PREVENTION. CARE. RECOVERY.

Guidelines for

THERAPISTS

Working with Adult Survivors of Child Sexual Abuse

2001

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Contents

Glossary of terms 2
Definitions of terms used in these guidelines

Preface 3

Introduction 4

The context 5
This section describes the extent of child sexual abuse (CSA) globally and in New Zealand, as well as some of the influences that may impact on the long-term effects

Long-term effects of CSA 8
An overview of the difficulties some CSA survivors experience, especially if there have been few or no positive interventions

Abuse-focused therapy: philosophy and practice 14
An introduction to abuse-focused therapy – key components and approaches

Ongoing process issues 18
An outline of some of the issues that continue throughout therapy and that may affect therapy progress

The three stages of abuse-focused therapy 28
Abuse-focused therapy has three recognisable stages – this section outlines the stages and provides useful strategies for therapists
Stage One: safety and self-work 30
Stage Two: exploration and integration 35
Stage Three: empowerment and reconnection 42

Bibliography 44

Footnotes 50

Appendix I: Third Schedule, Accident Insurance Act 1998 52
The part of the Act that describes the criminal acts that give rise to ACC cover for sensitive claims

Glossary of terms and definitions used in these guidelines

Abuse-focused therapy or trauma therapy:
(these terms are used interchangeably): therapy developed specifically for survivors of interpersonal violence (including child abuse).

Client:
a person who attends therapy to deal with the effects of CSA. The term 'client' is generally preferred to 'patient'.

CSA:
(child sexual abuse) includes intrafamilial (incest) and extrafamilial sexual abuse of a child. For clinical purposes a general definition of CSA is often adequate, such as 'the sexual use or exploitation of a child by an adult or peer'. However, to obtain ACC cover, the survivor must be able to give details of an experience of CSA that is included in specified sections of the Crimes Act (see Appendix I).

Therapist:
counsellor, psychologist, psychotherapist, psychiatrist and other mental health professionals who provide therapy, counselling or other therapeutic supports to survivors of CSA.

Traditional therapy:
therapy that does not include clinical guidelines specifically focused on interpersonal violence in general and CSA in particular.

Survivor:
a person who has experienced CSA. The term 'survivor' is generally preferred to 'victim'.

Vicarious traumatisation (sometimes referred to as secondary traumatisation):
the traumatisation of the therapist owing to the nature and intensity of their clients' experiences or interactions with their clients.

Preface

These guidelines were developed by Kim McGregor, (B.A. M.Ed Hons), Clinical Associate, Psychology Department, and Research Fellow, Injury Prevention Research Centre, Department of Community Health, University of Auckland. They have been published by ACC Healthwise, recognising their relevance to therapy for adult survivors of child sexual abuse in New Zealand.

The guidelines are summarised from *Abuse-focused Therapy for Survivors of Child Sexual Abuse* (1999), a literature review undertaken for Kim McGregor's PhD thesis. A list of documents reviewed for these guidelines can be found on page 44. References within the guidelines are to selected documents only – for a full copy of all references, refer to the complete literature review, which is available (at a cost of $25) from the Injury Prevention Research Centre, Department of Community Health, University of Auckland, Private Bag 92019, Auckland 1.

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Introduction

'Traumatised people are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete.'[1]

These guidelines centre on abuse-focused therapy for adult survivors of child sexual abuse (CSA). They include discussion on:

- the long-term effects of CSA that you (the therapist) may need to address in therapy
- an outline of abuse-focused philosophy and practice
- ongoing therapy process issues
- a three-stage therapy process.

CSA treatment has a controversial history. In the past century the fields of medicine, psychiatry and psychology have:

- vacillated between disbelieving and believing that CSA occurs[2]
- underestimated the numbers of children abused[3]
- minimised or not fully understood the effects of CSA.[4]

Consequently, until the mid-1980s there were virtually no comprehensive guidelines for therapists working with survivors of CSA. There were few central, guiding principles that could provide therapists with some security and self-confidence during a therapeutic course that may be prolonged and difficult.[5]

When comprehensive guidelines were first developed, they emphasised a post-traumatic perspective.

Recently 'second and third generations'[6] of treatment models have been developed and broadened to include:

- individualised treatment planning and client collaboration
- selecting and sequencing treatment with an emphasis on careful pacing
- developing clients' self-capacities, skills, functioning and life stability before focusing more closely on details of the trauma
- considering formative life events, characterological alterations, dissociative responses and other reactions that may have reinforced or diluted reactions to the abuse
- an increased focus on therapeutic neutrality on issues of memory – especially where there is a lack of continuous memories of the abuse
- acknowledging the unique transference, countertransference and vicarious traumatisation associated with CSA.

Basis of the guidelines

These therapy guidelines are mainly based on an amalgamation of works by abuse-focused and trauma therapists who have recently developed complete therapy guidelines for adult survivors of CSA.[7]

The focus is restricted to practice issues in one-to-one psychotherapy. However, this in no way suggests that other therapies, such as group therapy, couples therapy, family therapy or whanau-based approaches, are less valuable or effective.

While there are some differences, the authors reviewed for these guidelines provide a broad consensus on the treatment of CSA. However, as all therapists know, any therapy guidelines or treatment techniques are only ever guidelines – and as a therapist, you should always:

- be flexible and only provide therapy appropriate to each client and situation
- adhere to the ethics of the professional body of which you are a member, as well as the generic ethical basis of 'first do no harm'
- be aware that many therapy models are based on Western ideas and may be partially or wholly inappropriate to members of other cultural groups.

These guidelines provide an abuse-focused approach to therapy for adult survivors of CSA – they are not prescribed rules.

Today, a wide range of therapists work successfully with survivors of CSA, using such diverse models as psychotherapy, narrative therapy, family therapy, cognitive therapy, body therapy and many other therapy models.

The guidelines have been designed to provide therapists in New Zealand with useful information on practices that have been researched and recommended by some of the world's leading abuse-focused and trauma therapists. Their aim is to support the provision of safe and informed therapeutic services to survivors of CSA.

However, it is important to note that:
'No techniques can replace the respect and stable, affirming connection offered by good generic psychotherapy, irrespective of whether or not it is abuse oriented.'[8]

The context

Child sexual abuse appears to be a worldwide problem. When defined (for research purposes[9]) as 'sexual contact ranging from fondling to penetration by someone who is five years or more older than the survivor', the rate of abuse experienced by girls has been found to be between 20 and 30 percent of the general population across all racial, religious and socio-economic groups.[10] The rate for boys is generally expected to be around half the figure for girls.[11]

In New Zealand, the Otago Women's Health Survey[12] found that:

- 25 percent of women reported experiencing sexual abuse that included physical contact before the age of 16 years, and 16 percent before the age of 12
- the greatest age of risk for CSA to start was when the child was 8 to 12 years old
- the abuse was often severe, with 70 percent of CSA experiences involving some genital contact, attempted intercourse or actual intercourse
- intrafamilial abuse was more likely to be chronic than non-familial abuse
- of all CSA experiences, 20 percent continued over more than a year, with 10 percent for more than three years.

The perpetrator was a family member in 38 percent of cases, an acquaintance in a further 46 percent and a stranger in 15 percent. Stepfathers were 10 times more likely to be sexually abusive than biological fathers. Ninety-eight percent of perpetrators were male.

Of the women who reported some form of CSA, only a third told someone about the abuse within a year of it happening. A quarter told 10 or more years later.

Later disclosures were most frequently made to adult partners and mental health professionals. Those who told a mental health professional frequently did so when they saw a counsellor for a reason other than the abuse. Only 1 percent of the women who reported abuse remembered the CSA for the first time during therapy.[13]

Some of the reasons the women gave for not disclosing the abuse were that they:

- expected to be blamed
- felt too embarrassed to tell
- did not want to upset anyone
- expected to be disbelieved
- wished to protect the abuser
- feared the abuser.

These fears may still be present when the survivor enters the therapy room.

CSA – affecting child development

Childhood is a critical period when the child is developing physiologically, psychologically and socially. Although experiences alter an adult's behaviour, they can literally shape a child.

The sensitive brain of a child is much more malleable to experience than a mature brain. Over 100 billion neurons are organised to sense, process, store, perceive and act on external and internal information.[14] The more frequently any pattern of information is experienced (whether it be soothing, nurturing, frightening or shameful), the more indelible the internal representation.

In childhood the child's 'self' is being shaped, mainly in their relationships with others. Key people such as parent(s), caregivers and siblings have a particular role – in these relationships the child learns about issues such as trust, safety, and self-worth. Coping and interpersonal skills are being developed and assumptions about their identity, others and the world are being formed.

Prolonged trauma such as hostage situations, concentration camp internment and ongoing CSA differs from single incidents of trauma and non-interpersonal trauma such as natural disasters.[15] Abuse by a family member, a person in a trusted role within the child's community or an acquaintance involves profound role and relationship betrayal. A relationship of protection, support and danger produces a 'macabre double bind'[16] of love and hate, dependence and betrayal.

Children exposed to interpersonal violence such as CSA are at risk of profound and ongoing effects on their childhood, adolescence and adulthood development. Characteristics of abuse (such as the age of the child at the onset or the frequency or severity of the abuse) may partially but not fully explain the impact of CSA. Even a single episode may have profound effects on a child's development; these are due not only to the CSA but also to the ongoing consequences to the child's life.

Children tend to blame themselves for things that 'go wrong'. Even if they are shocked or hurt at the time of the abuse, they will often not disclose it for fear of somehow being to blame. Feeling unable to disclose the

abuse can leave them vulnerable to the abuse escalating over time and precludes the possibility of formal or informal interventions.

Being unable to access help after CSA can mean the child is left alone to cope with feelings such as betrayal, guilt, shame, fear, confusion and anger. Having to hide their response to the abuse and deal with it alone has the potential to alter their development and all their relationships.

However, disclosing the abuse can also create difficulties. Children who disclose abuse by a non-relative are more likely to be believed and supported than those who disclose abuse by a person close to the family.[17]

Lack of support can leave the child feeling that they (rather than the perpetrator's actions) are responsible for the family's distress, hostile response, or fragmentation. Consequently some survivors who have disclosed the abuse have a worse mental health outcome than those who have not.[18]

Incest and CSA do not occur in a vacuum. For example, when incest is committed within a family there are also likely to be[19]:

- disturbed family relationships and dynamics such as parental discord and immaturity
- parent-child role reversals and triangulation
- boundary violations
- entrenched patterns of denial, secrecy, rigidity and shame.

The impact of these family disturbances on the survivor may be seen as part of the effects of incest and will also require therapeutic attention.

There may be similar issues for those experiencing extrafamilial CSA that will also require therapeutic attention. For example, if non-offending caregivers do not notice a child has been abused, the child may infer that they condone the abuse or don't care enough to supervise them or 'pick up' the signs of their distress.

Whether or not the child's interpretation is accurate, the meaning they attach to the abuse may disrupt their attachment relationship with their caregivers. CSA therefore often has long-term effects on the survivor's life, not only because the abuse happens within the child's important developmental stages but also because it is frequently:

- perpetrated by a person or people close to the child or within the child's family (creating loyalty confusion and feelings of entrapment)
- ongoing (sometimes over years) with the severity of abuse often escalating over time – and sometimes including multiple abusers
- difficult to disclose (owing to loyalty, fear, threats, shame and dissociation)
- a precursor to further revictimisation experiences.

Some conditions have been found to result in a complex set of adaptations and long-term negative outcomes for the survivor's development.

These include:

- entrapment, dependence and/or subordination to the perpetrator(s)
- ongoing contact with the perpetrator(s), including the constant fear or anticipation that the abuse will recur
- having been 'groomed' to accept or even initiate sexual contact – feelings of complicity, guilt/shame or responsibility for the abuse
- multiple episodes of abuse and/or abusers
- having been young or in early puberty when the abuse started
- the abuse being of a longer rather than a shorter duration
- the abuse having escalated over time
- the additional use of force or violence
- physical penetration
- the perpetrator(s) being from within or close to the family
- the abuse being known about but not stopped
- the abuse being sadistic and/or the child having witnessed the perpetrator's pleasure in their pain or humiliation
- the abuse being embedded in other forms of family dysfunctions or forms of child abuse or neglect
- not having found a way to stop the abuse and not having been able to protect others (often siblings) from the perpetrator(s)
- negative outcomes following disclosure or discovery of abuse (the child is disbelieved, blamed, punished or ostracised, the family fragments into alliances)
- not having support after the abuse to make sense of what happened and place responsibility where it belonged.

Profound, long-lasting effects

Symptoms of CSA can manifest in different ways in childhood. Up to a third of children show no symptoms around the time of the abuse, however 'sleeper effects'[20] may be triggered later in life. CSA can leave children with a distorted sense of self. If there are no, few or ineffective early interventions to alter their negative self-perception, they can grow up feeling tainted, guilty and worthless.

During and after the abuse the child/adolescent may:

- be forced to cope alone with the effects of post-traumatic stress and develop 'primitive'[21] coping strategies, such as dissociation or self-harming behaviours
- develop a distorted cognitive understanding of themselves (helpless, bad), others (powerful, good) and their view of the future (fearful, hopeless)
- experience disrupted early attachment dynamics with their caregivers, extended family, teachers and peers
- express or repress feelings (resulting from the abuse) in ways that bring criticism, rejection or isolation – by becoming hostile or violent, over-using alcohol /drugs/ other substances, engaging in age-inappropriate or risky sexual practices, becoming withdrawn or depressed, or attempting to manipulate others in ways they have been manipulated.

The power of intervention

Many positive interventions can mediate the potential negative outcomes from CSA.

They include formal and/or informal interventions in childhood, such as an openness to discuss and deal with the abuse in a way that prioritises the child's safety and ensures they are not left feeling responsible or guilty for having disclosed the abuse. Safe, caring people such as caregivers, mentors, friends, life partners or loved ones can also sometimes help the survivor deal with many of the potential effects of CSA. Survivors who have had few or no such positive interventions may struggle with a variety of effects that become more severe over time. For example, it is common that, over time:

- childhood fears may develop into phobias or anxiety disorders
- childhood withdrawal, grief and loss (from consequences of the abuse, the betrayal of the perpetrator, or disbelief of disclosure and isolation and rejection from family or loved ones) may develop into episodes of depression
- symptoms of Post-traumatic Stress Disorder (PTSD) experienced in childhood may develop into Complex PTSD
- dissociation (which enabled the child to cope with ongoing abuse) may develop into a major coping strategy throughout life, causing the survivor other difficulties
- anger and humiliation may develop into difficulties with interpersonal relationships, so that when they enter therapy the survivor may have experienced a lifetime of miscommunication, isolation and loneliness.

However, not all will experience serious negative effects on their lives, so not all will require or seek lengthy therapy. Survivors who have received a great deal of support in their lives may never seek therapeutic support. Some prefer only a few therapy sessions as issues wax and wane or are triggered by life events. Others may feel overwhelmed and require a great deal of ongoing support, having battled years of symptoms.

Long-term effects of CSA

This section provides an overview of a range of difficulties (listed alphabetically) with which some survivors of CSA may be struggling, especially if there have been few or no positive interventions since the abuse.[22]

Because the effects of CSA are caused by human action and are not the result of a 'disease' or 'illness', these guidelines avoid using medical terms where possible. The term 'effects' is preferred to 'symptoms'. However, as much of the literature on which these guidelines are based is dominated by psychiatric terminology, it has been difficult to consistently avoid diagnostic labelling.

This section covers some of the effects of CSA:

- Anxiety
- Complex PTSD (CPTSD)
- Dissociation
- Depression
- Eating disorders
- Impaired self-capacities
- Impaired 'self' and 'other' boundaries
- Interpersonal and parenting difficulties
- Memory impairment
- Personality disorders
- Post-traumatic Stress Disorder (PTSD)
- Psychiatric symptoms
- Re-victimisation
- Self-blame
- Self-harm and suicidal behaviour
- Sexual difficulties
- Somatisation and physical effects
- Substance abuse.

It is important to note that each course of therapy must be individually tailored. For example, not all survivors of CSA will experience PTSD, dissociation, severe depression or will self-harm.

There is no one single diagnosis to describe the effects of CSA and no single psychometric tool sufficiently sophisticated to assess all the possible negative outcomes of CSA.

The therapist's involvement

You can help your client to recognise that the long-term cumulative effects of CSA are often necessary adaptive responses developed to deal with what may have been a series of disempowering or traumatic experiences beginning in childhood.

While their coping strategies may not be serving them well now, they were developed at a time of limited (childhood) resources, choices and options. Their coping strategies may have kept them alive, and should not be regarded as 'symptoms' that can be quickly eliminated or dismantled without first developing other (more positive) coping strategies.

You can avoid adding to your client's self-blame by explaining that what appear to be a collection of 'out-of-control symptoms' are in fact normal, logical and generally predictable developments following CSA. By helping them make sense of the way their 'symptoms' have developed, you can help your client regain some of the control and self-respect they may have been robbed of in childhood.

It is important not to assume that survivors of CSA will be 'permanently damaged', 'scarred for life' or 'beyond help'. The effects listed below are not exhaustive or designed to overwhelm therapists. Many overlap. Only PTSD and Complex PTSD have been more fully described. Your clients may struggle with one, some, all or none of the effects listed.

Anxiety

CSA can cause an over-activation of sensory stimuli during the child's sensitive period of development. The initial stage of threat can cause an alarm reaction in the child as the body prepares to defend, flee or fight. This can cause a large increase in activity in the sympathetic nervous system, resulting in increased heart rate, blood pressure and respiration, a release of stored sugar, an increase in muscle tone, hypervigilance and a tuning out of non-essential information.[23]

Following an acute fear response, systems in the brain can be reactivated each time the child is exposed to a reminder of the traumatic event, such as seeing someone who resembles the perpetrator. If the person who is harming the child lives with or near to them (as do many perpetrators),[24] they have little respite from re-stimulated traumatic arousal, such as anticipatory dread.

Over time, specific reminders may become generalised – for example, all those of the same gender as the perpetrator have the potential to trigger a fear response. CSA survivors have up to five times a greater likelihood of

being diagnosed with at least one anxiety disorder (such as generalised anxiety disorder, phobias, panic disorder, and/or obsessive compulsive disorder) than those who are not similarly abused.[25]

Complex PTSD (CPTSD)

Researchers[26] have argued that a diagnosis of 'simple' PTSD (see page 11) does not provide an adequate description of the effects of CSA owing to the significant impact CSA can have on a child's entire developmental years. Instead they use the terms 'Complex PTSD', 'Chronic PTSD', or 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS) to describe the multiple long-term consequences of trauma and CSA.[27]

CPTSD has been described as PTSD that has been generalised over time and incorporated into the survivor's bio-psychosocial being.

CPTSD can include alterations in[28]:

- **affect regulation,** including persistent dysphoria, chronic suicidal preoccupation, self-injury, explosive or extremely inhibited anger (which may alternate) and compulsive or extremely inhibited sexuality (which may alternate)
- **consciousness,** including amnesia, transient dissociative episodes, depersonalisation and derealisation. Survivors relive experiences in the form of either intrusive PTSD symptoms or ruminative preoccupation
- **self-perception**, including a sense of helplessness or paralysis of initiative, shame, guilt, self-blame, a sense of defilement or stigma and a sense of complete difference from others
- **perceptions of the perpetrator,** including a preoccupation with the relationship with the perpetrator, an unrealistic attribution of total power to the perpetrator, idealisation or paradoxical gratitude, a sense of a special or supernatural relationship and an acceptance of the perpetrator's belief system or rationalisations
- **relations with others,** including isolation and withdrawal, disruption in intimate relationships, a repeated search for a rescuer (this may alternate with isolation and withdrawal), persistent distrust and repeated failures of self-protection
- **systems of meaning,** including a loss of a sustaining faith and a sense of hopelessness and despair.

These symptoms are best conceptualised as dynamic and changing rather than static.[29]

Depression

Depression appears to be the most common effect of CSA. Survivors may have up to five times[30] as great a lifetime risk for a major depression than those without an abuse history. Chronic low self-esteem, coupled with an inability to self-soothe or self-nurture, often means the depression is tenacious.

Many survivors of CSA have a lot to feel angry or sad about. Many feel they have 'lost their childhood'. For some, losses may extend over decades. Some have been rejected by their families, with their children unable to have contact with grandparents and other extended family.

Dissociation

When attacked, an adult may have a 'fight, flight or freeze' reaction. The fight or flight options may not be possible for a child. Dissociation is a logical response to a physically inescapable situation.

Survivors of CSA describe more numbing, dissociative, 'out-of-body' experiences, repression of painful abuse-related memories and fugue states than those not similarly abused.[31] An association has been found between the severity of the child abuse and the extent of the dissociative symptomatology.[32]

Some studies have demonstrated a strong association between CSA and multiple personality disorder (MPD, now referred to as dissociative identity disorder). Because of their extraordinary dissociative capabilities (sometimes hearing voices as quarrelling alter-personalities), some people with MPD have been misdiagnosed as experiencing schizophrenia.[33]

Eating disorders

Survivors may use food as a vehicle to gain control or soothe emotional pain. They may not have been in control of their body during the abuse, but may now be in control of what foods do or do not enter their body. Gaining weight can help the survivor feel more powerful and able to protect themselves. Studies have also found CSA to be associated with eating disorders such as

anorexia and bulimia.[34] A review of studies[35] pointed to approximately a third of CSA survivors being diagnosed with an eating disorder.

Impaired 'self' and 'other' boundaries

An impaired 'self'[36] is difficult to define, as is the therapeutic work required to repair it. Once a child's boundaries have been violated, they are likely to develop difficulties understanding where their identity, perspectives and needs end and another person's begin.

Over a lifetime, a person without a sense of boundaries is likely to have interpersonal difficulties, sometimes ricocheting from being intense with others to feeling rejected by them and to isolating themselves to avoid future rejections.[37]

Impaired self-capacities

A child who develops free of abuse, with adequate nurturing and encouragement to self-soothe, should gradually learn to cope with everyday negative occurrences such as minor disappointments and rejections. Through this process this child should develop healthy (non-harmful) self capacities[38] that will enable them to tolerate or modulate (finding ways to self-soothe) gradually increasing amounts of everyday negative affect.

However, children who have been overwhelmed by traumatic experiences (such as CSA) are often less able to build such self-capacities. They are often less able to tolerate negative affect and build sufficient affect modulation skills to cope with the tension that negative affect causes.

Without these skills they may be forced to develop 'primitive' tension-reducing strategies, such as over-eating, using substances, attempting to control or manipulate others, dissociating or self-harming in an attempt to deal with distressing feelings or thoughts. Without intervention, these primitive attempts to deal with distress may continue into adulthood.

Interpersonal and parenting difficulties

Interpersonal difficulties are among the most pervasive and significant effects of CSA. They may include[39]:

- difficulties developing and maintaining friendships and intimacy
- over-enmeshment with and dependence on others
- social isolation, fear of being alone or being with others
- mistrust and/or hostility towards others, especially people with similar characteristics or sex to the perpetrator(s)
- increased rate of relationship difficulties, separations and divorces
- parenting difficulties.

Being harmed by another human being can have consequences on every other human relationship. Other people, including partners, children, workmates, employers and therapists have the potential to re-traumatise the survivor.

Memory impairment

In a clinical study of 450 women and men, 59 percent reported not having remembered the CSA at some point after the abuse but before their 18th birthday.[40] This study demonstrated a significant association between memory impairment, physical injury, the earlier onset and longer duration of abuse, multiple perpetrators and fear of death should the abuse be disclosed.

Survivors often feel shame if they do not have their entire life history available to them. Some have a dreadful fear of what might have happened to them that they cannot remember. Sometimes when their memories of abuse surface again they experience traumatic doubt – doubting themselves, and their own sanity, unsure if the abuse 'really' happened or if it was 'just a nightmare'.

Personality disorders

Personality disorders, particularly borderline personality disorder (BPD), seem closely associated with CSA.[41]

BPD has often been described as a complicated post-traumatic syndrome with the effects of the victimisation experiences integrated with the total personality.

The DSM IV (1994) criteria for BPD include typical effects found in child and adult survivors of CSA:

- symptoms of impulsivity associated with intense anger or suicidality

- self-mutilating behaviour
- affective instability with depression.

Post-traumatic Stress Disorder (PTSD)

Although the trauma may have happened many years ago, PTSD symptoms may be triggered by everyday life experiences that parallel the abuse experience in any way.

These triggers can include sexual stimuli or interactions, current abusive behaviours or interpersonal manipulations, seeing or reading sexual or violent media depictions, disclosing abuse experiences, and situations where the survivor does not feel in complete control of their lives or bodies (such as when giving birth or during surgical procedures).[42]

Symptoms of PTSD may include[43]:
- intense feelings of fear or helplessness
- recurrent and intrusive, distressing recollections of the event, including:
  - images, thoughts, perceptions and dreams
  - feeling as if the traumatic event were recurring (including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes)
  - intense psychological and/or physiological distress at exposure to internal or external cues that symbolise or resemble an aspect of the trauma
- persistent avoidance associated with the trauma, and numbing of general responsiveness such as:
  - efforts to avoid thoughts, feelings or conversations associated with the trauma
  - efforts to avoid activities, places, or people that arouse recollections of the trauma
  - an inability to recall an important aspect of the trauma
  - a diminished interest or participation in significant activities
  - a feeling of detachment from others
  - a restricted range of affection (eg, unable to feel love)
  - a sense of a foreshortened future, where they do not expect to live a full life (either with a relationship or children or having a 'normal' life span)
- persistent symptoms of increased arousal such as:
  - difficulty falling or staying asleep
  - irritability or outbursts of anger
  - difficulty concentrating
  - hypervigilance and startle responses.

Psychiatric symptoms

A history of CSA has significant associations with a wide range of psychiatric problems,[44] even when making allowances for the effects of family dysfunction.[45]

The more severe the abuse, the greater the likelihood of psychiatric disorder in adulthood.[46] Psychosis has been linked to a history of CSA,[47] as has schizophrenia.[48] Psychiatric admissions are five times more likely for women who have experienced CSA to the level of genital contact and 16 times more likely for those who experienced intercourse (when compared with women who have not experienced CSA).[49]

In a study of inpatients, those who had been seriously abused as children were three times more likely to be acutely suicidal.[50] When compared to other adults who have entered a psychiatric hospital,[51] those who have been abused as children enter at a younger age, and have longer and more frequent periods in hospital.

They:
- spend more time in seclusion
- are more likely to receive psychotropic medication
- relapse more frequently
- are more likely to self-harm and attempt suicide
- have higher scores on measures of global severity of psychiatric symptoms.

Re-victimisation

Development does not end with the onset of adulthood. It is believed that couples tend to create a union that confirms their views of themselves and their experiences.[52] This theory may in part explain re-victimisation of survivors of CSA in adulthood. For example, survivors with a deep sense of self-loathing, combined with an idealisation of 'others' and a lack of self-protection ideology, may be more likely to form relationships and partnerships with those who will re-enact their early environments of victimisation.[53]

Unfortunately these same dynamics also have implications for survivors' children. For example, the effects of CSA on the survivor-parent may cause them to have difficulty selecting a supportive and well adjusted partner. This goes some way to explain why the children of survivor-parents have a higher risk of being abused. A strained

survivor-parent/child relationship may also increase the child's vulnerability to CSA – for example, owing to their own experiences of abuse, the survivor/ parent may unconsciously avoid noticing indicators of abuse in their child(ren).[54] However, the majority[55] of survivors of CSA do not go on to sexually abuse others or their children. In fact they frequently try to protect their children in a way they were not protected.[56]

It is also not inevitable that survivors of CSA will choose abusive partners or develop into poor parents. Some of the harm of the sexual abuse and disrupted attachment difficulties may be reduced if the survivor, as a child, was able to attach to a supportive relationship inside or outside the home[57] or later form a relationship with a secure partner[58] or attach to a therapist.[59]

Women survivors of CSA report significantly more negative adult experiences, such as sexual assaults, physical assaults and force used against them.[60] The sexual abuse of survivors of CSA by therapists and other professionals has been described as the 'sitting duck syndrome'.[61] In one study of 958 clients[62] who reported having been sexually involved with a therapist, a third were survivors of CSA. In another study of women seeking shelter from domestic violence, 65 percent reported a history of CSA.[63]

Such an overall history of abuse and re-victimisation makes it less surprising that those with a history of CSA are over-represented in at-risk populations, such as the homeless, those in prison, substance abusers and sex-workers.[64] CSA has also been associated with those achieving a lower socio-economic status than would have been predicted from their background.[65]

The cumulative effects[66] of re-victimisation following CSA add to the complexity of clients seeking therapeutic help. Given that survivors of CSA are at greater risk of domestic abuse and adult sexual assaults, it is likely that symptoms from recent adult re-victimisation will exacerbate CSA symptoms and slow the rate of recovery.[67]

Self-blame

Constant blame, guilt and shame can develop into chronic low self-esteem and may trigger tension-reducing behaviours such as self-harming symptomatology, which includes alcohol or drug use, indiscriminate sexual behaviours, bingeing and purging and suicidality. Over-responsibility and perfectionism may also indicate chronic low self-worth.

Self-harm and suicidal behaviour

CSA has often been associated with suicidal ideation and behaviours.[68] In one study,[69] 79 percent of self-mutilating individuals reported a history of CSA. An Aotearoa/New Zealand study[70] found that survivors of CSA showed suicidal behaviour levels 20 to 70 times greater than the non-abused controls.

Sexual difficulties

Children who have been sexualised can have a range of responses to their own emerging sexuality and subsequent sexual encounters. They may become repulsed or fearful of sexuality or move towards the other end of this continuum and become compulsive about sexuality.

Those who have experienced traumatic shock, disgust or humiliation when they were abused as children may experience a life-long aversion to sexuality and attempt to suppress their own emerging sexual feelings. This may cause them further difficulties – especially if they become involved in a sexual relationship. It is not uncommon for the survivor to experience symptoms of PTSD at each potential sexual encounter.

Those who were abused by someone of the same gender as themselves may experience considerable confusion as their own sexual identity emerges.

Some children have been groomed to value themselves only in terms of their sexuality. Acting out sexually may become a compulsive behaviour that may be an attempt to feel valued, or a traumatic re-enactment attempting to reverse a feeling of disempowerment.

Survivors of CSA often have increased levels of indiscriminate sexual behaviour[71] and frequent short-term sexual activity with numerous sexual partners.[72] Such activities can leave the individual not only with low self-esteem and social stigma but also vulnerable to risky sexual practices such as unprotected sex. This in turn leads to the possibility of sexually transmitted infections and unwanted pregnancies and their consequences.[73]

Studies have revealed that 65 percent of female and male subjects infected with HIV have a history of childhood sexual or physical abuse,[74] while a community sample of women survivors of CSA reported they engaged in voluntary sexual intercourse at a significantly earlier age and had more sexual partners and briefer sexual relationships than non-abused women.[75] Sixty-five percent of exotic dancers and 55 percent of sex workers were survivors of CSA.[76]

Somatisation and physical effects

Somatisation is seen as a natural extension of sympathetic nervous system hyperarousal.

Some studies of women survivors suggest that they are more likely than those in comparison groups to report physical symptoms such as[77]:

- headaches
- gastrointestinal problems
- muscle tension
- chronic pain, particularly back and pelvic pain
- irritable bowel syndrome
- pre-menstrual tension
- pelvic inflammatory disease
- breast disease
- yeast infections
- sexually transmitted infections including herpes and HIV
- infertility
- pregnancy, and more complicated pregnancies.

You should also be concerned about psychological and physical impacts of re-victimisation such as:

- physical and/or sexual assaults subsequent to CSA
- the propensity to be drawn into at-risk sexual activities and sex work.[78]

Substance abuse

Several studies[79] have found that survivors of CSA have an increased use of alcohol and drugs. Survivors have been twice as likely to report a history of heavy alcohol consumption at some time in their life.[80] Between 71 and 90 percent of teenage girls and 75 percent of adult women who were admitted to an inpatient drug rehabilitation programme reported histories of CSA.

Abuse-focused therapy aims to help the survivor identify and strengthen their already existing skills to move beyond their current level of adaptive functioning and focus on their growth and development.

Abuse-focused therapy is based on a philosophy and practice that include:
- a knowledgeable and affectively available therapist
- appropriate client/therapist matching
- a focus on the client's strengths and growth
- a phenomenological perspective
- understanding the meanings of trauma
- understanding the functionality of symptoms
- an awareness of professional denial and abuse
- the therapist as ally
- therapist self-care.

A knowledgeable and affectively available therapist

To heal, many survivors of CSA require a relationship with a real, warm, concerned person who is actively involved with them in an empathetic, responsive way.[81]

Many are sensitive to any signs of 'phoniness' and 'distance'.[82] This means meaningful support and genuine empathy are likely to be more effective than a technically clever intervention.

This demanding and complex work requires therapists to[83]:
- become a 'good enough' therapist by conducting safe, bounded therapy
- be responsible for providing a respectful environment for the client to do their work
- regard the client as the expert on their life, history and meaning
- be willing to be regarded as a consultant or coach to the client rather than an expert with all the answers
- work towards developing an open, equal working relationship with the client where both parties are able to guide the therapy's pace and focus
- be emotionally present and genuine
- be willing to be involved and alert to a client's needs
- have good personal and professional self-esteem and be able to acknowledge their mistakes
- have good knowledge of trauma and abuse-focused therapy theory and practice
- have regular supervision
- belong to a professional body that has a code of ethics and a complaints procedure
- develop a network of colleagues including specialist psychiatrists who have knowledge of up-to-date psychopharmacological treatment choices and those who are able to provide adjunct services such as group therapy
- be flexible and open to continued learning in this fast-developing field.

Abuse-focused or trauma therapy is not for everyone. It requires therapists who are comfortable with being affectively available and able to handle the challenges presented by those who have been interpersonally harmed.

Client/therapist matching

Some guidelines[84] suggest that understanding, empathy and trust in the client/therapist relationship may be detrimentally affected if:
- the therapist's gender or characteristics matches that of the perpetrator
- the therapist is not matched with the client along gender or cultural lines.

While this is a complex issue, it seems that it is preferable (initially at least) that the therapist matches the client's gender and cultural background, unless the client wishes it otherwise.

A focus on the client's strengths and growth

Abuse-focused therapy recognises that adults abused as children have survived conditions that could have destroyed them; therefore they are survivors (not victims).

To survive they accessed survival strategies. This focus on clients' strengths and growth reframes so-called 'symptoms' as coping strategies – which were valuable

at the time of the abuse but which may have, in the longer term, become unhelpful.

It is important that you communicate to your client that they[85]:

- are the expert on their ways of coping and surviving
- are not 'sick' and therefore do not need to be 'cured'
- have done their best to survive an abusive environment
- may have current difficulties as a result of surviving an abusive environment
- may have been labelled as dysfunctional, by themselves and/or by others
- have the more difficult task (of the two of you) of facing the fears and hurts of the past.

Abuse-focused therapy assumes the potential for growth. Many clients believe they are 'genetically impaired' with no hope of ever being relieved of their symptoms.

Implying that they can achieve their goals can be seen as giving them hope – an important potential motivator in promoting change.

A phenomenological perspective

Rather than relying exclusively or predominantly on abstract theoretical notions to guide therapy, the trauma therapist adopts a 'phenomenological' perspective. This does not mean they give up their overall responsibility to provide safe, bounded, informed therapy. It means they listen closely to the survivor's personal experiences, perceptions and meaning. This perspective requires a great deal from the therapist and demands that they learn about the survivor's inner world and meaning.

Understanding the meanings of trauma

There can be no assumptions about the effects of CSA.

Your client must be the one who defines what is traumatic. What you imagine may be traumatic may not be so for them. Conversely, something that you assume would not be distressing, your client may find hugely traumatic.

For example, your client may not have trouble coping with their memories of the actual abuse, but with their interpretation (as a child) that the lack of protection meant they deserved to be abused.

Understanding the functionality of symptoms

Therapists unaware of the functional use of symptoms may attend to superficial outcomes and/or inappropriate goals.

For example, addressing only the behaviour in attempting to stop a person self-harming with alcohol, meaningless sexual encounters or a razor is unlikely to alter the drive to self-harm. The goal of treatment is not only to reduce (and eventually remove) the 'symptoms' but also to alter the abuse-distorted belief structure that underpins the symptomatology. For this reason symptoms reduction may only represent the first stage of the required therapeutic work.

An awareness of professional denial and abuse

Abuse-focused therapy acknowledges that historically, and currently, society and the mental health profession may have:

- disbelieved the reality of CSA survivors
- treated their reality as fantasy
- blamed or stigmatised survivors for their symptomatology by ascribing their symptoms to such as labelling CSA symptoms as 'histrionic' or having a 'borderline' disorder[86] rather than linking cause and effect.[87]

Your client may have internalised some of these attitudes, so it may be helpful to ask if they have previously disclosed their history of CSA to anyone. Establish the sort of response they received and address any negative reactions.

It is important to note that some clients may have been re-victimised by professional 'helpers' in subtle to extreme ways, ranging from voyeurism to verbal insults, sexual harassment, physical assaults or rape.[88] It is understandable that they will have a great deal of difficulty even considering re-entering therapy.

The therapist as ally

Therapists doing this work need the capacity to bear witness to some of the most tremendous pain possible in a human being.

Your client may have felt the burden to remain silent about the abuse for many years, and talking about it may take a great deal of courage.

No matter how long ago the abuse took place, they may fear an angry backlash from you, as well as their family and loved ones when they finally speak out.

Such courage deserves to be heard by an ally who is able to support them through the potentially fearful, shameful, isolating times following a disclosure of CSA.

Traditional therapies that advocate therapist distance and 'objectivity' can be counterproductive in trauma work because a survivor needs an ally.

Technical neutrality, which is designed to allow the client freedom to experience conflict, is not the same as moral neutrality.

The therapist is asked to bear witness to a crime, therefore the therapist 'must affirm a position of solidarity with the [client]. This does not mean a simplistic notion that the [client] can do no wrong; rather, it involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice.

This affirmation expresses itself in the therapist's daily practice, in[their] language, [their] moral commitment to truth-telling without evasion or disguise'.[89] This role asks a great deal of a therapist.

Therapist self-care

Because this work can be so challenging and intense, therapist self-care is vital.

It is common for therapists working in the area of interpersonal violence to experience vicarious traumatisation. You will inevitably be affected by hearing your clients' accounts of victimisation. You may also feel the effects, as some severely traumatised survivors constantly 'test' their therapist or relate to them with hostility, expecting the therapist to betray or abuse them – based on earlier experiences.

To keep any negative effects (on your life and your work) to a minimum, make sure your personal and professional life is balanced and you have enough personal and collegial support, as well as specialised supervision to keep you and your work safe.

Discuss any disturbances to your life in supervision. Signs of vicarious traumatisation include:

- fear
- anxiety
- hypervigilance
- depression
- sleeping
- eating or sexual disturbances
- anger
- irritability
- numbing
- dissociative experiences
- addictions
- intrusive symptoms
- nightmares
- startle responses
- disturbances in the self with others and with worldview (for example, seeing trauma, abuse or evil everywhere)
- social and emotional withdrawal
- exhaustion
- cynicism and loss of empathy and hope.

Most therapists will also have personal stressors in their lives from time to time. It is important to include physical exercise in your usual self-care routine, reduce your workload at times of stress, take regular breaks and have personal therapy when needed.

Self-care for parallel issues

Any therapist working with an issue parallel to their client (such as infertility, death of a parent, a relation-

ship break-up or a history of childhood abuse) will need to have sufficiently worked through these issues themselves.

If they have not, they risk a range of therapeutic errors, including projecting their own experiences on to their client or trying to stop the client discussing the topic to the depth they need.

As reflected in the general population, a percentage of therapists will have histories of interpersonal violence or childhood abuse.

Personal therapy is a prerequisite for this situation. However, those who have dealt with difficult personal issues can be 'optimally suited' to provide 'sensitive, non-discounting' therapy to other survivors and 'can ultimately become the best of therapists'.[90]

In contrast, therapists who have had relatively stable childhood experiences may have the advantage of being less encumbered by 'significant countertransferential responses to their client'.[91] However some of them may be disadvantaged and 'run the risk of not entirely understanding the demons with which many survivors struggle'.[92]

In general, therefore, all therapists need ongoing self-monitoring and supervision.

Ongoing process issues

This section outlines some of the issues that continue throughout therapy:

- The need for a flexible therapy framework
- The client's reason for and process of entering therapy
- The complexity of assessing the long-term effects of CSA
- The intertwining of assessment and therapy
- The need to provide structure and predict processes
- Requirements for a safe therapeutic relationship
- Dealing with inter-session needs
- Maintaining therapeutic boundaries
- Normalising transference and countertransference responses.

The need for a flexible therapy framework

It is important to remember that:

- CSA can affect every aspect of a person's being, from biological and psychological to emotional and interpersonal, so abuse-focused therapy must be equally as comprehensive
- no single therapeutic approach can be applied unilaterally to survivors of abuse
- one treatment approach used at one stage may not be useful at another; it may even be harmful
- effective treatment is likely to require a staged, multi-modal approach
- clinical guidelines for abuse-focused therapy can only be regarded as a flexible framework because new issues will arise throughout the therapy
- the concept of the 'therapeutic window' (see page 36) can be useful in every therapy session.

The client's reason for and process of entering therapy

Adult survivors rarely enter therapy with the specific goal of working through unresolved CSA.

They are likely to present with a complex array of difficulties and concerns and may have a low sense of entitlement, believing they do not deserve help or even compassion. They may apologise for wasting your time and initially minimise the degree of abuse and its effect on their lives. Some clients may attend therapy owing to a crisis and after it has passed may not wish to continue. Others may arrive demanding intense support.

- Often a survivor will seek therapy to deal with an issue they are struggling with in their current life. As it would jeopardise your rapport to override their presenting issues and focus on the CSA (apart from gathering minimum details if they wish to submit an ACC claim), you may accept any realistic goal your client suggests.
- You can be fairly confident that most issues your client will wish to work on (that may appear to be surface issues) will be related to the effects of childhood abuse or its context. For example, relationship difficulties, depression, substance abuse or abusive relationships may be a result of CSA.
- Reaching the point where you can discuss CSA may take some time, as few clients enter therapy having identified their experience of CSA and its effect on their current mental health difficulties. They often need to go through a slow and careful process of identifying how their life has been affected by the abuse, and then decide whether they wish to enter the painful process of addressing these childhood traumas.

Your client may initially contract you for short-term work to 'test the waters' before considering a longer-term commitment[93] (if this is needed). They need to be confident of your acceptance and understanding before they proceed.

They may also wish to leave therapy if it becomes obvious they need to face what they have avoided and that treatment will involve a considerable amount of pain. Not all clients will wish to undertake or commit to long-term therapy. Many will require the flexibility to access therapy at times when they can no longer cope alone.

- It is important not to pressure a client into continuing therapy if they do not wish to.
- To help them decide on whether to continue with therapy, you can:
  - reassure them that you would like to see them again (or suggest a referral if this is not appropriate)
  - acknowledge the difficulties of their decision and the work ahead
  - acknowledge that therapy takes time and effort and can make life more difficult for a while
  - reassure them it is OK if they decide the time is not right for them to continue with therapy – they may wish to access therapy again later
  - discuss their options, including perhaps an interim plan, until they feel ready to reconsider therapy

  - ensure they know that if they begin therapy they have every right to leave it at any point or take a break (having preferably first discussed their decision with you).
- Remember, the client is the expert on their inner experiences. You may wish to reassure them of your continued concern and interest in their wellbeing. Supporting them in their decision to end therapy can sometimes make it easier for them to return to or stay in therapy.

The complexity of assessing the long-term effects of CSA

CSA survivors often have little awareness of the link between their childhood trauma(s) and their current cognitive, emotional, physical, behavioural, and interpersonal difficulties. Indeed, one study revealed that almost half of psychiatric inpatients saw no connection between their experiences of CSA and their current mental health difficulties.[94]

Assessing the effects of CSA can be initially particularly difficult because:
- there is no one single pattern of effects experienced by all survivors of CSA
- not all those sexually abused as a child will develop recognisable or severe symptoms
- some survivors will not have a conscious memory of their history of CSA
- those who have some awareness of a history of CSA will not necessarily make a connection with their current difficulties
- some people who have not experienced CSA develop similar symptoms to those who have.

- You may not be able to complete a full assessment of the effects of CSA until well into therapy. It may take a great deal of time and trust-building before the full extent of the abusive experiences surfaces and is able to be discussed and treated.

The intertwining of assessment and therapy

Pre-assessment preparation

- It's good practice to let your client know what to expect (perhaps over the phone before the first session), including that they will be asked a number of questions (and that if they wish to submit a claim to ACC, you will be required to ask some basic questions about any abuse that occurred).
- Advise them that they may have reactions to questions asked. As much as possible, any reactions will be dealt with in therapy. However, they should be further prepared for potential reactions after the therapy session. Discussions about self-care may help them deal with such delayed distress.
- Suggest they choose a time for their therapy sessions that allows them to arrange for a support person to be available, or enough time for them to process issues raised in the session (before returning to work or collecting children, for example).

Assessment must be ongoing

In abuse-focused therapy, assessment is an ongoing process – not a one-off snapshot. Clients who have suffered prolonged, repeated abuse often appear with disguised presentations and have multiple difficulties that initially may appear unrelated to the abuse. Many survivors will be unwilling to disclose much information until they feel they can trust you. Survivors dealing with severe dissociation can be most difficult to assess.
- Many survivors of CSA have learned to disconnect from or hide internal pain. In therapy they may present as high-functioning individuals and report that everything is fine (the 'cover story'[95]). It's a good idea to accept such a cover story without challenge to protect your client's need for control over the pace at which they release information.
- You need to be continually attuned to the pace of the assessment process your client can sustain without their needing to resort to harmful tension-reducing activities.

Balance information collection with care for the client

Be careful to balance the need for information (to assess for treatment or for an insurance claim) with care for your client. For ACC purposes, collect only the minimum of information.

- Let your client know that once you have collected the minimum information about their experience of CSA for their ACC claim, the therapy can re-focus on issues and symptoms they decide are important. They may need reassurance that they will not be

asked about the abuse in each and every session.
- Reassure your client that after the assessment, the therapy will focus on establishing their safety and stability until those goals are met. The actual experience of abuse may be discussed in the first stage of therapy, but the 'effects' of the abuse will be the main focus.

Releasing personal information can be an extremely frightening experience for your client. They may have kept silent about the abuse and hidden their distress for many years. For this reason it is not unusual for clients to (initially at least) deny aspects of or all abuse experiences or to minimise the effects of abuse.

- At the beginning of therapy, you may only be able to gather your client's current understanding of their childhood history and symptoms, problems, strengths, capacities and resources.

Assessments need to be handled with care; asking questions about an abusive history can sometimes plunge a client back into the past and re-traumatise them.

After giving information, your client may experience a wide range of overwhelming feelings including shame, fear, vulnerability and symptoms of PTSD.

- Before asking any questions, ask your client how they may deal with any distress caused by the assessment.
- Discuss the possibility of delayed reactions and how these may be handled. By predicting delayed distress you are helping your client to be prepared.
- Ask questions using empathetic neutrality, where you neither over-react nor under-react to their descriptions of abuse. Provide support to help them process their feelings.
- Continually assess your client's capacity to deal with the distress the questions may evoke.
- Pace your questions according to your client's ability to cope.
- Be aware that some clients may not show any outward distress, but may be dissociating.
- Watch for distress in their body language such as changes to skin coloration, pinching themselves, rocking and difficulties with breathing.
- Use signs of client distress to move from a focus on exploration towards one on consolidation and safety (see a description of the therapeutic window on page 36).

Carried out well, assessments can affirm your client's strengths and abilities and demonstrate your awareness of the effects of abuse and your care for their wellbeing. The assessment process can also provide you the opportunity to gauge levels of client self-blame and reframe 'symptoms' and 'diagnoses' as normal human reactions to overwhelming experiences.

A psychosocial assessment

After explaining the reason for the assessment, discuss with your client issues such as informed consent and the limits of confidentiality.

Assuming the client is not in crisis, you may consider an assessment process that focuses on a wide range of issues. This is likely to take more than one session and sometimes may not be completed for many months.

The assessment may focus on:
- the reason they are seeking therapy
- the onset, sequence, course and duration of any symptoms they report
- their current needs and priorities
- what they hope to achieve from therapy
- their current general functioning levels (including sleeping and eating patterns, mood disturbances, substance use, social supports, relationships, work patterns, financial stability, parenting issues)
- how they deal with stress and emotional distress
- their past treatment history (including helpful and unhelpful contact with mental health professionals and previous symptoms and diagnoses)
- a full psychosocial history, including:
  - birth, developmental and attachment history
  - family/whanau environment during childhood
  - school, friends, sexuality during adolescence
  - major relationships in adolescence and adulthood
  - support history
  - any problematic experiences including family violence, sexual, physical and emotional abuse, neglect, medical traumas, accidents, significant personal and family losses or natural disasters
  - medical history, including gynaecological/obstetrical history (for women), any substance abuse, family medical and mental health history
  - education/training/employment history
  - any involvement in the legal or criminal justice system
  - religion, spiritual beliefs, cultural beliefs and background

- current safety issues, including any threats of harm to/from self or others
- strengths and resiliency factors.

If your client is a parent you may consider (at an appropriate time and in a way that does not alienate them):
- asking if they have any concerns either for themselves or in the wider family networks about parenting, supervision or discipline issues
- discussing the importance of teaching children self-protection strategies
- asking if they have any concerns that they or others may emotionally, physically or sexually abuse children within their environment
- discussing options, such as gaining supportive interventions, if necessary.

Undertaking such a full assessment will indicate to your client that all these issues are relevant and open to discussion. It can help you and your client to prioritise therapy areas.

Asking about CSA

If your client wishes to have a claim submitted to ACC based on their experience of CSA, you will need to ask them about as many of the specific details of the CSA as they feel able to disclose.

- Ask questions about abuse in a supportive way that is neutral, open-ended and neither suggests nor suppresses their experiences. You may wish to record some of your client's actual words and descriptions about the abuse as a factual record.
- If they have some memories of abuse and some memory gaps:
  - avoid 'filling in', 'confirming' or 'dis-confirming' their 'suspicions' of the non-remembered parts of their abuse history.[96] Simply record any areas of uncertainty
  - you both need to maintain an open mind. CSA will not be the only possible explanation for the gaps or your client's distress or symptoms. Take particular care to avoid influencing clients who seem to be easily influenced or have a tendency to look to you as an authority figure.

(For ways to deal with this situation see the section on forgetting and remembering on page 37.)

Questions that focus on abuse may include:
- their age when the CSA began and ended
- the age of the perpetrator(s) at the time of the abuse
- their relationship with the perpetrator(s) (relative, friend, stranger). It is important to remember that in New Zealand, anyone who is named or may be identified in correspondence can ask for any information that refers to them. Take care, therefore, not to open your client or yourself to risk in the way you document information about the perpetrator(s). For example, rather than document specific details of the perpetrator's identity, you should use general terms such as 'close relative', 'family friend', 'acquaintance'
- the level of severity of abuse
- a history of any disclosures of the abuse, confrontations about the abuse or obstacles to disclosing abuse
- whether any positive or negative interventions took place and their impact
- their way of coping with the abuse at the time and afterwards
- a history of the way they thought of the abuse, including whether there were any gaps in their memories then and now. If there were gaps, or periods of not thinking about the abuse, you may ask how their memories of abuse re-emerged or what triggered them to re-focus on the abuse
- any physical effects at the time of the abuse, such as weight alterations, chronic pelvic pain, any sexually transmitted infections, pregnancies or abortions
- any impacts on other aspects of their lives, including cognitive and social development, relationships, schooling, work and spiritual beliefs
- whether they have been involved or plan to be involved in any criminal justice or legal issues regarding the abuse, and the impact of any effective or ineffective statutory or legal interventions or processes.

- As your client discloses CSA experiences you should acknowledge their disclosure. You may also wish to:
  - say you are sorry those things happened to them
  - express the idea that abuse is not OK or that CSA is against the law and all children deserve to be protected.
- You may wish to say that perpetrators are responsible for involving those younger and less powerful in sexual activities, even if force was not involved, and that children are not to blame for CSA. However,

you should not insist that your client was not to blame. Some survivors have been told they are not to blame so often that the meaning has been lost. Others feel patronised by the statement and unable to express their feelings of guilt or shame about the abuse.

Remember that some survivors feel guilty if they became aroused during the abuse and may believe this means they enjoyed it or wanted it to happen. You may wish to offer a clear understanding of what constitutes informed consent: where two equals (not an adult and a child) agree to sexual contact. Physiological responses to stimulation do not imply informed consent.

In some cases survivors of CSA who have been sexualised beyond their years have, as children, acted out sexually on their peers. They often feel a lot of guilt and shame about their actions and may take a great deal of time and trust-building before they feel able to discuss this issue. They may wish to discuss options for dealing with any past harm they caused.

Although uncommon, if a client reports they are 'currently' sexually abusing or physically harming others, the limits of your confidentiality are breached and you will need to discuss with them the steps you need to take to make these others safe. (See 'Crisis situations' below.)

You should not work in isolation with a client who is currently sexually abusing others or harming others in any other way, but in conjunction with protection agencies (such as Child, Youth and Family or the Police) or specialist agencies such as those that provide sex offenders programmes or stopping violence programmes.

The need to provide structure and predict processes

From the very beginning of the client/therapist relationship, it is important to nurture an open environment that encourages discussion about the process and progress of therapy. As much as possible you should explain as you treat. Explain what you are doing and why.

You may like to provide your client with verbal or written information on:

- their and your rights and responsibilities, including the time structure of sessions, fees, limits to confidentiality and limits of your availability
- what generally happens during a therapy session and over the course of therapy
- predictable responses to therapy. For example, sometimes talking in therapy may re-stimulate feelings and memories so that in some cases your client may feel worse before they feel better
- the therapeutic relationship – that both of you contribute to this relationship and that it will be beneficial if you develop a culture of openness so that either may discuss patterns or concerns about the relationship at any time
- the possibility of transference and countertransference issues – that both of you will be sharing from current experiences but that sometimes both will respond based on assumptions and learning from past experiences
- the likelihood that during the course of therapy you will inevitably make at least minor therapeutic errors and there may be miscommunications along the way.

Discuss how you could both deal with these:

- report writing requirements – for example therapy that is funded by ACC requires regular progress reports that must be endorsed by your supervisor
- alternative avenues if they have concerns about the therapy they feel unable to discuss with you
- your accountability – who your supervisor is and how they may contact them, which professional body you belong to and a copy of your code of ethics.

Build a collaborative relationship

By consulting your client over the focus, goals, direction and pace of therapy, they can be encouraged to feel an equal partner in this collaborative therapeutic process. Therapy should be empowering and based on informed consent.

A collaborative relationship works both ways. At the beginning of therapy, ask your client to discuss with you or inform you before they do anything that may affect the therapeutic relationship – for example, if they plan to make a disclosure or confront anyone about abuse issues, or if they decide to embark on another (parallel) course of therapy.

Crisis situations

Where possible, 'trouble shoot' crisis situations before they happen by informing your client (either verbally or in writing) about the limits of your confidentiality and

how you may need to act under certain situations – such as if you discover they are about to harm themselves or another. Advise them of your obligations, for example that you will call in a crisis team if they are at risk of suicide. Let them know what may happen if the crisis team is called in.

Sometimes clients require urgent medication, hospitalisation, the safety of a refuge, or are under pressure to decide what to do in a legal process. It is important that you consult them as much as possible rather than unilaterally deciding what is 'best' for them.

- During a crisis:
  - clarify any referral or other processes that apply to your client's situation and discuss the options, priorities and potential consequences for each situation
  - acknowledge, normalise and help them work through any strong feelings they may have about the situation
  - keep them informed as much as possible about developments throughout the process
  - stay connected with them if possible – if they enter a treatment centre, for example, you may wish to discuss arrangements for any possible future contact.
- If clients do not wish to make themselves safe or are at risk of harming others, you can outline your concerns for their or others' safety. You can explain (or repeat) your areas of responsibility, the limitations of your confidentiality and your obligations in the situation.
- If you feel the need to act to make your client safe from themselves or on behalf of others, it is important to inform your client first of the actions you are about to take on their behalf.

Report writing

Your client should be given the choice to have access and input to all reports written about them. Some may wish to be involved in wording ACC counselling progress reports. The choice must be theirs.

Care must be taken if your client reads very full reports about their life or symptoms. For many clients it is not advisable to read such reports alone or without qualified therapeutic support. Some clients (especially those who have been dissociated) may feel overwhelmed by such overviews in written form. Reading them can trigger negative reactions such as dissociation, self-blame or self-harming behaviour.
You may need to help your client work through any negative feelings from descriptions of themselves in reports. Some clients may feel stigmatised by psychiatric diagnoses and add this to their self-denigration. They may decide that psychiatric labels 'prove' to them and the world that they are 'mad' or 'hopeless'.

- Your client needs to be aware that your supervisor will read their progress report and will write comments.

Requirements for a safe therapeutic relationship

Effective abuse-focused therapy requires a consistent, reliable and stable therapeutic relationship.[97]

Healing through healthy attachment

> 'The primary healing of psychotherapy with adult survivors of childhood sexual abuse occurs in the context of the therapeutic relationship.'[98]

For therapy to be effective there needs to be a 'special relationship' in which the therapist feels 'genuinely caring' toward the client.[99] When working well together, you and your client can develop a shared sense of purpose, commitment and emotional investment in the therapy. The therapeutic relationship can heal by providing the opportunity to rework the damage done in earlier relationships.

Through a successful therapy relationship, your client may be able to 'attach' to you and feel safe in that attachment. As you show respectful, supportive, positive regard, your client can develop the capacity to interact in similar ways in other relationships. They may be able to move on and develop feelings of autonomy and new behaviours that previously were too risky to contemplate.

Attachment[100] is quite different from dependence.

While an abuse-focused therapist supports positive attachment, they discourage dependence by helping the client to:

- make their own choices and decisions
- develop their self-capacities so that they can learn about and self-manage their feelings and behaviours
- widen their support systems so that they are not solely reliant on the therapist.

Many clients and therapists worry about dependence in therapy. Your client may feel guilty or embarrassed about their feelings of need for you, for example if they think about you out of session. You may fear you are promoting dependence if your client is too attached to you. Such fears can sometimes cause a therapist to push their client away from them thinking they are doing it 'for their own good'. Such issues are complex and should be discussed with a knowledgeable supervisor. (For further discussion see 'Internalising your care' on page 34.)

- Beware of prematurely pushing your client towards independence; you may, ironically, reinforce dependency. Feeling premature abandonment may cause them to feel the need to cling to you.

A healthy attachment does not mean bowing to your client's every attachment need. It means attending to your client's appropriate therapeutic needs (such as support and care – within the bounds of the therapeutic relationship) and supporting their growth and independence by encouraging the development of their 'self' and 'other' supports.

- You may be able to sustain your client's (sometimes intense) feelings of attachment and need for you by reminding yourself that the client should eventually work through this need and become self-reliant.

Dealing with inter-session needs

Because the process of attachment to you is likely to bring out some of your client's most deeply held unmet needs:
- explain that the therapist role is in many ways unique. It is not the same as a friendship, because although the relationship may become warm and intimate it is not able to be reciprocal. Constraints are in place to keep both parties safe – such as being free from the conflicts of any dual role relationships
- let your client know how they can contact you, and under what conditions, should the need arise
- discuss the extent of your availability so your client knows what to expect
- you will need to be predictable and reliable, which means holidays and other professional and personal obligations require explanations and, whenever possible, preparation to help your client deal with any fears of abandonment.

Therapeutic support is mostly limited to a weekly or bi-weekly session. Advising your client that your therapy role is limited to these times will prepare them to extend their sources of support wider than the therapeutic relationship.

- Help your client to develop a range of people they can contact or seek support from when you are not available.
- Acknowledge that your client may sometimes have an intense need for contact with you. Make sure you plan ahead and find ways for them to get through this time with other supports.
- It may help to provide notes of encouragement, tape-recorded sessions and other support contacts, including a 24-hour support service phone number.

Maintaining therapeutic boundaries

Many survivors of CSA have poor 'self' and 'other' boundaries. Some have been groomed to take care of others. Some have learned, through experience, that they only 'get anything' by manipulating others. For these reasons it is vital that you maintain appropriate therapeutic boundaries.

For example, make sure that you:
- do not treat your clients as personal friends (by becoming involved in their lives outside the therapy room)
- do not become involved in dual role relationships with your client (such as becoming involved in business activities with them)
- do not over-disclose personal issues or problems in therapy or use a client for friendship, self-esteem or other needs. Some clients have complained that some therapists spend more time talking about themselves and their problems than listening to them[101]
- deal with overly giving clients. Small occasional gifts from clients may be acceptable, however talking about gift giving (without shaming the client) can help you both understand the meaning attached to such giving. Excessive gift giving may be a sign of

not feeling worthy of attention unless they give
- keep 'touch' within the therapy relationship to a minimum. Some trauma therapists suggest that you and your clients should only shake hands.

Others suggest that you may briefly touch or hug your client but only if:
- the client initiates the contact
- the client gives verbal permission
- the touch is not routinised
- the touch is not sexual.

These are all complex issues. Find ways (perhaps in supervision) to handle such issues in a way that does not shame or blame your client.

In general, if you consider altering your usual therapeutic boundaries in any way, think about your reasons for doing so and the potential consequences for you and your client.

- Avoid sudden and unexplained boundary shifts.
- Explain any need to alter your boundaries.
- If you ever need to refuse a client's request that you step over your usual boundaries, do so in a way that does not leave them feeling rejected or humiliated.
- Have regular supervision about boundary issues.

Written or verbal information about boundaries at the beginning of the therapy relationship may help to deal with some of these issues. Open discussion throughout therapy about some of the difficulties for you both in maintaining boundaries can be a healthy, educational, non-shaming way of dealing with them.

Normalising transference and countertransference responses

The concepts of transference and countertransference have a long and complex history. Therapists from different disciplines have various responses to the use of these terms.

Trauma therapists regard transference and countertransference as neither 'neurotic' nor 'undesirable' but as 'normal', 'inevitable', 'logical' responses.[102] Both therapist and client may have a mix of conscious and unconscious reactions that are both projections from the past and based on current issues. The task for you both is to become aware of this mix and be able to identify and make use of this information.

Your client's responses as well as your own can be useful in informing you about your and your client's unconscious processes.[103] Demystifying, normalising and educating your client about this process can help them to learn about their own processes, and yours, within the safety of the therapeutic relationship.

Transference

Survivors of CSA have grown up with the experience that some humans (who may have been trusted and depended upon) turned out to be dangerous, untrustworthy or harmful. From these experiences their perceptions and responses to relationships, authority and power have altered.

Disillusionment with and mistrust of authority figures may sometimes be transferred to therapy, and you may be 'tested' throughout. For example (although they may not be aware of it), your client may fear that eventually you too will treat them badly and exploit or reject them. This fear can cause them to react towards you in a range of ways, from being hostile (expecting that eventually you will hurt them so they might as well 'get in first') to being a 'good' client so that you won't abandon them.

Your client may hold a deep need, and wish or fantasise, that you could be the all-powerful rescuer they hoped for as a child. They may wish you could be a best friend or a lover, if only there were not ethical restrictions. Rather than being about you or your actual traits, many client fantasies may be in a code form that can alert you to their earlier experiences and current needs. Their responses may be based on abuse dynamics such as secrecy, violation, traumatic sexualisation and the creation of a perverse feeling of specialness. Parallels within the therapeutic relationship (such as the mix of intimacy and intensity) can trigger these fantasies.

- It is important that (without shaming or blaming them) you help ground your client in reality. For example, if at the beginning of therapy your client idealises you, it is important not to reinforce their belief in your 'wonderfulness' or infallibility. Over time they will realise you are a normal human being with strengths and weaknesses.

As therapy progresses, your client may go through a process of overvaluing and undervaluing you. Being human, it is likely that you will have feelings and coun-

tertransferential responses to this process. It is important to have sufficient grounding, self-esteem, reflection and supervisory support to weather this process.

Through a process of 'slow de-idealisation' your client should eventually become aware that you are not the only important supportive person in their life. They may also gradually trust that although you may hurt them in small ways (such as being late for an appointment or not returning their calls as quickly as they would like), overall you will not turn into the perpetrator and hurt them in a major way.

- Throughout this process you may wish to reassure your client that as you both work to build a safe and caring relationship, they will have the opportunity to enjoy a 'real' relationship (albeit a therapy relationship). This therapy relationship has the potential to be more secure and substantial than any of their earlier 'wished-for' relationships.

Take care when enquiring about your client's feelings and responses. Some have reported feeling patronised and dismissed if they are labelled as simply 'transferential'. For some it implies their responses are not based on reality.[104]

To avoid this, treat all client responses as valid and worthy of respectful consideration. They are likely to be a complex mix. For example, a client's anger at a therapist who withholds warmth may mirror childhood abandonment but may also be appropriate anger owing to a therapeutic error.

In general, to deal with such issues:
- discuss with your client the possibility that their early responses to violation may reappear in therapy owing to the intimacy and intensity of the therapeutic relationship. This discussion may help your client to discuss feelings and responses that may otherwise seem shameful
- take care not to reject or ridicule any of your client's responses, but sensitively and respectfully help them make their own connections with dynamics that may have led them to these responses
- help them to assess any parallels between their current responses and the dynamics of the abusive environment in which they grew up
- be careful not to make firm, definite statements about what is 'reality', as this may reinforce their fantasy that you are all-knowing and add to the myth that you are able to solve their problems. This can be disempowering of your client and potentially destructive to the therapeutic relationship
- encourage your client to find their own truths and make their own connections and interpretations.

Countertransference

Because countertransference responses can emerge at multiple levels in the therapist's awareness, you need to be acutely aware of your responses to your client.[105] There may be at least six[106] contributing factors in any countertransference response when working therapeutically with a CSA survivor.
These include your:
- response to hearing about CSA experiences
- response to your client's transference (for example, the client reacting to you as they would to those in the past who hurt them)
- response to your client's post-CSA adaptations, such as numbing, despair, dissociation, chronic suicidality, self-loathing or re-victimisation experiences
- personal history, coping style and personality
- response to vicarious traumatisation from working in this field
- theoretical perspective on trauma, as well as collegial and mentor relationships.

Therapists may believe they can hide their responses from their clients. However, because many survivors have learned to be hypervigilant in relationships (for their own safety), a client may in fact misinterpret a therapist's non-response.

Therefore, when appropriate, you need to be prepared to share your responses with your client in a way that does not shame, blame or overburden them.

Careful, sensitive and appropriate countertransference disclosures can:
- provide your client with information about their effect on you (and therefore potentially others)
- help them with reality testing
- help deal with miscommunications
- establish your honesty and genuineness
- deepen the therapeutic relationship
- help to 'move on' therapy that seems to be 'stuck'.

Potential distancing and intrusion errors

Countertransferential responses that are unacknowledged or mishandled can be divided into:

- 'distancing errors',[107] which may include forms of denial, minimisation, distortion, avoidance, detachment and withdrawal[108]
- 'intrusion errors',[109] which may include co-dependent relations, enmeshment, over-commitment and over-identification, rescuer activities and over-emphasis on the role of the traumatic event in the life of the client.[110]

Distancing errors may arise if, for example, you do not acknowledge (even to yourself) your countertransferential responses (such as fear, disgust, or anger) to your client's account of abuse or their presentation in therapy (being angry, late, crying). Instead of acknowledging your own responses (such as irritation or embarrassment), you may instead distance yourself from your client and adopt an objective stance. The client may interpret your distancing response as your dislike of them, which may cause them to respond with fear and hostility, or to end therapy.

Distancing errors can cause your client a great deal of pain and conflict. They may feel you have abandoned them at a time when they are most needing support. One study[111] found that 76 percent of clients who regarded therapy as unsuccessful cited a distancing error that preceded the therapy ending.

Intrusion errors may include inappropriate influence or control over your client's self-perception, behaviour, memory or affect. For example, a therapist feeling overwhelmed by their client's pain may intervene to end their affective reaction by offering advice or changing the subject. Other more obvious intrusion errors range from the blatant, such as sexual contact, to the more subtle, such as fascination with aspects of the traumatic material, voyeurism, or sexual innuendo.

To avoid countertransference responses affecting therapy negatively, it is important that you:

- continuously self-monitor your internal responses in therapy sessions
- find sensitive, respectful ways to acknowledge and discuss your responses and any countertransferential reactions with your client without blaming, shaming or over-burdening them
- work to develop a therapeutic relationship where both parties are encouraged to be aware of, monitor and discuss their responses and deal with any mis-communications
- deal early on with any personal stressors that arise and any signs of vicarious traumatisation
- reflect on each session
- have supervision and consult on a regular basis.

Well facilitated transferences and countertransferential responses have the potential to enrich the therapeutic process by allowing the client to rework (sometimes unconscious) patterns of thinking, feeling, or behaving that may not be possible in any other relationship. The examination and processing of these patterns can lead to new, non-abuse-related ways of being.

Gains for the client may include:

- an enhanced sense of self and other boundaries
- increased flexibility in perceptions of relationships (rather than 'all or nothing', 'black or white', 'good or bad' dichotomies)
- fewer difficulties with authority figures
- greater potential to develop trust in relationships
- greater interpersonal skills.

For further reading on the topic of trauma and countertransference, see Dalenberg, C.J. (2000). *Countertransference and the treatment of trauma.,* Washington, D.C.: American Psychological Association and Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton.

The three stages of abuse-focused therapy

This section provides guidelines on three recognisable stages in abuse-focused therapy:
1. Safety and self-work
2. Exploration and integration
3. Empowerment and reconnection

A spiral process

It is important to note that these nominated stages are an attempt to simplify dealing with the psychological chaos that trauma can cause. They are abstract concepts and should not be taken too literally – indeed, in practice they are very likely to overlap. The process could be described as more like a spiral, where earlier issues that you and your client have already dealt with are continually reworked at higher levels of integration.

For example, it is important not to assume that because the main focus of Stage One is self-care there should be no discussion of abuse-related issues. Establishing safety and dealing with presenting symptoms will often require discussion of what led to those symptoms being developed. The emphasis on carefully paced therapy is in part a response to early trauma therapies that encouraged focus on the trauma, sometimes without enough regard for the pain and distress and the destabilising effect this could have on the client.

The three stages parallel the concept of working within the 'therapeutic window' (see page 36) where therapy is divided into predictable and manageable thirds. The focus of therapy begins in the present, returns to the past and ends in the present again.

The likelihood of 'relapse'

Be aware that despite carefully paced therapy in which your client may appear to be making good progress, they may sometimes regress to tried and true but often maladaptive coping skills.[112]

Although this may feel disheartening for both of you, this healing process is common. Healing has been described as a movement of two steps forward then one step back. Such 'relapses' should be treated as expectable occurrences in the learning/healing process.[113] This spiral process allows your client to relearn a concept or skill at a deeper level each time a similar issue is covered.

Varied pace and length of therapy

- Your client may ask how long therapy will last. Although there is no clear-cut answer, it will inevitably take longer than they wish, but cannot be hurried.

Your clients' needs for therapeutic support are likely to vary and you will need to consult them regularly about the pace at which they wish to work. A client may need bi-weekly therapy sessions at times of particular distress, then reduce to weekly then fortnightly sessions. Some clients vary their weekly therapy sessions to fortnightly or monthly as a way of slowing down the process to a sustainable pace. Longer-term clients may wish to take breaks (of perhaps months or years) from regular weekly therapy sessions.

Current abuse-focused and trauma therapists recommend that therapy proceed at a pace your client can tolerate without having to resort to old (harmful) coping strategies or tension-reducing activities. In order to face traumatic material, many survivors need a great deal of therapeutic assistance to build new (healthy) coping strategies.Those who have experienced less harm to their self capacities are likely to need much less therapy in Stage One than those who have experienced severe harm.

A marathon for some

Therapy has been described as a marathon[114] for some severely harmed clients, where they build up their 'emotional muscles' throughout Stage One so they are more robust emotionally by Stage Two to face the often deep pain of coming to terms with traumatic material such as betrayal, humiliation, cruelty or sadism.

By Stage Three, the client prepares to cross the finish line (as it is they, not the therapist, who have run the race). The therapist may have played the important role of coach and supporter in their healing marathon, but it is the client who has had to find the strength and energy to sustain the (sometimes) lengthy journey.

Not all survivors choose to journey through all stages. Each route will be individually charted and paced. Some will wish to complete their marathon at the end of Stage One. Facing past traumas must be the client's choice, and not all will wish to proceed to Stage Two – there

must be sufficient benefits for them to face such pain. Survivors who have been able to reduce the effects of CSA in Stage One and who have stabilised their lives may not wish to destabilise their hard-won gains. Others will need to work through Stage Two to reduce the effects of abuse and gain stability in their lives. Stage Three can be an important stage to consolidate earlier gains.

Overall therapy goals

The goals of abuse-focused therapy have seven 'domains of experience'.[115] Survivors are likely to be at varying stages of healing in each of these domains throughout therapy:

1. **Self-Esteem:** Self-hate, shame and feelings of badness will be replaced with more positive and realistic self-views. Responsibility for the abuse and any shame about adaptations following the CSA will be put into perspective. The survivor will be able to be self-caring.
2. **Symptom Mastery:** Psychological and psycho-physiological symptoms will decrease and be manageable.
3. **Affect Tolerance:** Emotions will no longer be feared as overwhelming. The survivor will have access to a full range of feelings, which they will be able to name and experience without distress.
4. **Memory and Affect are Linked:** The survivor will be able to look back over the trauma in the 'here and now' and acknowledge how they felt, without being plunged into feelings of the past.
5. **Attachment:** Safe relationships will have been developed. Isolation will be replaced by an ability to connect to others. Perceptions of others will become more realistic and less 'black and white'.
6. **Meaning:** The survivor will have been able to develop views of themselves and the world that are complex. They will be able to incorporate contradictory and ambiguous views of reality. They will have a realistic sense of optimism about the future.
7. **Memory:** Control over memories will develop to the point that the survivor can choose whether to think about traumatic events or not. They will have come to terms with their memories (or degree of memories) of abusive events.

Stage One takes place after you have carried out an assessment and discussed therapy goals, your mutual rights and responsibilities and safety issues. For some clients this may be the longest stage. Throughout the process, you and your client may postpone working on some issues owing to safety issues or changing priorities.

The goals for Stage One are to:
- attend to any life-threatening crises
- encourage your client to establish safety and stability in their lives
- build a therapeutic relationship that provides safety and caring
- educate your client about the effects of CSA and support them as they review the effects on their life
- learn about and deal with triggers that increase their symptoms
- work towards reducing the most severe symptoms
- deal with cognitive distortions including low self-worth and self-blame
- build 'cognitive life rafts'
- help build your client's self-identity
- help your client to identify their 'self' and 'others' boundaries
- help your client to identify and express their feelings and needs
- allow your client to internalise your caring as a way of building self-capacities
- encourage your client to treat themselves with care and respect
- encourage them to develop positive interpersonal relationships and widen social supports.

Attend to life-threatening issues first

Life-threatening issues must take priority in therapy. You will need to continually assess your client's capacity to take care of their personal physical safety, their self-regulation skills and stress-management abilities.

At the beginning of therapy you may need to help your client deal with a variety of life-threatening symptoms such as suicidality, major depression, self or other harming behaviours, chronic addictions, an eating disorder and/or re-victimisation issues. For some clients, working through these issues will be the focus of therapy for months or even years.

Mental health and physical health are often intertwined. Survivors who have been set on a path of self-destruction following the abuse will have little motivation to take care of themselves. Working with survivors to 'not want to kill themselves' may be the major underlying therapeutic tasks throughout most of the course of therapy.

- Help your client gain control of their physical self and:
  - live free from physical or sexual abuse
  - be able to self-regulate their sleeping and eating patterns
  - find ways to gain control of any addictions or compulsions
  - find ways to deal with any health problems, such as physical or medical neglect.

These tasks may take a long time to achieve and may be interwoven throughout therapy. What appear to be simple self-care tasks may be extremely complex. For example, a client may avoid attending a dentist owing to earlier oral abuse, or avoid taking medications if drugs were used as part of the abuse.

Once they gain some stabilisation in their physical self, your client may be able to focus on increasing their control in other areas of their lives, such as their relationships, parenting and work.

Help create safety and stability

Sometimes survivors have to give up almost everything, including home, friends and community, economic and social supports, to move from an abusive environment to safety. Some of the early tasks of therapy may be to connect your client with other resources to help them meet basic needs such as:
- finding a stable, safe home (free from re-victimisation)
- developing a support system (free of associates who devalue them)
- establishing as much employment and financial stability as possible
- having medication needs reviewed (preferably by a psychiatrist who has specialist knowledge of the effects of interpersonal violence including CSA).

At the beginning of therapy your client may be reluctant to disclose a range of safety issues, such as:

- violence they are experiencing from others
- their degree of self-harming behaviours
- their levels of substance use

- their fears of (or actual) harming of others.

There may be a number of reasons for this, such as feelings of shame or being unable to trust you so early in the therapy.

- You may be able to help by advising your client that it is common to feel more comfortable discussing difficult issues as time goes on.

For some, the process of establishing safety in their lives may be achieved in only a few sessions; for others it may take several months and in some cases years. Those who have little experience of feeling safe or have had few positive, trustworthy relationships may have relapses (such as feeling lonely and returning to an abusive relationship). This process can be exhausting and frustrating for you both, but change involves loss. Losses need to be acknowledged, honoured and grieved for.

The tasks of this stage can be difficult and demanding, and both you and your client are likely to want to bypass them. Some clients may believe that if only they could 'just get it all out' (disclose the abuse to you) they will 'feel better'. This may seem tempting, but in most cases it would be a therapeutic error to engage prematurely in exploring traumatic material, especially if your client is living in an unsafe or unstable environment or has few self-capacities to cope with facing the pain of the traumatic material.

- Continue to explain the process of therapy and the rationale behind your client learning self-care before focusing deeply on traumatic material. Remind them that although they may have braced themselves and were able to 'endure' the abuse, the healing process is different. The aim is not endurance but self-care.

Your client may be triggered to revisit aspects of the trauma (perhaps through life events such as a new sexual relationship; if their child reaches the age at which they were abused; if they see or hear about the perpetrator). You will need to help them deal with traumatic material that is thrown into their lives; it provides the opportunity to teach them self-soothing and self-regulation skills.

A flexible sequence of therapy tasks

Throughout therapy you will need to be flexible in focus. The process is far from linear. For example, if your client is battling suicidal thoughts, stabilisation work will be needed. If they present as relatively stable, you may proceed to work with issues you and your client have prioritised, such as dealing with interpersonal difficulties, parenting issues or sleep disturbances.

Therapy may move forward and backward and you will often need to go over the same issues a number of times.

- You can reframe a client's embarrassment at needing to repeat issues by emphasising their learning at a deeper level. If the lower-level stressors are not dealt with, they can develop into issues that destabilise the client's progress later on. This is where listening to your client closely is important. Issues that may seem trivial (and not worthy of therapeutic attention) sometimes are only the surface of a much larger (perhaps core) issue.

Self-work

Self-work has been described as helping a survivor to build a positive source of identity, so they can monitor their internal state and call upon their 'inner resources in times of stress, maintain internal coherence in interactions with others, and foster improved affect regulation'.[116]

The younger the age of onset and the more severe the abuse, the less developed self-awareness is likely to be. This means many survivors enter therapy with little knowledge or awareness of their own feelings, rights, entitlements or needs.

In contrast, however, severely harmed survivors are often strongly focused on others ('other directed'). Much of their early life and energies may have been taken up with closely watching others for signs of danger. They may have grown to be exquisitely attuned to other people's feelings and processes to the detriment of learning about their own.

This has consequences. For example, many adult survivors will not make a connection between a current conflictive interpersonal interaction and sudden self-harming thoughts. Depression, suicidal thoughts and self-harming behaviours may appear as out-of-control behaviours with no apparent connection to current issues such as interpersonal stressors or post-traumatic triggers.

Because the survivor has been unable to learn ways of tracking their feelings or noticing stress building inside them, they may engage in self-blame, telling themselves, 'I'm a hopeless case', 'I'm my own worst enemy', 'I do these things to myself, no one can help me'.[117]

Over time, you can help your client with their self-work by helping them to:

- learn about and label their feelings and needs
- begin to tolerate and manage small doses of feelings
- learn to recognise early feelings of distress
- learn positive ways to intervene to interrupt distress or prevent negative thoughts from becoming overwhelming
- learn about the difference between emotion and action
- learn grounding, self-care and self-soothing skills
- identify and develop healthy 'self' and 'others' boundaries
- work towards building positive, strong, stable self-identity, self-esteem and self-worth
- continue to expand their self-capacities of affect tolerance and affect modulation
- learn about and build positive interpersonal relationships and social supports (which are not built on the client's low self-esteem, hypervigilance or need to control).

You will help your client do much of this work in any regular therapy session. For example, as the client discusses interpersonal relationships they may simultaneously be labelling and expressing feelings, learning about their 'self' and 'others' boundaries, adding to their self-identity, expanding their self-capacities and identifying ways to improve their social supports.

- You may wish to suggest that clients who enjoy keeping journals learn more about themselves by writing about their feelings and tracking their thoughts and patterns. Some clients like to express feelings through other creative media such as art.

Educate about the effects of CSA

Clients often clearly describe ways they have been abused, but cannot cope with naming the experiences as abusive. For many survivors, acknowledging for themselves that they have been abused takes a great deal of time. It can be a particularly painful process to come to terms with and accept that others (sometimes people they have loved) could harm them. Educating, normalising and reframing the effects of abuse can be a powerful way of reducing secrecy, shame and feelings of inadequacy.

When relevant issues arise in therapy you can help your client make sense of the effects of CSA on their lives by:

- providing information about some of the common effects on a child's development (following CSA)
- describing some of the common effects experienced in adolescence and adulthood
- referring to abuse-related 'symptoms' as logical responses to abuse
- providing information about non-traumatic child development. Knowing 'normal' developmental steps can help survivors to realise their own adaptations to abuse
- supporting them as they process and make sense of the effects of CSA on their lives.

In processing the past your client can link current symptomatology with the original cause. They can make meaning of the effects of abuse on their lives as they move between the 'here and now' and the 'then and there' and back again, along 'affect bridges'.[118]

Gaining an adult's perspective of what happened to them as children can help a survivor undo the myth of personal badness. As they find new meanings for the abusive experience, the trauma can be integrated and they are less likely to hate and blame themselves. They may be able to understand the perpetrator's motivations from a new (adult) perspective.

Attend to self-blame

Many survivors of CSA were and are (in their current environment) encouraged to carry the burden of responsibility for the abuse and for not stopping it. They often see their adaptations to the abuse as confirming that they were 'mad', 'bad', or inadequate. They will probably continue with these beliefs until they are challenged.

To interrupt this thinking, you can ask your client to help you understand how they learned who was responsible for the abuse. By encouraging them to view the past from an adult perspective, they may be able to critique their childhood beliefs and perspectives on what happened, and why. Discussing how they came to hold negative beliefs about themselves entails some

reviewing of past hurts and traumas. In this way your client will gradually get used to moving from the present to the past and back to the present in each therapy session.

Believing that their inherent badness caused the abuse can lead to negative moods, such as depression, anxiety or altered patterns of behaviour such as self-harming.

To help your client guard against and reduce any self-blaming messages:

- challenge their self-blaming comments and behaviours
- be as tenacious as their self-critic and never overlook a self-negating comment
- be creative in finding ways to respectfully disagree with their views. For example, you could externalise the negative self-talk as a tape recording of all the negative things said to your client from a young age. You can then comment on 'the volume being loud today' or 'the tape seems to be dominating today'.[119] This frame also makes it less easy for your client to blame themselves for 'thinking wrong'.

Build 'cognitive life rafts'

Clients are likely to have an 'easier time' with the emotional aspects of the traumatic material if cognitive work precedes emotional discharging. The following strategies may be useful to help your client deal with abuse-laden feelings such as post-traumatic intrusions of flashbacks, dreams or dislodged fears.

Building 'cognitive life rafts'[120] can include:

- helping your client differentiate their current thoughts and beliefs from those they developed as a child during the time of the abuse
- providing a 'cognitive map', such as referring to the movement between talking about the 'here and now' and the 'then and there'.[121] A cognitive map that differentiates the past and present can remind your client that they are in the present and are safe. While they may re-visit the past in therapy, the danger is not current (although it may feel as though it is); it is a memory and they are safe now
- helping your client to create their own 'safe place' in their mind. Help them to practise going to their safe place in therapy. A safe place visualisation is something they can have wherever they are
- teaching your client techniques for coming back to the present, such as 'grounding' by:
  - gripping objects
  - concentrating on their breathing and body
  - saying their name, the date, and that they are safe now.

Build self-regulation skills

You can help your client with self-regulation by helping them find ways to deal with symptoms such as panic attacks, depression, anger and self-harming thoughts and behaviours. Build in success by setting realistic, achievable goals in symptom reduction. Relapses may be an expected part of the process.

- Help your client to:
  - learn to recognise, track and predict experiences and situations that add to or trigger their symptoms. Help them guard against or alter these triggers and responses
  - brainstorm practical and achievable ways of dealing with effects (other than through resorting to disempowering tension-reducing thoughts and activities). For example, if each time after visiting their family of origin your client becomes suicidal, brainstorm ways they can visit their family without such a result. They may consider strategies such as taking a supportive person with them, or only visiting for short, manageable amounts of time.
- Help your client to develop strategies to deal with intrusive material, such as:
  - using grounding, thought stopping, breathing and relaxation exercises
  - encouraging them to practise these techniques in session, for example to interrupt a panic attack or an episode of dissociation
  - encouraging them to identify and prepare other practical ways they can deal with distress outside therapy, including the use of distractions and self-soothing techniques such as physical exercise, reading, watching TV, drawing, talking to others and accessing support services.

Support emotional expression

When a survivor begins to express feelings (such as fear, sadness or anger) for the first time, they may fear they will become out of control and, for example, never stop crying or become so angry that they may kill.
In this case they will need reassurance from you that, by

beginning to express some affect, such terrible things will not happen. Remind them of the difference between feelings and action. Teach them about feeling processes, such as that sadness often comes in waves, that anger is often an umbrella feeling with a mix of other feelings under it such as hurt, disappointment, guilt and so on. Help them to remind themselves that feelings pass and change and that they will not feel this way forever.

- You could brainstorm with your client ways they may feel in control while expressing feelings.
- Your client may expect you to react to their expression of feelings in similar ways to those in their original environment (angry, rejecting, abandoning). When you do not react negatively, they can feel increasingly safe with you and be able to take more risks with expressing their feelings, both inside and outside the therapy room.

Over time, your support and validation may be internalised and your client should eventually be able to relate to themselves and others in a more sophisticated way without your support.

Support the internalising of your care

Your client is likely to internalise more than your spoken words and specific beliefs – they also internalise your indirect attitudes and opinions of them. One aim of therapy is for them to be able to maintain their own self-soothing thoughts and behaviours. This means that relying on external judgements, whether blame or praise, is not in line with overall treatment strategies.

- Demonstrate support rather than talking about it, by listening and providing an affective presence and the most focused attention you are capable of.

If you are affectively present and show that you value and care about your client, they may alter their negative view of themselves to a more positive one. Their internal critic is confronted, not by a borrowed belief system, but by a sense that they matter.[122]

However, if your client does begin to internalise your supportive messages and caring outside the therapy hour, you may need to attend to any feelings of guilt or inadequacy they may have about this process.

- Reassure your client that internalising your care is part of the work in therapy.
- Explain some of the developmental stages they may have missed, such as feeling safe enough to attach or developing the ability to self-soothe.
- Reassure them that by completing unfinished developmental tasks in the safety of therapy they will be promoting their self-reliance.

Ending Stage One

Although this process is not linear and there are unlikely to be any single dramatic milestones to mark the end of Stage One, your client will usually have:

- gained some safety and stability in their life
- increased their self-confidence and ability to protect themselves from abusive people
- gained some control over the most disturbing symptoms
- increased their self-capacities and firmed their self-identity
- increased their feelings of self-competence and self-esteem
- decreased self-blaming
- learned about bounded relationships
- begun to believe they deserve good things in life and to be treated with respect and consideration.

The therapeutic alliance should seem secure. Although you and your client will have been reviewing past events throughout Stage One, at this point you may wish to discuss whether they are ready to work at exploring traumatic experiences at a deeper level. Some survivors who were chronically abused may take years to reach this point and may not wish to go any further. Others will reach this point much more quickly and will wish to move on to Stage Two. The choice must be theirs.

By now your client should be used to the process of therapy. They should have built enough self-capacities and cognitive life rafts to move into going over traumatic material at a deeper level than they could have coped with at the beginning.

Although abuse-related issues may have been discussed lightly in Stage One, this stage involves ensuring that the traumatic material has been sufficiently desensitised and integrated with the survivor's life rather than, for example, being split-off or avoided. Unintegrated traumatic material can continue to trigger symptoms such as PTSD, depression and dissociation.

The goal of trauma therapy is integration through testimony. Your role is as ally and witness to events that have felt unspeakable.[123] The shame and humiliation of the trauma should gradually be left behind, and your client may learn to appreciate the strengths and dignity they were unable to appreciate when their memories were frozen in fear and shock.

In Stage Two, the safety and security of the therapeutic relationship should continue, so that your client can tell of their traumatic experiences more fully, at their own pace, with the depth and detail for which they feel ready. They need to decide which aspects of the traumatic material they wish to focus on, and when.

Many abuse-focused therapists suggest it is not essential to revisit all traumatic experiences in order to heal. Indeed, there is a danger in the therapist and client believing that 'trauma work' is the goal of therapy. In fact the painful telling of traumatic material may be measured in minutes, compared with the sometimes years required for the overall tasks of healing and coming to terms with the harm done to a survivor's life and all the losses they may have sustained along the way.

Why explore trauma?

Stage Two focuses more on exploring the traumatic material in order to process and desensitise the associated painful abuse-related affect. The greater knowledge a survivor has about their past and present, the greater their empowerment.

Once enough of the traumatic material is integrated into their life, your client will have less need to dissociate or use tension-reducing behaviours to control abuse-related distress. They may be able to express emotions they were unable to express at the time of the abuse. Completing this task and making sense of the impact of the abuse in their lives can give them new confidence in themselves.

Stage Two focuses on:
- controlled exposure to small aspects of traumatic material, within a safe therapeutic environment
- desensitising painful abuse-related affect
- integrating the desensitised traumatic material and affect.

Your client should eventually reach a point where they can appreciate that the trauma is in the past; that it affected them in certain ways, but they are able to move on. Until they reach this point, they risk re-enacting the trauma daily in their lives, for example through passivity, depression, interpersonal difficulties and symptoms of PTSD.

Your role is to:
- continue to assess your client's safety and stability (in the therapy relationship and in their lives)
- continue to work collaboratively and consult your client over the pace and focus of the therapy
- support your client to explore the abuse at a pace that does not cause them to resort to severe self-harming or other harmful tension-reducing behaviours
- allow them to vent emotions
- listen to and share the emotional burden of their pain
- normalise your client's feelings and symptoms
- continue to allow them to find their own meaning for the abuse in their lives
- support them as they re-evaluate, process and integrate their new awareness of the impact the abuse has had on their lives
- continue to be an ally for your client, respecting and supporting their dignity throughout this stage.

Pace and intensity in exploring trauma

'Persuading an adult survivor to go back fully into such old and uncomfortable territory is as difficult as persuading someone with a snake phobia to hold a live snake.'[124]

One of the difficulties of this work is that you are required to carefully guide your client towards the traumatic material that they may have spent much of their lives trying to avoid. As you ask them to relive the experience by talking about it, their worst fears may come true. Going over trauma can revive old terrors and trigger symptoms of PTSD.

'Telling' about the abuse can trigger a range of abuse-related affect including dissociation, self-harming, depression, and suicidality. For this reason it is important not to 'push' your client to talk about traumatic material. Your task is to find a place in the middle of the therapeutic window (below) so that your client does not experience severe destabilisation through this stage.

- Find the appropriate pace and intensity of therapy to help your client face small aspects of the trauma.

Assess pace continually

- Only work through the traumatic material at a pace with which your client can cope.

Opening up too much traumatic material can disrupt hard-won stability. Prepare your client for this, so that the difficulties of this stage can, where possible, be factored into their life. For example, if your client is starting a new job, you both may decide to delay delving into trauma-laden material until their life is less demanding. Dealing with traumatic material may occasionally require a pre-planned, protective setting.

The 'therapeutic window'[125]

Working within the therapeutic window involves finding a pace that avoids overwhelming your client but that stimulates the optimal amount of trauma-based material they can integrate – without overwhelming their self-capacities and causing them to resort to harmful, tension-reducing behaviours.

Effective window-centred therapy can be achieved by attending to three aspects that lie on a continuum between support and growth. When in doubt, err on the side of caution and stay close to the supportive end of each continuum.

1. From consolidation to exploration:
'Consolidation' involves helping your client anchor their self-capacities through actions such as grounding, and bringing the client's attention to the 'here and now'. 'Exploration' is an invitation to your client to focus on some of their traumatic history that has not been explored or fully experienced to date. The aim is to help your client to explore something new within the safety of therapy.

2. From low to high intensity control:
Every therapy session should begin at a relatively low level of intensity, build to reach a peak just before mid-session and then level off to around where the session began by the end. Help your client to approach their traumatic material gently and gradually. Help them to deal with small, manageable pieces of material in the safety of your office and then feel sufficiently de-aroused and calm to re-enter their present world. A session divided into manageable 'thirds' helps your client to gradually gain confidence in this predictable and controlled process.

3. A goal sequence from self-work to focus on the trauma:
Be aware and make your client aware that the intense re-experiencing of traumatic events can reduce self-function temporarily.[126]

- Be careful not to assume your client's readiness to work on traumatic material. Clients who may appear to have good self-capacities may in fact be using dis sociation. As therapy progresses, however, their dissociative strategies should reduce. You may then find that your client's self-capacities prove inadequate for further exploration into trauma. If this is the case, return to the predominant focus of self-work.

Difficulties of working within the 'therapeutic window'

Beware of 'undershooting' the therapeutic window by avoiding traumatic material altogether or over-focusing on validating and supporting your client. It can be a waste of time and resources (although unlikely to be harmful).

On the other hand, 'overshooting' the window by a small amount may cause your client mild distress (such as a moment or two of dissociation or low-level

self-harming such as pinching themselves), either in the therapy room or later on.

Seriously overshooting the therapeutic window, however (by guiding your client into too much abuse-focused material, too fast), may flood your client with intrusive material that they are unable to defend themselves against. If they cannot accommodate the material, they may resort to more harmful, tension-reducing behaviours or 'fragment' to the point where they appear to be functioning at a primitive or even psychotic level. If this happens, your client has to survive therapy as much as surviving the abuse. While the effect on them from such gross errors may not be permanent, it may be disheartening or stigmatising for them and disturbing for you.

- To help your client through a particularly painful memory, move through it as quickly as possible – for example by asking, "What happened next?" – until they are on the other side of it. Get the brief overview first. They can go back for details later if they want to.
- Gently move them from a focus on feelings to thinking.
- If you notice your client has dissociated, is pinching themselves or is rocking in their chair, help to ground them back to the present and discuss ways they may continue to take care of themselves until the next session. You may need to discuss extra supports between therapy sessions.

Exploring trauma

This section discusses some of the difficulties in exploring accounts of trauma.

Abuse-focused therapists recommend exploring available memories, so that you and your client gain an understanding of the abuse and their responses to it. By going over the abuse with a safe, supportive ally, over time your client may be able to consider the effects on their lives in detail, without minimising or denying the impact.

Talking about it aloud allows the survivor to hear their own current views and reactions to the abuse, which may not have changed since childhood. By repetitively going over parts of the trauma in safety, painful affect can be reduced and sometimes eliminated. Their capacity to focus on deeper and more painful aspects of the trauma can strengthen through this process.

Putting trauma into words

The task of 'telling' may simply involve asking the client to describe what happened to them, allowing them to put the traumatic material into as much of a narrative form as possible. Both of you may notice any gaps in the narrative and any particular parts that cause distress. In an attempt to gain as full a life narrative as possible a survivor may sometimes wish to explore their history for themselves by:

- constructing life maps, family trees
- talking to family, neighbours, old friends
- looking through old photographs, diaries and letters.

Making meaning

As they tell you about the abuse, your client is very likely to want you to validate their distress, give constant reassurances (for example that they are not 'going mad' and that they will get through this), and allow them to go over the trauma as many times as is necessary to desensitise it.

- It is important to avoid making assumptions about which parts of the trauma are significant for the survivor. A minor detail for you may be a major issue for them. Helping the client to unpack the trauma slowly allows you to check what each part means to them.
- You may need to support your client as they try to make sense of the abuse, understand why it happened, and come to terms with questions such as "Why me?".
- You may wish to affirm that you believe that abuse is not acceptable and support your client while they find their own moral stance on these issues.

Arriving at a new understanding of the abuse may allow your client to act differently, perhaps more assertively in their lives. This can be extremely difficult if their new behaviour conflicts with people in their life who preferred them the way they were (such as passive). Others may respond by becoming critical of or rejecting new behaviours (such as assertiveness).

- Your moral stance is likely to be enormously important at this point.[127] You may need to continue to support your client's new strengths and encourage them to

associate with others who also value similar positive behaviours.

Forgetting and remembering

The issue of memory can be problematic for both therapist and client. Some survivors have complete and continuous memories of their experiences of CSA, and most say they have always had at least some memories. However, others report they have had some or all aspects of the abuse unavailable to their recall at some point in their lives.

This section discusses some of the ways you can help:

- some clients come to terms with the possibility of having permanent gaps in their memories of CSA
- others (even those who thought they had continuous memories) to cope as additional memories of traumatic material surface either within or outside therapy.

Possible reasons for lack of continuous memory

Trauma researchers suggest many possible reasons for either partial or whole gaps in continuous memory for one or more experiences of CSA. For example, for some children ongoing, escalating, violent, painful or sadistic abuse may motivate (either at the time or after) strong psychological defences including 'denial, repression, dissociation, self-anaesthesia and self-hypnosis'.[128] Traumatic memories may be encoded partially at the somatosensory level as opposed to the exclusively cognitive or verbal level.[129]

Even non-physically violent CSA may motivate a child to consciously or unconsciously avoid being aware of all or some aspects of the abuse, for example to retain an attachment to a caregiver. Few children can cope with the conscious knowledge that some people (especially those on whom they depend) would want to harm them.

Other children's encoding of a memory may have been influenced by a perpetrator (and/or others) encouraging them to forget, telling them it didn't happen or that they dreamed it. Perpetrators also sometimes try to shift the meaning of the child's experience (suggesting that they instigated, wanted or were responsible for the abuse). Some survivors describe actively pushing the memories of abuse out of their minds as they have grown, or trying to pretend it did not happen so they could 'get on with life'.[130]

Coping with emerging traumatic material

Consequently if new traumatic material is triggered or surfaces in a survivor's day-to-day life or in therapy through nightmares, flashbacks or images, they can feel 'crazy'. This tension may be felt by both client and therapist.

If your client experiences intrusive material that arrives in a 'drip feed' fashion, it can be stressful for both of you. However, you both need to keep an open mind (sometimes for years) about the fragments of traumatic material. The way memories unfold may mean some degree of uncertainty about either the details or the basic facts of the events. As missing pieces emerge over time, the understanding of the trauma may change.

- The metaphor of a jigsaw can also be useful. Whereas small, individual pieces of memory may give little information, together an overall pattern emerges. In the end, even if some pieces are still missing, they make little difference to the overall picture.
- Early in their remembering, your client may want you to support them in a particular version of events. You may wish to respond to such a situation by saying that while you could not pretend to know what happened in their childhood, it is important that together you try to understand the whole picture and keep an open mind about events as the jigsaw is put together.

Working with gaps

Clients with gaps in their memories can feel anxious about what may be in those gaps. Motivated by an anxiety 'to know', they wish that the therapist could short-circuit the process and purge them of this torment.

Therapists can feel pressured by the client's urgent need for this purging. Help your client find ways to cope with the pain of not knowing their entire history. This may be similar to working towards acceptance in a grieving process. Be aware however that for some, facing a therapist's neutrality in this area can feel like a betrayal or a rejection. For this reason it is important that you provide empathy and support for your client as these issues are processed.

- If a client presses you to help them 'find' 'lost' memories, you will need to find ways to deal with this (sometimes insistent) request in a way that does not seriously damage the therapeutic relationship. (It may be a good idea to practise handling such situations in supervision.)
- It may be useful to explain the fluidity of both non-traumatic and traumatic memory processes. Advise your client at the beginning of therapy that both of you will need to keep an open mind about many aspects of the trauma, possibly for some time.

The issue of whether a memory is accurate within the context of therapy can be important. The meaning of the memory can sometimes have a powerful effect on the client's distress levels and their relationships. Clearly it can be harmful to the client if they believe they were harmed or abused and they were not. The accuracy of memories becomes an even greater issue if forensic or legal systems become involved. For these reasons abuse-focused therapists avoid 'memory recovery' techniques such as hypnosis or other methods used specifically to recover currently unavailable memories.

Non-traumatic as well as traumatic memories are 'reconstructive', 'subject to error' and influenced by conditions in which they emerge, so it is important to take a cautious approach.[131] This is especially so when memories of the trauma are only partially available to consciousness and/or are recovered after a period of unavailability.

However, this caution should be 'counterbalanced' so that 'vague or partial accounts of abuse and trauma are not prematurely dismissed or automatically assumed to be false'.[132] The re-emergence of suppressed or non-remembered memories does not mean they are any more or less true than other memories.

- Provide your client with this information, and foster an open relationship that allows them to come to their own understanding of the aspects that emerge and change over time.

While your role is not one of 'advocacy',[133] you can 'endorse the reality of the client's pain, as well as the general plausibility of his or her explanation for such distress (if in fact, it is plausible), while giving [the client] sustained permission and support to avoid a prematurely definitive conclusion regarding what exactly happened'.[134]

If your client has significant gaps in their memory, you may both need to tolerate the level of ambiguity this lack of overall knowledge implies.

In such cases it is important that you:
- don't 'fill-in', 'confirm' or 'disconfirm' their 'suspicions of a non-remembered' or partially remembered abuse history[135]
- avoid leading questions and a premature focus on CSA as the only possible explanation for these absent memories.
- Avoid attempting to accelerate your client's pace of remembering through hypnosis or any other method. Hypnosis and any experimental treatments such as EMDR should not be used as shortcuts that will give your client quick and easy solutions to their problems of remembering. They are not magic keys to discovering or validating memories and have the potential to create unreal memories and distort other memories. Memory retrieval techniques may also interfere with any future opportunities your client may consider pursuing, such as judicial recourse. Advise your client of these potential limitations.

Getting used to processing trauma

Abuse-focused therapists consider the non-suggestive, free-recall approach of generic psychotherapy may be all that is required for the client to gradually reduce their need for avoidance defences to traumatic material.

The process of building self-capacities first can provide your client with support for their memories of abuse, even painful ones, to emerge without their having to search for them and without the extreme pain the memories may have produced at the beginning of the therapy.

Through the staged therapy process your client can:
- get used to the process of dealing with increasingly disturbing intrusive material (the more painful memories often emerge later in this process)
- gain skills to deal with each painful memory as it surfaces (within or outside therapy)
- find that eventually emerging traumatic material will cause less disruption to their lives.

Even so, some memories, such as avoided or 'state-dependent'[136] memories (see below), may be so traumatic (such as being humiliated or terrorised, or experiences that trigger extreme guilt reactions) that they will produce post-traumatic symptoms whenever they are recalled.

For clinical guidance on safe practice and risk management issues, ways to manage variable memories of CSA and maintain clinical records, see Courtois, C.A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines.* New York: W.W. Norton.

State-dependent memories

Some aspects of trauma (such as those that are extremely severe or perhaps are perceived to be life threatening) may be encoded in such a way that they are unable to be accessed unless the person re-enters a similar state, such as a state of terror. These types of memories have been referred to as 'state-dependent'[137] memories. A typical therapy session will not trigger such a state of fear.

However, clinical evidence suggests that recalling aspects of the abuse can be spontaneous.[138] Sometimes memories are triggered in response to life events, especially those that share key elements (such as feeling fear or not feeling in control) with the original trauma (examples include re-victimisation, surgery, the birth of a child or a significant death).

Helping your client understand the way such experiences may be triggered can provide them with a context for what can feel like an overwhelming, out-of-control and disempowering experience.

- Exploring parallels between the original and the current situation may help your client feel more in control. Understanding traumatic triggers can provide them with ways to predict times when such memories may be triggered again.

Tolerating not knowing

There is some debate over whether all traumatic memories are required for survivors to complete their healing process. When a client has to live with gaps in their overall knowledge of the abuse, many abuse-focused researchers suggest that:

- you honour your client's choice (albeit an unconscious one) 'not' to remember
- they may not need to access and work through a complete memory of all abusive events before the trauma's meaning can be resolved
- you discuss with them the emotional cost of their wish to uncover and process the suppressed memories they suspect may be hidden
- you process with them the option of learning to live with some unresolved trauma
- you help them to tolerate not knowing.

Avoided memories

Although many survivors have conscious memories of the abuse, they may wish to avoid talking about them. They may feel that if they focus on traumatic material, they could be overwhelmed and lose control, or feel emotions they do not want to feel, such as shame, humiliation and vulnerability. They may also fear judgements from you.

- Continue to provide a safe, open and supportive approach.
- Accept and acknowledge painful information without disgust, shock, or pity – this can communicate your competence as a facilitator of what may feel, to your client, like overwhelming material.
- Remember, your client may never wish to focus on or talk about particular parts of a trauma. You may wish to predict this as a common situation in trauma therapy, and reassure them that it is appropriate for them to have control over what they do and do not discuss in therapy.

Integration work

This section outlines the therapy that takes place after focusing on traumatic material. 'Integration' is a period of emotionally processing the dislodged affect that is commonly attached when talking about traumatic material.

Dealing with intrusive material

Going over events of the trauma will inevitably cause painful affect and has the potential to trigger:

- overwhelming amounts of affect including feelings of vulnerability, anger and/or grief
- re-experiencing intrusive material through nightmares, flashbacks or startle responses
- forms of denial such as dissociation, detachment or feeling numb
- alternations between experiencing intrusive material and avoidance responses.

- If your client experiences intrusive material, you can help with containment strategies and support.
- If they experience denial and numbing, expressive strategies may be appropriate. You may consider ventilation and assimilation strategies, such as

empty-chair exercises, role plays, journal work, art work, or letters (not to be sent) of therapeutic expression toward the perpetrator(s) and/or others.

Desensitisation

Abuse-focused therapy facilitates the airing of painful accounts of trauma with the relief of sharing them in safety, and in the presence of support and caring. Through this process the survivor may be slowly desensitised to abuse-related material and may be more able to talk and think about the abuse without having to resort to dissociation or tension-reducing behaviours.

Desensitisation happens as accounts of traumatic events are repeatedly worked through in a safe, supportive environment.

Traumatic material is often processed in a step-by-step fashion. As one account is desensitised and integrated, the survivor has a greater capacity to deal with another part of the trauma (perhaps material from a deeper level).

The process of desensitising trauma within a supportive therapeutic relationship can also demonstrate to the survivor that they are valued even when they allow themselves to be vulnerable. Feeling valued can reduce abuse-related fears of being vulnerable within intimate interpersonal relationships.

Emotional processing

Eventually survivors may be able to experience virtually all the traumatic material without using avoidance strategies such as dissociation. To achieve this state, your client may need to repeatedly discharge the emotion as it is dislodged. At this point some clients may wish to use other expressive media such as writing letters (without sending them), or poetry, or using artwork to express how they feel.

A considerable portion of your time may be devoted to supporting emotional expression, whether it is your client's response to current life events or the ventilation of affect associated with memories of childhood injury.

Difficulties for clients

Survivors may wish to avoid 'feeling' the pain that is attached to focusing on traumatic material, and may attempt to reduce their contact with emotional pain by reducing their 'contact time' with their feelings.

- Encourage your client to practise staying with their feelings for just a moment or two longer than they otherwise would. This gradual process can help them to keep their avoidance strategies away for longer periods of time and increase their self-capacities.
- Your client may need reassurance that what they are feeling is a normal process after childhood trauma, but that as they have survived the abuse they are also able to survive their feelings from it. Your support may allow them to feel less anxious and help them to sustain abuse-related feeling states.

Difficulties for therapists

Although this is difficult and sometimes uncomfortable work, it is necessary.

- You need to be consistent in the way you validate your client's emotional discharge. For example, if you verbally validate your client's expression of strong feelings (such as rage or grief), but then look uncomfortable when they express these feelings, they may get the impression that such expression is in some way inappropriate or that you dislike them for their expression. They may be quick to blame themselves.

As the survivor becomes used to feeling and expressing strong emotions, they can increase their tolerance of this process and have less need to use tension-reducing behaviours.

For this reason abuse-focused therapy supports and encourages emotional processing more than traditional models do. Eventually your client's self-capacities should be strong enough to deal with most ongoing abuse-related pain and triggers and they will need your support to process their affect less and less.

Ending Stage Two

Having had the courage to face what may have seemed a terrifying trauma, your client will be likely to have made many gains, including that:

- while the events are not forgotten, the trauma is able to be assigned to the past
- most of their available memories will have been integrated into their life and will hold less affect
- they will have shed much of the burden of hurt, grief, shame, humiliation, anger, and/or guilt that was sapping their energies
- their energies and strengths will now be able to be redirected into other areas of life.

Once the abuse no longer takes central stage in their life, survivors are able to focus on other parts of themselves and their life with new hope and energy.

'Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery.'[139]

The 'fun' stage

Stage Three is much less intense than the earlier two stages and has been referred to as the 'fun' stage.[140]

The goals of Stage Three are to:
- consolidate gains
- assess responsibility for the CSA
- orient to 'normal' life
- reconnect with others
- gain empowerment
- prepare to end therapy.

Consolidating gains

Through the process of therapy your client may have moved from feeling fearful and disempowered to feeling self-reliant and self-confident.

In this final stage it is important to provide them with enough support so that they may:
- consolidate the considerable gains they may have made
- complete a deeper exploration of any issues that still require attention
- celebrate gains.

Assessing responsibility for the CSA

In Stage Three some survivors may look to place responsibility for the abuse where it belongs. They may look at the role of the perpetrator and at the role of passive bystanders and society. Although some may wish to confront the perpetrator, the majority simply wish to confide in those who may be supportive. Take care not to influence or instruct your client to take any particular form of action on disclosures or confrontations.

Disclosures of abuse or confrontations should not be held out to survivors as the 'ultimate goal' of therapy.[141] However, when well planned and prepared for, they can be empowering, especially if the survivor can simply feel satisfied with their own action (for example, no longer remaining silent). Just disclosing to their therapist can be a huge relief as well as an act of courage.

Disclosures outside the therapy room can be a novel experience for the survivor, as this time they are in control and initiating, rather than the reverse.

However, they must be prepared not to depend on the need for any particular response from others, such as the perpetrator or significant others.

- The results of confrontations or disclosures can vary and even be a devastating failure.[142] If your client chooses to confront, make sure they are carefully and fully prepared. For example, some perpetrators may have a lot to lose if the abuse is disclosed. In some cases survivors and their supporters (sometimes including the therapist) need to be prepared for a range of responses from the perpetrator and/or the perpetrator's supporters. These may include denials, threats to sue and threats of violence, as well as suicidal threats. There may be actions without threats.
- To ensure your client is fully prepared for all results, discuss graded scenarios and potential outcomes.

Any disclosure is likely to cause feelings of exhilaration and empowerment, but also fear and grief. Your client may feel sadness at having faced the reality of the abuse and may have to face the end of hoping that someone they loved would acknowledge their pain. They may face new or increased rejection and isolation from their family and may require therapeutic support at this time.

Orienting to 'normal' life

CSA survivors often need to re-educate themselves about how to act in 'normal' life and in non-abusive relationships.

Throughout their lives they may have felt 'different' from others and may frequently ask you how 'normal' people feel and react.

- At this stage your client may benefit from non-trauma-based groups. For example, many incest survivors do not have safe homes where they may simply enjoy not feeling anxious. It may be helpful to connect them to supportive groups where they can relax and practise relating with others in ways not based on trauma.

Adjunct activities such as self-defence classes and Outward Bound courses may be helpful in providing exposure to increased controlled challenges.

Reconnecting with others

By now it is expected that your client will have learned enough assertiveness and self-protection to be able to keep themselves safe from others harming them. As they learn about appropriate trust and boundaries in relationships, they may be more able to connect with others at a deeper level of intimacy.

- Your client may have the space to appreciate the role of their supporters during this process, which may mean acknowledging the toll the healing process has taken on any significant relationships.
- If they have been able to reclaim their capacity for sexual pleasure, any unresolved sexual difficulties may be dealt with at this stage.
- If your client is a parent, they may be able to reconnect with their child(ren), who are less likely to trigger unpleasant reminders of the survivor-parent's abusive childhood. Your client may be more able now to share their trauma story (if they wish) with their child(ren) in a way that is not shameful or overwhelming.
- Your client is likely to be less demanding of you at this stage. Whereas you may have been idealised, feared or resented before, the relationship should now be more balanced. Your client should be able to tolerate your limitations and strengths without fearing exploitation, abandonment or rejection.

Gaining empowerment

At this stage your client may be able to acknowledge what happened to them and the effects of the abuse, knowing that most of these effects are not permanent.

Looking back, some survivors may find positive aspects of themselves that arose out of the abuse. From this stage they can admire the ways they coped during the traumatic events.

Shame and humiliation may be replaced by a new sense of pride and empowerment. Your client may experience increased control over their own lives and direction over their future.

Preparing to end therapy

'Resolution of the trauma is never final; recovery is never complete. The impact of the traumatic event continues to reverberate throughout the survivor's lifecycle. Issues that were sufficiently resolved at one stage of recovery may be reawakened as the survivor reaches new milestones in [their] development.'[143]

The end of therapy can trigger abandonment fears as well as re-stimulate abuse-related symptomatology and harmful tension-reducing behaviours.

- Provide your (long-term) clients with perhaps three to six months of preparation for ending therapy. You may gradually reduce contact over those months.
- There may be a grieving process with ending therapy, and your client may require a great deal of reassurance of their gains. Reassure them that although they may feel they have completed their work within the therapy relationship, it is 'they' who have done the work and their gains stay with them.
- Prepare your client for 'relapse planning'[144] – the likelihood of a resurgence of symptoms from time to time. This does not mean they have failed or will require huge amounts of time in therapy.
- You may suggest that your client may wish to return for an occasional 'tune-up' or check-in.[145] Make sure you guard against future dual role relationships, so that your client can return to the safety of the therapy relationship if necessary.

Healing is not linear; the cycle is often repeated. The time for a survivor to leave therapy is when they are more interested in their present life and relationships than in the past, and they have the capacity to enjoy the present.[146]

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Footnotes

[1] Herman, 1992b, p.123
[2] Olafson, Corwin & Summit, 1993
[3] van der Kolk, Weisaeth & van der Hart, 1996
[4] Salter, 1995
[5] Meiselman, 1990
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[22] Although using retrospective research methodologies cannot prove a definitive causal relationship between CSA and a wide range of psychological and interpersonal difficulties, the number of consistent findings leads researchers and clinicians to conclude that CSA is a major risk factor for these outcomes (Berliner & Elliott, 1996; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Green, 1993; Neumann, Houskamp, Pollock & Briere, 1996; Polusny & Follette, 1995)
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Appendix 1: Third Schedule, Accident Insurance Act 1998

Cover for Mental Injury Caused by Certain Criminal Acts Crimes Act 1961

Section

128	Sexual violation
129	Attempt to commit sexual violation
129a	Inducing sexual connection by coercion
130	Incest
131	Sexual intercourse with girl under care or protection
132	Sexual intercourse with girl under 12
133	Indecency with girl under 12
134	Sexual intercourse or indecency with girl between 12 and 16
135	Indecent assault on woman or girl
138	Sexual intercourse with severely subnormal woman or girl
139	Indecent act between woman and girl
140	Indecency with boy under 12
140a	Indecency with boy between 12 and 16
141	Indecent assault on man or boy
142	Anal intercourse
142a	Compelling indecent act with animal
194	Assault on a child, or by a male on a female (to the extent that the assault is by a female on a child under 14 years old)
201	Infecting with disease
204a	Female genital mutilation
204b	Further offences relating to female genital mutilation

Contents

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