "Contextual factors".

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Appendix A



SCHOOL OF PSYCHOLOGY
Rāraŋa Whātumanawa
Private Bag 11 222
Palmarston North
New Zealand
T 0900 200 235
F 64 6 359 2264
<http://whatumana.wa.massey.ac.nz>



THE PSYCHOLOGY CENTRE
PO Box 4423
Hamilton
New Zealand
T 07 834 1520
F 07 834 1519
<http://www.tpc.org.nz>

SURVEY FOR BEST PRACTICE GUIDELINES

This survey is about your sensitive claims work with clients who have experienced sexual abuse

SECTION A

1. Please complete the following –	
Professional association (e.g., NZAC)	
Discipline (e.g., counsellor, psychotherapist, child psychotherapist, psychologist)	
Primary therapeutic practice (e.g., Narrative, CBT, Art therapy, Mauri therapy)	
Ethnicity	
2. How long have you been working as a therapist/counsellor?	
3. How long have you been working with people who have been sexually abused and/ or assaulted?	
4. How long have you been registered with ACC?	
5. How many ACC sensitive claims clients are you currently seeing?	
6. Please tell us your practice location(s) -	
Government organisation (e.g., Child Youth and Family Service) -	
Non-government organisation (e.g., community organisations such as Methodist Social Services, Hauora Provider, etc.) -	
Private practice –	
Other (e.g., University clinic) –	

7. Below are five groupings of client characteristics. Please tick the group(s) you primarily work with.

<i>Gender</i>	<input type="checkbox"/> Males
	<input type="checkbox"/> Females
<i>Age Groups</i>	<input type="checkbox"/> Children (aged between 0 and 10 years and 11 months)
	<input type="checkbox"/> Adolescents (11 years to 17 years and 11 months)
	<input type="checkbox"/> Adults (18 years and over)
<i>Ethnicity</i>	<input type="checkbox"/> Pākehā
	<input type="checkbox"/> Māori
	<input type="checkbox"/> Pacific Island People
	<input type="checkbox"/> Other (<i>Please state</i>) -
<i>Occurrence of Event</i>	<input type="checkbox"/> Historical
	<input type="checkbox"/> Recent
<i>Type of Sexual Abuse</i>	<input type="checkbox"/> Sexual Abuse
	<input type="checkbox"/> Sexual Assault, e.g. rape

8. **Rank order** the statements which you think are the most significant to least significant in determining when and how your client is making **progress** in therapy.

_____	By what the client tells me
_____	By what the client does (both in and between sessions)
_____	By my observations during sessions (e.g., verbal and nonverbal cues/behaviours)
_____	By what I'm told by others (client's spouse, parent, child, employer, etc.)
_____	By my own professional impression, based on training (e.g., training involves short courses, university courses, and/ or supervised practice)
_____	By my own professional impression, based on experience
_____	By client responses to questionnaires/ surveys (e.g., a post-traumatic stress rating scale, Beck Depression Inventory)
_____	By client responses to other monitoring measures (e.g., Visual Analogues,

Subjective Units of Distress)

_____ By client responses to satisfaction indicators (e.g., client feedback)

_____ By the client achieving their goals in therapy

_____ By ACC progress reports

_____ By symptom (problem) reduction

_____ By improvements made by the client outside therapy (e.g., quality of life)

_____ By the time spent in therapy (e.g., predetermined number of sessions)

_____ Other indicators

9. **Rank order** the statements which you think are the most significant to least significant in determining a client's **readiness** to end therapy.

_____ By what the client tells me

_____ By what the client does (both in and between sessions)

_____ By my observations during sessions (e.g., verbal and nonverbal cues/behaviours)

_____ By what I'm told by others (client's spouse, parent, child, employer, etc.)

_____ By my own professional impression, based on training (e.g., training involves short courses, university courses, and/ or supervised practice)

_____ By my own professional impression, based on experience

_____ By client responses to questionnaires/ surveys (e.g., a post-traumatic stress rating scale, Beck Depression Inventory)

_____ By client responses to other monitoring measures (e.g., Visual Analogues, Subjective Units of Distress)

_____ By client responses to satisfaction indicators (e.g., client feedback)

_____ By the client achieving their goals in therapy

_____ By ACC progress reports

_____ By symptom (problem) reduction

_____ By improvements made by the client outside therapy (e.g., quality of life)

_____ By the time spent in therapy (e.g., predetermined number of sessions)

_____ Other indicators

10. Do you use measure(s) and/ or tool(s) in your current practice?
(Please note that this includes both standardised and non-standardised measures, such as questionnaires or psychometric measures for depression, anxiety and post-traumatic stress disorder, as well as methods such as continuums, client drawings, visual analogue scales.

No(Go to **Question 12**)

Yes (Go to **Question 11** and **Complete** the table)

<p>11. List each measure and/ or tool you use. (Please write the full name of each measure.) <i>E.g., Initial Trauma Review – Revised, Client Drawings, Goal Attainment Scale.</i></p>	<p>Explain why you use each measure/tool.</p>

12. Do you receive feedback from your clients about your practice?

No (Go to **Question 13**)

Yes. **Explain** the type of feedback you ask clients to provide (e.g., verbal feedback, client satisfaction questionnaires).

13. Do you use a system to monitor change and outcomes of therapy? This system may involve the use of standardised and/ or non-standardised measures (e.g., Goal Attainment Scaling, Likert Scales, and Visual Analogue Scales).

No (Go to **Question 14**)

Yes. **Explain** your system and why you use it.

14. What might prevent some practitioners from employing formal or structured strategies to monitor change and/ or measure outcomes?
 (**Rank order** the statements which you think are the most significant to least significant in preventing practitioners from using structured systems).

Measures are not relevant to my theoretical stance
 Measures available are not satisfactory for use with sexual abuse clients
 Norms and cutoff scores are not relevant for use in Aotearoa / New Zealand
 Measures are culturally inappropriate for use in Aotearoa / New Zealand
 Measures are not client-friendly
 Costs associated with purchasing measures
 Qualifications required to purchase and/ or administer measures
 Measures may become obsolete (e.g., new editions or versions)
 Time involved in training and learning a new measure or tool or system
 A limited awareness of the range of measures available
 Numbers do not adequately reflect the changes that have occurred with a client
 Other factors.....

15. If there were **no barriers** (e.g., cost, time involved) in my practice I would:

Not use any measure(s) to assess change or monitor outcome.
 Use the measure(s) I am currently using in my practice listed in **Question 11**.
 Change my practice. Please outline the ideal system you would use and why.

SECTION B: SURVEY QUESTIONS

The following questions address some of the ways you might think about sexual abuse, as a professional. We understand that your thoughts will be more complex than can be expressed on a questionnaire. We are interested in the issues that are most important to you. Please attach additional sheets if needed.

16. The experience of sexual abuse means different things to different people. As a professional, what are the key thoughts that come into your mind when you think about what the experience of sexual abuse means?

17. When people have experienced sexual abuse, they are affected in different ways. What do you think are the most critical consequences affecting individuals who have been sexually abused?

18. When people present for therapy or counselling following sexual abuse, they bring with them unique histories, stories, concerns, issues, or problems. How do you think about and strategise how to help each client? What do you need to know to decide how to help them?

19. When working with clients who have been sexually abused, different people recommend different types of therapeutic interventions. What interventions have you found to be useful?

20. Various aspects of counselling/therapy are necessary for addressing particular issues faced by someone who has been sexually abused. What in your opinion are the essential components that need to be operating for counselling/therapy to be successful?

21. When people receive counselling/therapy for the emotional or mental consequences of sexual abuse, what sorts of changes take place in that person?

22. Different barriers may interfere with positive progress for survivors of sexual abuse. These include hindrances to effective therapy as well as obstacles to the recovery process. With respect to the following three areas, counsellor/therapist, client, and ACC, identify the barriers to effective therapy that you have found and any obstacles you think interfere with the recovery of clients who have been sexually abused.

Barriers to the effective delivery of therapy in the following three areas are:

- a. Therapist

- b. Client

- c. ACC

Barriers to the positive recovery of clients who have survived sexual abuse in the following three areas are:

- a. Therapist

- b. Client

- c. ACC

23. Many cultural groups seek counselling/therapy for sexual abuse. How do you adapt your practice to reflect cultural preferences?

SECTION C: SCENARIO (OPTIONAL)

*Section C involves questions around two scenarios. Although this section is **optional**, we would appreciate your response to these scenarios, as it will be useful in finding out what is most helpful for clients. You may choose to respond to one or both scenarios. If you would prefer to respond to one scenario, please choose the one that most closely represents the client group you currently work with (i.e., adults or children). Assume in both scenarios that these clients have received approval from ACC to obtain sensitive claim services.*

Scenario 1 - Adult

X is a 23-year-old woman who was abused by her father throughout her childhood. Her parents separated when she was 11 but she continued to see her father for unsupervised access every second weekend. She remembers being touched and fondled as well as being kissed. She doesn't remember intercourse but sometimes experienced vaginal pain after her father's visits. X is the eldest child of a family of five. She tried to talk with her mother once about the abuse, but her mother couldn't believe that her husband would do such a thing.

X has come to see you reporting the following concerns:

- Vivid nightmares, and intrusive memories of the abuse during the day. She has difficulty falling asleep and often wakes up in a cold sweat following nightmares.
- Panicky feelings, shakiness, agitation, difficulty breathing, and pounding heart. She feels especially unsafe in the presence of middle-aged men.
- Afraid of leaving the house. This interferes with her ability to make friends, work, and daily living activities such as shopping.
- Her only friend is her neighbour. She relies on her for everything (e.g., shopping) and is afraid her neighbour will move away and leave her on her own.
- Sometimes she feels very low and depressed, cuts herself, and has contemplated suicide on several occasions.

Scenario 2 - Child

Two brothers, aged 6 and 9, have been referred to you by their mother. She is concerned about deterioration in their behaviour, which includes temper tantrums and refusing to do their chores. Furthermore, they have begun wetting their beds at night. They have also started drawing sexually explicit pictures. The mother is upset because she and her husband are busy running a small business and don't have time to deal with these changes in the boys' behaviour. They have a live-in boarder who is always happy to baby-sit for them and is very kind to the boys, taking them on outings to give the parents a break. The mother is concerned that the boys are spoiled because of this and she is embarrassed at their unreasonable behaviour. The boys become very aggressive and angry when their parents leave them with their baby-sitter. The mother also worries because the boys have now started causing trouble at school, are hitting other children, and have fallen behind in their schoolwork.

You may choose to respond to one or both scenarios. If you would prefer to respond to one scenario, please choose the one that most closely represents the client group you currently work with (i.e., adults or children).

24. List the information, other than disclosure that, for you, indicates the client has been sexually abused.

Scenario 1 - Adult	Scenario 2 - Child

25. What additional information do you feel is needed to relate the client issues contained in the scenario to sexual abuse?

Scenario 1 - Adult	Scenario 2 - Child

26. Describe how you would proceed with counselling or therapy with this client to achieve an effective outcome.

Scenario 1 - Adult	Scenario 2 – Child

27. What are your ideas about the links among the client issues described in the scenario?

Scenario 1 - Adult	Scenario 2 - Child

SECTION D: FEEDBACK (OPTIONAL)

We are interested in receiving feedback about the survey and the broader research programme. Your opinions are valued.

28. Would best practice guidelines be useful for you in providing services to sexual abuse claimants?

29. Do you think there are any additional issues that should be considered when formulating best practice guidelines?

30. Do you have any further comments about the survey or the broader research programme?

Thank you for taking part in this research. Please check that you have answered the questions and return this questionnaire in the pre-paid envelope provided. If you have any further questions, please contact Anne Ryan at 0800 200 235 or Andrea Hodgetts at 07 834 1520.

THANK YOU FOR YOUR PARTICIPATION

Appendix B



SCHOOL OF PSYCHOLOGY
Rārangā Whātumanawa
Private Bag 11 222
Palmerston North
New Zealand
T 0800 290 235
F 64 6 350 2264
<http://whatumana.massey.ac.nz>



THE PSYCHOLOGY CENTRE
PO Box 4423
Hamilton
New Zealand
T 07 334 1520
F 07 334 1516
<http://www.tpc.org.nz>

A Survey of ACC Sensitive Claim Practitioners

INFORMATION SHEET

Introduction

You are invited to participate in a survey. Your participation is voluntary (your choice). This survey forms part of a broader research programme entitled *Research services on mental injury in survivors of sexual abuse: Diagnosis and rehabilitation guidelines*. The main research objective is to develop national rehabilitation guidelines that specify i) appropriate and effective ways of assessing mental injury following sexual abuse and sexual assault, and determining progress and outcomes; and ii) appropriate and effective therapies and approaches (see below for the web address which outlines the specific research objectives for each research project). The research team is committed to ensuring that the guidelines are appropriate for the unique needs of New Zealanders and that recovery from injury is maximised by tailoring interventions to meet specific client needs. The research team is utilising multiple research methods, including: individual key informant interviews, practitioner and consumer focus group discussions, Q-Sort, archival file analysis, and a practitioner survey.

We will submit the findings and the best practice guidelines to ACC. These guidelines will ensure safe and effective treatment for sexual abuse claimants. ACC will use the guidelines to inform its decision-making processes for managing claimants with mental injury following sexual abuse and/ or sexual assault. Although the project is funded by ACC, the research team is independent. At the end of this information sheet are a series of frequently asked questions, which outline the research programme in more detail.

We want to provide all professional bodies with the opportunity to have a say in the development of the best practice guidelines. As a practitioner, your experience and expertise in this area are valued contributions to this project.

The survey is being conducted by Cheryl Woolley from the School of Psychology at Massey University in Palmerston North and John Fitzgerald (Director) at The Psychology Centre in Hamilton. The research team consists of a multi-disciplinary group of skilled staff in the areas of research, as well as working with survivors of sexual abuse. These areas include: Counselling, Psychotherapy, Social Work, Maori and Pacific peoples, Psychiatry, General Practice, Child and Adolescent Psychology, and Clinical Psychology.

What is this study about?

This particular phase of the project involves distributing a survey to current sensitive claim treatment providers. The survey explores the diverse theoretical orientations practitioners use, the types of interventions offered to clients, and the ways in which

practitioners measure change. You may note that the questions we are asking you are similar to the ones ACC require for registration. Owing to ethical issues surrounding accessing this documentation we have decided to repeat these questions in the survey.

Am I eligible to take part?

You are eligible to take part in this study if you are registered with the Sensitive Claims Unit (ACC) to provide professional services to sexual abuse clients.

It is hoped that all registered practitioners will be involved in this project, as we are committed to obtaining input from the wide range of disciplines and cultures represented by practitioners in this field. We have experienced Māori researchers and clinicians who are an integral part of our Advisory Committee and research team. Issues relating to bicultural concerns are automatically considered in our approach.

What am I being asked to do?

If you agree to take part, you will be asked to fill out an anonymous survey about your current practice with clients who have experienced sexual abuse. This survey contains questions about your background and theoretical orientation, how many clients you have on your current caseload, and your thoughts on how to work effectively with clients and monitor change over time. The survey takes around 40 minutes to complete.

It is not anticipated that there will be any risk or discomfort to participants as a result of completing the survey.

What will happen to my information?

Completion and return of the survey implies consent. Be assured that no one will be able to identify you. All returned surveys are to be stored in a locked cabinet in the Psychology Clinic at Massey University in Palmerston North. The research teams in Palmerston North and Hamilton will conduct analysis of the survey data. At the end of the study, the surveys will be destroyed. We will send a summary of our findings to all registered Sensitive Claim practitioners at the end of the study.

A website (<http://Whatumanawa.massey.ac.nz>) will provide the survey feedback and reports from the project will be available to the public. Information resulting from the different projects, such as the survey, will be used to develop guidelines for working with survivors of sexual abuse in Aotearoa. ACC-registered practitioners will have access to these guidelines.

What can I expect from the researchers?

If you decide to participate in this project, the researchers will respect your right to:

- ask any questions of the researchers about the study at any time during participation;
- decline to answer any particular question in the survey;
- withdraw from the survey;
- provide information on the understanding that it is completely confidential to the researchers;
- be given a summary of the findings. A summary of the study will be sent to all registered Sensitive Claim practitioners. Further feedback about the study and the broader research project will be available at <http://Whatumanawa.massey.ac.nz>

Who can I speak with about my participation in this project?

If you have further questions or concerns, please contact Anne Ryan or Andrea Hodgetts at:

Anne Ryan (Research Officer)

School of Psychology, Massey University, Private Bag 11-222
Palmerston North

Telephone: 0800 200 235

Email: a.ryan@massey.ac.nz

Andrea Hodgetts (Research Officer)

The Waikato Clinical Psychology Educational Trust
1st Floor, 2 Von Tempsky Street, P.O. Box 4423, Hamilton

Telephone: 07 834 1520

Email: andrea@tpc.org.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Application 04/165. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz.

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone:

- Northland to Franklin 0800 555 050
- Mid and lower North Island 0800 423 638 (4 ADNET)
- South Island except Christchurch 0800 377 766
- Christchurch 03 377 7501

Frequently Asked Questions:

1. *Who are in the research teams?*

Listed below are the members of the two research teams.

Palmerston North: Cheryl Woolley (Principal Researcher), Ian Evans (Principal Researcher), Joanne Taylor, Shane Harvey, Jan Dickson, Jhanitra Murray (Ngapuhi), Ruth Mortimer, Karen Frewin, Pia Pechtel, and Anne Ryan.

Hamilton: John Fitzgerald, Tracey Augustine, Jan Brassington, John Collier, Juanita Ryan, and Andrea Hodgetts.

2. *Do you have an Advisory Committee?*

Yes. Our Advisory Committee contains experienced clinicians, service providers, and tangata whenua. A consumer representative is a member of one of the research teams.

3. *How are the concerns of Māori addressed?*

The concerns of Māori are particularly important for this study. The project is being conducted under the direction of Māori research leaders who are either in the research team or on the Advisory Committee for the project. These members are involved with the project on a regular basis to ensure that the research addresses the needs of Māori and is conducted in a culturally appropriate manner. Treaty obligations of meaningful partnership make this a necessity.

4. *Who funded the research programme?*

Accident Compensation Corporation.

5. *Do you intend to utilise different research methods?*

Yes. We will use quantitative and qualitative methods.

6. *What will ACC do with the research findings?*
ACC have contracted us to review service provision in the areas of assessment, treatment, progress, and outcome, with a view to developing safe and effective treatment guidelines for survivors' of sexual abuse. We will submit the research findings and the developed guidelines to ACC. ACC will use the guidelines to inform its decision-making processes for managing claimants with mental injury following sexual abuse and/ or sexual assault.
7. *Whether ACC accept or reject your findings, will I be informed about the results and the developed guidelines?*
Yes. ACC has agreed to allow the research team to disseminate the research findings to practitioner and consumer groups. Three strategies will be employed to disseminate the findings:
- Individual and Public Information: Several strategies will be employed for each of the research projects. Individual feedback will be provided in a summary of the research findings. Public feedback will include: (1) posters displayed in various community organisations; (2) summaries published in national, regional and local newspapers; (3) all participants will be provided with the web address where public information is available; and (4) public seminars will be held throughout New Zealand.
 - Journal Articles: Academic articles are to be submitted to national and international peer-reviewed journals.
 - Conference Presentations: In order to achieve more rapid dissemination of findings that are relevant to the providers of services, the team will present individual and/ or team papers/posters/symposia at professional organisations and meetings, both nationally and internationally.
8. *Will the new practice guidelines impact on my practice?*
Our literature review is concerned with identifying evidence-based practice. The intention of the guidelines is not to stifle creativity or pursue a certain agenda, such as cognitive behavioural therapy. The guidelines are intended to be dynamic and utilised by different practitioner bodies. Our intention is to ensure that practitioners have access to up to date information and materials on sexual abuse.
9. *Will the research team conduct the practitioner focus group discussions throughout New Zealand?*
Yes. At this point in time focus groups will be held in Auckland, Hamilton, Rotorua, Palmerston North, Wellington, Christchurch, and Dunedin.
10. *Who can I contact if I want to participate in a focus group discussion or obtain further information about the research programme?*
You can contact the principal investigators or the Research Officers, Anne Ryan and Andrea Hodgetts (see the contact details above).

Appendix C



SCHOOL OF PSYCHOLOGY
Rāanga Whatumanawa
Private Bag 11 222
Palmerston North
New Zealand
T 0800 200 235
F 64 6 350 2264
<http://whatumanawa.massey.ac.nz>



THE PSYCHOLOGY CENTRE
PO Box 4423
Hamilton
New Zealand
T 07 834 1520
F 07 834 1519
<http://www.tpc.org.nz>

Practitioner Focus Groups and Key Informant Interviews

INFORMATION SHEET

Introduction:

You are invited to participate in a research project that forms part of a broader research programme entitled *Research services on mental injury in survivors of sexual abuse: Diagnosis and rehabilitation guidelines* commissioned by ACC. The Rāanga Whatumanawa Research Team consists of a variety of highly skilled staff both in the areas of research, as well as in working with survivors of sexual abuse.

ACC has commissioned a research project to examine the areas of assessment, treatment, and progress and outcome, with a view to developing safe and effective treatment guidelines for survivors of sexual abuse. This project involves conducting focus group discussions and key informant interviews with practitioners in order to better understand the relationship between professional discipline and orientation and diagnostic systems used. We shall also explore issues of effective therapeutic practice in the New Zealand context.

The findings from this research will be put as recommendations to ACC to assist in the further development of best practice guidelines for safe and effective treatment.

Contact Details:

Cheryl Woolley (Principal Researcher), Ian Evans, Joanne Taylor, Shane Harvey, Jan Dickson, Jhanitra Gavala, Anne Ryan, Ruth Mortimer, Karen Frewin, Pia Pechtel, Lana Morrison.

School of Psychology
Private Bag 11 222
Palmerston North.
Telephone 06 3505196 or 0800 200 235
<http://whatumanawa.massey.ac.nz>

John Fitzgerald, Andrea Hodgetts, Tracey Augustine, John Collier, Jan Brassington, Juanita Ryan
The Psychology Centre
1st Floor, 2 Von Tempsky Street
P.O. Box 4423,
Hamilton
Telephone 07 8341520

Participant Recruitment:

Potential participants will be practitioners working in the area of sexual abuse. It is hoped that 75 – 150 practitioners will be involved in this project, as we are committed to obtaining input from the wide range of disciplines and cultures represented by practitioners in this field. As experienced Māori research clinicians are an integral part of our team, issues relating specifically to bicultural concerns are automatically considered in our approach. It is not anticipated that there will be any risk or discomfort to participants as a result of participation.

Project Procedures:

The focus groups will be conducted with groups of approximately six practitioners in the presence of a moderator. Tikanga Māori will be adhered to when and where appropriate. The focus group discussion will be audio taped and transcribed. A second researcher will be present to assist the moderator and take notes regarding any features of the discussion that may not be captured by the tape. Participants will agree to preserving the confidentiality of opinions expressed by other members of the group, as well as respecting all views and perspectives.

Individual interviews will also be taped and all transcripts will be analysed for existing decision-making processes that can then inform the development of a decision tree. The analysis will also consider commonalities and differences associated with participants' judgments of what are considered effective therapeutic approaches. All participants will be assured of anonymity through the use of pseudonyms in any written products. All identifying material and tape recordings of the discussions will be kept (separately) in a locked filing cabinet at the research team location. The transcripts will be stored separately in a locked filing cabinet and/ or password protected electronic file. The tapes will be destroyed at the end of the research project. The transcripts will be held for five years following the conclusion of the research project, as is normal practice for research data, and then destroyed. A website will provide reports from the project that are available to the public, and details of the website will be provided in any publicity generated from the project. Information resulting from the project will be used to develop diagnostic and rehabilitation guidelines for working with survivors of sexual abuse. The participants will have access to these guidelines.

Participant Involvement:

If you choose to participate in this study, you will be asked to take part in an informal, semi-structured discussion with a small number of other practitioners or an individual interview. The topic of discussion, facilitated by the moderator, will relate to diagnosis and effective therapeutic practice with survivors of sexual abuse. The discussion will take place in suitable professional premises in a convenient geographical location. Refreshments will be provided. It is anticipated that the focus group or interview will run for one and a half to two hours.

Participant's Rights:

You are under no obligation to accept this invitation. If you decide to participate you have the right to:

- ◆ Decline to answer any particular discussion question.
- ◆ Withdraw from the study at any time during the research period (April 2005 – June 2005).
- ◆ Ask any questions about the study at any time during participation.
- ◆ Provide information on the understanding that your name will not be used unless you give permission to the researcher.
- ◆ Ask for the audiotape to be turned off at any time during the discussion or leave the focus group or interview at any point.
- ◆ Request removal or amendment of any part/s of the recording, resulting from your discussion.
- ◆ Be given access to a summary of the project findings when it is concluded.

Support Processes:

The focus group or interview should provide a positive experience, but if any participants feel unduly affected by the process, they should feel reassured that support measures are in place. (At least one of the researchers involved with each focus group will be trained and experienced to be able to assist participants if they experience any discomfort as a result of their participation.)

Project Contacts:

If you have any questions or concerns about the research, please feel free to contact any members of the research team.

M.U.H.E.C. Approval Statement:

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN protocol **04/166**. If you have any concerns about the conduct of this research, please contact Dr John O'Neill, Chair, Massey University Human Ethics Committee: Palmerston North. Telephone 06 350 5249, email humanethicspn@massey.ac.nz

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone:

- | | |
|------------------------------------|-----------------------|
| ■ Northland to Franklin | 0800 555 050 |
| ■ Mid and lower North Island | 0800 423 638 (4ADNET) |
| ■ South Island except Christchurch | 0800 377 766 |
| ■ Christchurch | 03 377 7501 |

Appendix D



SCHOOL OF PSYCHOLOGY
Rārangā Whātumanawa
Private Bag 11 222
Palmerston North
New Zealand
T 0800 200 235
F 648 350 2284
<http://whaturanawa.massey.ac.nz>



THE PSYCHOLOGY CENTRE
PO Box 4423
Hamilton
New Zealand
T 07 334 1520
F 07 334 1510
<http://www.tpc.org.nz>

Practitioner Focus Groups and Key Informant Interviews

Participant Consent Form

This participant consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to not disclose anything in the Focus Group. (If applicable)

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Full Name-printed:.....

Appendix E



SCHOOL OF PSYCHOLOGY
Rāanga Whatumanawa
Private Bag 11 222
Palmerston North
New Zealand
T 0800 200 235
F 64 9 350 2264
<http://whatumanawa.massey.ac.nz>



THE PSYCHOLOGY CENTRE
PO Box 4423
Hamilton
New Zealand
T 07 834 1520
F 07 834 1510
<http://www.tpc.org.nz>

Thank-you

The Rāanga Whatumanawa team (at Massey University) would like to express our sincere thanks for your participation in an interview / focus group.

Your valuable contribution to this research endeavour has been much appreciated.

Information and feedback from the analysis of these interviews and focus groups, along with other research outputs will be available on our website:

<http://whatumanawa.massey.ac.nz>

(You will also receive personal feedback if you have requested)

Please don't hesitate to contact us on:

0800 200 235 or

a.ryan@massey.ac.nz

if you have any questions, or comments you would like to contribute.

Kind Regards

Anne Ryan (Project Co-ordinator)
Rāanga Whatumanawa

Appendix F

Objective 1 and 2: Practitioner Focus Group Discussion Protocol Final

Notes: Name tags

Information sheet – go over and answer any questions

Consent form – all participants to sign, collect in.

Sound check – start 2nd tape 5-10mins after 1st tape

Introduction:

We are interested in discussing the professional services you provide to sexual abuse clients, to find out what works and how it works. The purpose of this group is to create an opportunity for us to discuss your approach to working with this client group; types of approaches offered to clients and the ways to track client change. This discussion is being audio taped so we can get an accurate record of the conversation and concentrate on what is being said. Before beginning I would like to discuss the following guidelines, which are designed to allow our discussion to run smoothly:

1. There are no right or wrong answers
2. Each person is entitled to speak to each question
3. Feel free to respond to others after they have finished speaking
4. Feel free to disagree but respect the views of others
5. Bring up whatever you think is relevant
6. When making a point it's useful if you can give a brief example
7. If you have any questions feel free to ask them at any time
8. Just remember that we would like for what is said in this room to stay in the room

Start Tape

Introduce ourselves ask practitioners to do an introduction round with name, working area, what formal/informal training they have undertaken relevant to their sexual abuse counselling.

Comment, if appropriate about the wide range of client groups that practitioners are working with and that we would welcome a discussion about the commonalities and differences in their work, so please be sure to refer to the specific client group in the discussion.

Discussion Questions:

1.

What are the most common effects following sexual abuse that you have seen with your clients?

- What do you see as some of the key differences, if any, brought to counseling for adult/child, male/female clients? What are the similarities?
- When working with clients from different cultures are there any differences in the most commonly displayed effects following sexual abuse?
- What, if any, are the key differences in effects experienced by adults who have been raped compared to adults who have been sexually abused as children?
- As practitioners we often notice, that effects develop over the lifetime. What patterns have you noticed?
- What are the effects on the family system (child/ adult)?

How do you gather information about the effects following sexual abuse?

How do you determine a mental injury has occurred as a result of sexual abuse?

- What “processes” or “tools” are used to find out about effects?
- How do you collect information about the development of symptoms over a period of time?
- How do you find out about potential influences on the family systems?

How does the information on the client's effects influence further treatment strategies?

- How do you prioritise the client's effects?

2.

What is your worldview (belief system/philosophy/theoretical orientation) for treating sexual abuse clients?

How much does it influence your current practice?

How much does it enhance your understanding of sexual abuse?

Why do you use the approach you use?

Are there any therapeutic approaches you would not recommend?

Is there anything that prevents you from working in ways you would prefer?

3.

What do you think are the essential ingredients for counseling/therapy?

- How would you explain these ingredients?
- What commonalities and differences exist and why?
- When working with someone from a different culture do you adapt your therapeutic practice? And if so, how?
- What differences, if any, in therapeutic approach would you suggest for adults who have been raped compared to adults who have been sexually abused as children?
- What role does the family have in treatment?
- What role does resilience play?
- What ideas or strategies can you consistently rely on?

How do you find out if what particular treatment works/ doesn't work?

- How would you describe your goals in treatment? Your client's goals?
- How do you ensure gains made in therapy can be maintained in the longer term?
- In your experience what sorts of things have your clients said they found most helpful during treatment? Least helpful?
- What do you find most difficult? What do you find most rewarding?

4.

What sorts of barriers constrain or influence effective counseling/treatment?

- For clients (e.g., family environment, moving in and out of mental health system?)
- For therapists (e.g., working environment)?
 - Organisational and structural barriers?

Closing Statement

Would you like to comment on anything that hasn't come up that you believe is important?

- How did you find the session?
- Do you have any questions concerning what happened today?
- If you think of something afterwards that you feel is important to share please feel free to call us or put your thoughts in writing and send them in. We certainly value whatever input you can offer.

Thank you for your participation.

Role of Co-facilitator:

Check the physical set up of the room, refreshments etc.

Ensure both tapes are going with a 5-10min gap between them

Scan the group, check body language and if people are getting upset or agitated – intervene if necessary

.Record what is not being taped – record times

Team tag with other moderator to facilitate the discussion

Appendix G

Substantive Codes	Axial Codes	Selective Codes	
-Transmission of attachment style & pathology -Inheriting legacies, repeating patterns & behaviours -Cultural history / forces	Vertical stressors	Vulnerability	The Core Social Process of Recovery and Healing in Sexually Abused Families
-Co-occurring abuses / parallel events -Cycle of poverty -Destructive lifestyles	Horizontal stressors		
-Rigidity & enmeshment -Power imbalances -Silence	Family organisation & adaptability		
-Interrupted development -Children's dependence on others -Attachment relationships	Developing and/ or coping within the family context	Relational interruptions	
-Toxic relating skills -Dysfunctional intimate relating -Compromised parenting -Relations in the family of origin	Compounding / interacting issues perpetuating problems		
-Not believing -Not protecting/preventing -Putting parent needs first -Parental emotional unavailability & pathology	The I/me focused parent	Alienation	
-Equilibrium restored via silence -Disengaging & isolating -Splintering -Scapegoating	Systemic response to stress		
-Family centrality to resilience -Parent-child attachment -Parenting skills & behavioural management	Becoming an I/we responsive parent		
-Communication -opening up -Appropriate roles & boundaries -Attending to everyone's needs -Support in the extended environment -Reconnecting with culture / identity	Unbundling restraints	Reconnecting	

Appendix H

Substantive Codes	Axial Codes	Selective Codes	
-Role as therapist -Positioning systems work -Professional rivalries	Therapist beliefs and attitudes	Contextual Factors impacting family work	Therapist related themes of factors informing our understanding of therapist actions
-No training in sexual abuse -Need specialised training for child work -No language to describe & detect phenomenon	Therapist training and skill base		
-Team work & peer support -Support at an organisational level	Conditions for systems work		
-Medical model vs counselling -Legislative issues -Governmental policies & funding - Social discourse: gender issues	Conflicting models of practice		