Towards curing the unthinkable:

Reflections on the process of working with survivors of child sexual abuse

by

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Declaration of powers of discretion

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Key for abbreviations

CSA: Child Sexual Abuse

TABS: Trauma and Attachment Belief Scale

ProQol: The professional quality of life compassion satisfaction and fatigue subscales

P-SQAPRESA: Sotrilli's Questionnaire on Attitudes and Practices of Routine Enquiry of Sexual Abuse

C-SQACRESA: Sotrilli's Questionnaire on Attitudes of Clients on Routine Enquiry of Sexual Abuse

VT: Vicarious Trauma

ST: Secondary Trauma

CF: Compassion Fatigue

SECTION A: Introduction to the portfolio

One of the things that makes me most proud for being a counselling psychologist is how much the counselling training has helped me to become a reflective practitioner. That means being able to pay attention to the process of the therapeutic work, feel the process with all my senses and work with it, sometimes choosing to become deaf to a client's words and instead opening my eyes and looking the mouth that produces words and just observe the person and reflect. It also means not being afraid of looking at myself as a person, and as a practitioner, recognise limitations and remembering to question my skills from time to time in order to allow new things to contribute to existing knowledge.

This thesis is about reflection on the work with survivors of sexual abuse. It attempts to press for a little while the "pause" button on the extensive and continuous production of literature on the problem of child sexual abuse (CSA) that has added and keeps adding valuable knowledge on its effects and on the therapeutic techniques that help survivors of such a crime to recover. Instead it invites researchers and clinicians to reflect on themselves and their practices. The result of my reflection on both clinical and research work in the sexual abuse field led to the realisation that inadequate attention has been paid to the therapist regardless of the plethora of anecdotal evidence pointing to its importance. Therefore, **the aims of this thesis** will be 1) to bring into therapists' awareness some of the main concerns involved in working with sexually abused clients, and to examine the implications of these concerns on therapists' practice and training (refer to extra literature review, Section D) and 2) to fill the critical gaps in the empirical literature that refer to the therapist by examining three specific issues in a combined way – the issue of enquiry -how

therapists feel about working with sexually abused clients and the impact of such work on them in terms of vicarious traumatisation (VT) and secondary trauma (ST) (refer to empirical research- Section B). Finally, issues from clinical practice will be presented through a case study on the long -term work of an abused and neglected child.

In particular, this thesis includes four sections (A, B, C and D).

Section A includes this brief introduction, which links all sections of the thesis.

Section B refers to the main part of the thesis comprising of an original piece of research. This research study attempted to explore professionals' attitudes and practices as well as their feelings about the work with sexually abused individuals. Specifically, it aimed to explore whether professionals enquire about CSA experiences during an initial assessment, how comfortable /competent they feel to both enquire about CSA and work with CSA survivors and what is the impact that such work has on them in terms of secondary trauma and vicarious traumatisation.

Given that clients with histories of sexual abuse will present frequently to psychiatric services (Lombardo and Pohl, 1997, Price et al., 2001), more research on professionals' needs regarding such work becomes vital. Exploring therapists' attitudes, feelings and practices as well as the impact that such work has on them seems important as it is further highlighted in Section B of this portfolio (Pearlman and Saakvitne, 1995). In particular, focusing on therapists is crucial because their feelings regarding such work will influence the service they provide, the way clients' problems are understood and the quality of treatment clients receive. This research

study attempts to explore these issues in relation to therapists who work within adult mental health and adult specialist services and not exclusively on professionals who only do trauma work as most previous studies have done. Also it is the first time that clients' opinions were included and contrasted with those of therapists' on the issue of routine enquiry about sexual abuse during an assessment.

Section C refers to professional practice and includes a case study on a child who has suffered abuse and neglect. Although this portfolio refers on the therapeutic work with adult survivors of sexual abuse, and although a lot of my clinical work is currently devoted to adult survivors of trauma, I have decided to present a case study about a child who suffered abuse and neglect. A number of reasons led me to present this case here. First of all this work was long term (2 years), quite challenging and very rewarding in the end. I consider that the work with this child has greatly influenced my therapeutic work with adult survivors of childhood trauma since it has taught me to be creative in my work, understand the "child" that is hidden in every traumatised adult and improve my skills in processing developmental difficulties with which many adult survivors of sexual abuse present. Moreover, although my main theoretical approach is Cognitive Behavioural, working for two years with this child using the psychodynamic model has contributed in refining my skills when working with adult survivors of sexual abuse and to adopt a more integrative approach. I consider my work with this child a significant learning experience and turning point for my work with sexual abuse survivors.

Finally, **Section D** of this portfolio involves a critical review of the literature on different concerns discussed in scientific literature for therapists who work with

sexually abused clients. Clinical practice has highlighted the fact that working with sexually abused clients seems to be a very demanding job that requires a lot of personal development, excellent skills and knowledge on the part of the therapist. Moreover a number of concerns regarding such therapeutic work are mentioned in the scientific literature (Sanderson, 1995, Pearlman and Saakvitne, 1995, Courtois, 1999). In particular, Christine Courtois (1999) gives a detailed account of the number of transference-countertransference phenomena that could influence the therapeutic process and pose a threat to the therapeutic relationship. Pearlman and Saakvitne, (1995) discuss issues of vicarious traumatisation and its implications to clinical practice. Other clinicians stress the importance of therapists being aware of their attitudes towards sexuality and sexual abuse (Bolen, 2001, Draucher, 2000), of the possible impact that their gender has on the process of such work (Sanderson, 1995, Dolan, 1991) and to be able to recognize their own personal issues (i.e. personal experiences of abuse, socialisation processes and personal family dynamics) in order to be able to work with CSA clients in an ethical and professional manner. This part of the portfolio attempts to collect most of these themes and concerns, critically review their presentation in scientific literature and discuss their implications to clinical practice.

Presenting these three pieces of work (research, literature review and case study) I certainly do not wish to discourage people from working with survivors of sexual abuse by highlighting the complexity of this work. Instead, I hope most of all to raise the awareness of professionals in terms of what they bring into the therapeutic work of survivors, how they can protect themselves and how they can maximise their effectiveness and so experience the multiple rewards that such work can bring.

SECTION B: Research

Title: Attitudes and practices on routine enquiry about child sexual abuse with adult clients during an assessment and the impact of such work on the therapist.

ABSTRACT

Objective: There is little consistency into the how a history of sexual abuse is assessed in clinical settings. Although some research has explored therapists' attitudes towards this issue, none has yet examined this in relation to clients' attitudes. This study explored attitudes towards routine enquiry of child sexual abuse during initial assessment in both clients and therapists in order to test whether therapists act in a way that is consistent with clients' views. The study also explored professionals' feelings about this work and its impact on them. **Method:** Seventy- two mental health professionals and sixty clients from outpatient clinics within South London and Maudsley NHS Trust completed a questionnaire that asked about their experience and attitudes towards enquiry of sexual abuse. Professionals also completed measures of professional competence as well as the Trauma and Attachment Belief Scale (TABS) and the Compassion Satisfaction and Fatigue Scale (ProQol). A combination of quantitative (chi-squared analyses, Pearson correlations and ANOVA) and qualitative (inductive method of coding open-ended questions) analyses were used. **Results:** The results of this study showed that most professionals did not routinely ask their clients about a possible history of sexual abuse in spite of the fact that they reported feeling competent and comfortable doing so. Clients on the other hand revealed that they would not mind being asked during an assessment and in fact indicated that they preferred to be asked directly by the professional rather than for the professional to wait for the client to initiate disclosure. In addition, professionals reported more negative than positive feelings regarding such work but, as a result of this work, they were at greater risk of developing vicarious traumatisation than compassion fatigue/secondary trauma. **Discussion:** The results of this study show there are still barriers that prevent professionals from routinely enquiring about sexual abuse during an initial assessment. They also highlight the specific nature of sexual abuse work and the risks to professionals. Clients' responses contradict clinicians' concerns regarding routine enquiry and suggestions for future research are made. The need to incorporate the topic into professional courses is highlighted and further implications for clinical practice are discussed.

CHAPTER ONE: Introduction

During this study the term childhood sexual abuse (CSA) will refer to all experiences of childhood sexual contact with a trusted significant adult or older person. In addition, the terms therapists, clinicians, professionals and clinical / counselling psychologists are used synonymously and interchangeably. Moreover, the terms clients/patients are also used synonymously and interchangeably.

It is essential before one goes on reading about this study to understand the rationale behind this research idea and the context in which it was developed and took place. I will therefore start with a very brief outline of the issue of sexual abuse and then move on to the rational and the context in which it took place.

Definition and Prevalence of child sexual abuse

Sexual abuse of children is a serious problem that has gained attention of researchers over the past few decades. There have been numerous attempts to define child sexual abuse many of which incorporate severe limitations and shortcomings (Hopper, 2003, Bolen, 2001). For example the legal definition of child sexual abuse focuses on the nature of sexual act, which must include sexual intercourse but ignores the full range of sexually abusive acts that have been reported and violate the child's boundaries and persona (Bolen, 2001). However, many research studies (Bagley, 1991, Rind et. al., 1998, Briere, 1997, Finkelhor et. al., 1990) have tried to use definitions that incorporate the full-range of intrafamiliar and extrafamiliar child sexual abuse and the complete spectrum of sexually abusive acts against children (i.e. physical contact behaviours like kissing, fondling of genital area, fellatio, penile penetration of the vagina etc, as well as non-touching behaviours which include voyerism, nudity, genital exposure, sexualised photographs etc.).

The prevalence of sexual abuse has been also debated with prevalence rates ranging between 3% and 63% in community samples (Rind et al., 1998, Dallam et al., 2001) and 24% to 70% in clinical populations (Price et. al., 2001, Hopper, 2003). Empirical research on the effects of child sexual abuse confirm the presence of initial effects that include fear, anxiety, depression, anger and sexually inappropriate behaviour whereas the long-term effects include, self-destructive behaviour, anxiety, depression, poor self-esteem, difficulty in trusting others, tendency towards revictimisation, substance abuse, sexual maladjustment and psychosis (Finkelhor, 1990, Briere, 1997, Goff et. al., 1991). More recent studies have established a strong link between child sexual abuse and an elevated suicide risk (Young et. al., 2001).

The development of this research idea and the context in which it was developed

I have been working in a Community Mental Health Team (CMHT) since I was training to become a chartered counselling psychologist, and my ideas to research this topic came from a combination of personal interest, reflections on myself as a therapist and my clinical work as well as from questions that were generated as a result of my everyday work with adult survivors of sexual abuse.

During my work within the different CMHTs my caseload contained a large number of sexually abused clients and so my skills in the area of sexual abuse developed and my attention was gradually shifting, from therapeutic techniques and client issues, to what I bring as a therapist to this work and how I influence the process of the therapy. Such a shift of focus in my thinking from the client to the therapist opened a whole new path for me and further contributed in my decision to research this topic. In particular, I discovered that literature, (Pearlman and Saakvitne, 1995, Salston and

Figley, 2003, Linley et.al., 2005) which will be discussed in detail later, had emerged on the impact of working with trauma survivors and specifically with sexual abuse. Moreover, books about sexual abuse (Sanderson, 1995, Draucher, 2000, Glaser and Frosh, 1993) included whole sections highlighting the importance of the therapist as a person in this work and what she or he brings to the therapy (i.e. gender, sexuality, attitudes). While I was reading on issues concerning professional practice (Read and Lindsay, 1997) the topic of enquiry also came up, and how that may contribute to the underestimation of rates of sexual abuse among clinical populations. At the same time the lack of focus on the therapist was evident in the workplace. A combination of the above factors resulted in the development of the idea for this study, the philosophy of which is the importance of being a reflective practitioner, looking at what we as therapists bring into the therapeutic work and how we influence that work through our personal bias, limitations or particular knowledge.

The context in which this idea was developed is also very relevant to this research study. Most of the work I have undertaken with survivors of sexual abuse has been while working within a community mental health team (CMHT) within an NHS setting, therefore my ideas and questions are strongly influenced by my experience within this setting. Particularly the fact that I have worked within multidisciplinary teams and attended meetings in which different professionals presented their views on clients' difficulties, including sexual abuse has contributed to me questioning the way survivors of sexual abuse are managed and treated. Also my ideas are affected by the current policy of the borough in which I work, which is that clients who are referred for psychological therapy will undergo an initial assessment with a psychologist who at the end of the assessment will decide how the client will be best managed and

either being put in the treatment waiting list or will be referred to other appropriate services. Therefore assessment procedures are vital for the management and care plan of clients in this setting, so the issue of enquiry about sexual abuse during this initial process seems very important. I would also like to acknowledge the fact that the main approach used in this setting is Cognitive Behavioural Therapy, which might have influenced the way I view assessment procedures compared to other approaches (Corey, 1996). Nevertheless, the topic of sexual abuse enquiry seems relevant to most settings within NHS where doing a lot of assessments in order to design clients' care plans is often part of a psychologist's job.

CHAPTER TWO: Review of the literature

In the last two decades the public and professional interest on child sexual abuse (CSA) has risen, contributing to an increased awareness and acceptance of the issue (Neumann et al., 1996, Dallam et al., 2001, Sanderson, 1995, Davies et al., 2000). However, in practice, the horror of the act of childhood sexual abuse seems to remain the same since both clinical experience (Etheringhton, 2000, Courtois, 1999, Nyman and Svensson, 1997, Draucher, 2000, Dale, 1999) and research (Cheung et al., 2000, Day et al., 2003) suggest that childhood sexual abuse evokes unpleasant feelings particularly in professionals who work with victims. Evidence suggests that trauma victims differ from clients with different psychological disorders (i.e. depression, anxiety etc) since although they might also present with similar symptomatology such as depression or anxiety, during the exploration of their traumatic history the therapist becomes a witness to the trauma their clients have been through and is exposed to traumatic material in an indirect way (Pearlman and Saacvitne, 1995). Trauma work, and especially working with sexual abuse can have complex and distressing effects on therapists, causing a phenomenon called vicarious traumatisation (VT) (McCann and Pearlman, 1990) and could result in traumatizing the professional (Figley, 1995). This is specifically explained in a later section of this review, titled "secondary trauma and vicarious traumatisation.

Moreover, there is evidence to suggest that professionals feel under equipped and unsupported to work with CSA cases (Gallop et. al., 1995, Day et. al, 2003) and that most professionals avoid routinely enquiring about sexual abuse (Pruitt and Kappious, 1992, Lab et al., 2000, Young et. al., 2001). Thinking about sexual abuse and how much publicity it has received since the late 60s one could assume that the topic has

been adequately addressed and covered. However, my work experience, several informal discussions with colleagues and readings on the topic generated the following questions that would be explored in detail through the review of scientific literature that follows: why do empirical studies show that there are still difficulties determining the prevalence of sexual abuse due to problems of underreporting and under detection? Why do professionals still fail to ask about sexual victimization? How comfortable and competent do therapists feel about addressing issues of sexual abuse? Do therapists feel uncomfortable, traumatized and inadequately trained to meet the high demands of such work? Is routine enquiry of sexual abuse important? Do therapists systematically assess sexual abuse? If therapists do not routinely enquire what prevents them from doing so? Does professionals' current practice, despite the publicity and increase of knowledge on this area, still contribute to the silencing of clients? Research suggests that mental health professionals are not immune to the material that clients bring, so does exposing themselves to sexual abuse work traumatize them in certain ways? Relevant evidence regarding the above questions follows.

1) Enquiring about CSA during assessment

The issues that surround the work with CSA survivors have been under addressed both within professional guidelines and training (Read and Lindsay, 1997). One of these issues refers to the importance of routinely enquiring about CSA experiences. Although the nature of the crime of sexual abuse is intertwined with the issue of victim secrecy, clinicians do not seem to have gone far with freeing survivors from that burden, since one theme that remains the same in research is that sexual abuse is still extensively undisclosed and underreported (Bagley, 1992, Jacobson et.al.,1987, Read and Frazer, 1998). Studies on professionals indicate that one of the reasons for this underreporting might be the fact that professionals do not enquire about histories of sexual abuse (Holmes et al., 1997, Read and Argyle, 2000) and even if they do they don't use systematic methods (i.e. routinely enquiring using the same structure with all clients or using a relevant questionnaire every time they make such enquiry) (Lab et al., 2000).

Particularly the issue of enquiry and its importance, was initially addressed some time ago (late 80s) when mental health professionals highlighted the importance of systematic and routine assessment of abuse in patients/clients by recognising that many such histories go undetected within the mental health system. In particular, Jacobson and Richardson (1987) conducted a study where they interviewed 100 psychiatric patients about experiences of physical and sexual assault. When a year later they reviewed the medical notes of these same patients for the admission they found out that only 9 per cent of the abuse experiences reported during the interviews were recorded (from 154 reported assaults only 14 were recorded)(Jacobson et. al., 1987). They therefore concluded that the figures of prevalence increase when

clients/patients are asked directly about assault experiences rather than when clinicians wait for the clients to volunteer such information.

Moreover, Lanktree et. al., (1989) reviewed charts of outpatients and found that rates of sexual abuse increased from 7% to 31% when clients were asked directly by clinicians whether they had been molested. Rose at al., (1991) interviewed 89 clients referred to an intensive case management program in New York about abuse experiences and the attention these experiences had been given by mental health providers in the past. What they found was that even if there were some indications in a client's life that they experienced abuse as children, (i.e. PTSD symptoms, dissociative disorders, sexual dysfunctions, self mutilation etc) clinicians still didn't ask the clients and they found that clients' physical and emotional abuse, along with denial, secrecy among family members compounded by a sense of deep shame made it particularly problematic for clients to understand their experiences and trust others in authority (Rose et al., 1991). Their results (50% of participants reported incest) confirmed the extensive childhood sexual abuse among mental health consumers and more importantly suggest that routine enquiry along with the development of appropriate support for victims deserve serious scrutiny by mental health policy and program planners (Rose et al., 1991).

The fact that sexual abuse experiences remain undetected due to lack of direct enquiry is further supported by studies that reveal how such histories go undetected by hospital staff and that people never reported such experiences because they were never asked (Craine et. al., 1988, Cole, 1988, Jacobson and Herald, 1990). In particular, Craine et al., (1988) conducted a study during which they interviewed 100

acute and chronic patients from 9 state psychiatric hospitals in Illinois. They found that 51% of the patients disclosed sexual abuse in response to direct enquiry of whom 56% had never been identified during their course of their treatment as victims of sexual abuse and many patients said they never disclosed it because they were never asked. Interestingly 66% of those who were abused met DSM-III criteria for Post-traumatic stress disorder but none of them had received such diagnosis.

Cole (1988) also suggests that routine enquiry during assessment is a sound procedure since the findings of her study showed that patients readmitted to the hospital in which the study took place answered positively on questions of abuse whereas their initial record showed no abuse history. Moreover, Jacobson and Herald (1990) suggest that routine enquiry of sexual abuse is necessary during assessment following their findings that one in six male inpatients and one in five women inpatients reported childhood sexual abuse while interviewed for the study (40% of the 100 patients interviewed were sexually abused). Interesting finding of their study was that 56% of the patients who experienced sexual abuse had never revealed that to their therapists which is the same percentage reported by Craine et. al. (1988) as already discussed above. Jacobson and Herald (1988) suggested that only patients who spontaneously talk about their abuse are recognised, whereas the ones who find it difficult to talk about it, without a prompt or without being asked are never recognised which might seriously compromise their treatment.

More recently, David Mitchell and his colleagues (1996) sent a survey questionnaire about current practices relating to assessment of a history of sexual abuse to every general hospital in the US that offered inpatient services. Although respondents at 69

percent of the 466 facilities that participated believed that the admission assessment of psychiatric patients should always include a history of sexual abuse only 43% included such history in admission assessment (Mitchell et al., 1996).

Read and Frazer (1998) on the other hand found that even if clinicians were given a form to use during admission of patients that contained an explicit section on sexual abuse, two-thirds did not complete this section. The form explicitly requested professionals to record any negative reports as well, and if they didn't enquire to record the reasons for not enquiring. Therefore since the majority of professionals left this section blank, the researchers concluded that leaving decisions about whether to enquire about abuse to the clinical judgement of individual practitioners results in the loss of important clinical data. They also reported that it doesn't seem adequate to rely on an admission form, which explicitly addresses abuse history in the absence of a unit policy that all clients/patients will be asked about abuse. The above studies were conducted on mental health staff generally and refer mainly to practices of psychiatric nurses and psychiatrists.

It may be though that participants' internalised beliefs about sexual abuse and the aetiology of mental illness have influenced their decision about what information is important during an initial assessment. In particular, clinicians who place greater emphasis on endogenous factors in the development of mental illness might not consider traumatic life events such as a history of sexual abuse, important when assessing onset and maintenance of symptoms (Jackson and Nutall, 1993).

Therefore it seems important to look at studies that were conducted specifically on psychotherapists/ psychologists and see whether their results agree with the studies mentioned above. A review of the literature revealed that some studies have been conducted on psychologists' practices in general regarding treatment of sexual abuse (Alison, 1998) but only few studies were found (Pruitt and Kappious, 1992, Young et. al., 2001) that refer to the issue of enquiry during an assessment. In particular, the vast majority of therapists surveyed in a study by Pruitt and Kappious, (1992) endorsed the belief that clients should be directly asked about sexual abuse, however only 51% of the respondents reported that they asked all or most of their clients about abuse at some point during therapy. In addition, Young et. al., (2001) found that the probability of psychologists enquiring about sexual abuse during assessment was 47% compared to 62% who reported that they would ask once rapport has been established. Therefore Young's study indicates that routine enquiry during assessment takes place much less than during therapy (Young et al., 2001).

These results show that the probability of psychologists to enquire is increased compared to general mental health professionals. However, there is not much research on psychologists/therapists and no studies that explore specifically their practices around enquiry and their attitudes in order to establish whether they differ somehow from other mental health professionals regarding routine enquiry. On the contrary, it seems that although attitudes towards enquiry are a bit more positive for psychologists, professionals are still reluctant to routinely enquire about sexual abuse experiences. Moreover, apart from Young's et. al. (2001) study there is little to indicate whether there is a preference between asking during an initial assessment or during later in therapy. This study intends to fill the above gaps. In particular,

following the results of the studies presented above and the reluctance that still seems to exist regarding routine CSA enquiry, it was hypothesised that the majority of professionals (psychotherapists/psychologists) in this study would believe that clients should be asked about sexual abuse only sometimes or never during an initial assessment (Hypotheisis 1, page 59). It was also hypothesised that in terms of their actual practices they would say that they never or only sometimes enquire (Hypothesis 2, page 59). Moreover, since there are indications (Young et. al., 2001) that professionals prefer to enquire when the therapeutic relationship has been established it was hypothesised that from those professionals who would say that they enquire about sexual abuse, the majority would do this during therapy rather than during an assessment (Hypothesis 3 page 59)

Barriers to routine sexual abuse enquiry

There is some speculation and some research, which will be discussed here, regarding therapists' reasons for not routinely enquiring about sexual abuse. In particular Cole, (1988) reports that professionals tend to focus their attention on high- risk populations and so only enquire when they believe the particular client meets these risk factors. Pruitt and Kappious, (1992), agree with Cole (1988) and their findings suggest that a high percentage of therapists don't routinely enquire unless the client presents with specific symptomatology that according to therapists indicates a probability of abuse. Specifically they found that 38% of respondents indicated that they ask about sexual abuse only if the client presents with symptoms that they believed might have been caused by sexual abuse. The above studies indicate that therapists probably lose sight of the possibility of sexual abuse in populations that are perceived to be in the lower risk category. In addition this seems problematic since although there might be some

symptoms that have been particularly associated with a history of sexual abuse such as PTSD, dissociative disorders, sexual dysfunctions, self mutilation and borderline personality disorder (Rose et al., 1991, Browne and Finkelhor, 1986, Briere et. al., 1997, Courtois, 1999) most victims manifest a high variety of symptoms and there is no single set that is considered characteristic of CSA (Finkelhor, 1990, Briere, 1997, Courtois, 1999).

Furthermore, other studies found that mental health professionals support routine enquiry about sexual abuse, but one of the reasons they avoid doing so is because of their own discomfort with talking about sex, their own fears about sexual violence or their lack of confidence in dealing with such an issue (Gallop et. al., 1995, Gallop et al., 1998, Agar, 1998, Young, 1999). From the above researchers, Gallop et al. (1998) found in particular that respondents in their study identified a gap in their training about enquiry and response practices and expressed a desire for graded skill acquisition. As a result the researchers suggested that training packages should include self-educational resources such as videos and interactive study modules.

One other reason that professionals do not enquire seems to be time constraints with respondents reporting that they had too many other immediate concerns to deal with (Mitchell et. al., 1996, Young, 1999). Another common reason for professionals avoiding enquiry is the attitude that clients would not be willing to discuss the issue (Gallop et al., 1995). Psychiatric nurses taking part in Gallop et. al., (1995) study held the view that those who want to disclose should be allowed to bring this topic up by themselves, as opposed to being "forced into it". However enquiry doesn't force clients to disclose any CSA experiences, instead it gives them the opportunity to

discuss it safely if they wish. Therefore, this argument seems to be a misperception or a result of lack of knowledge in terms of how such enquiry should be conducted.

Another common reason that therapists give for not enquiring about sexual abuse is similar to the one mentioned before and relates to a concern about client embarrassment and that clients will volunteer this information if the therapeutic relationship is strong (Pruitt and Kappious, 1992) which leads most therapists to leave the responsibility of exploring such a topic to the client (Lab et. al., 2000). This seems problematic since without enquiring, clients' willingness to disclose cannot be known. Also, we do know that the topic of sexual abuse is intertwined with shame and secrecy and so many survivors will not disclose such experiences spontaneously (Jacobson, 1989, Eilenberg et. al., 1996). Empirical data actually support that there are many barriers that would prevent victims from making such a disclosure spontaneously, including feelings of shame and guilt, powerlessness, and isolation (Bagley, 1992) as well as self-blame and feeling there is something wrong with them (Johnson, 1987, Cole, 1988).

The reasons for clients not disclosing a history of sexual abuse may also include the fact that victims feel humiliated by the assault, as well as being uncertain of the clinician's response (Lister, 1982), out of loyalty to their family (in incest cases) (Jacobson et. al., 1987), or because they believe their abuse has nothing to do with their current difficulties (Fong-Beyette, 1987). Moreover, Courtois (1988) has suggested a number of possible reasons for non-disclosure including: having used denial to cope with the abuse, feeling stigmatised, mistrusting others, having being severely intimidated at the time of the abuse regarding the negative consequences of a

disclosure. There are also some survivors who report that the only reason they have never disclosed their abuse is that they have never being asked (Craine et. al., 1988). More findings suggests that people are very willing to disclose when they are directly asked about it (Read and Fraser, 1998, Jacobson et. al., 1987, Rose et. al, 1991, Al-Mateen et.al., 1996, Mitchell et al., 1996). Therefore, according to the above studies it seems that argument that professionals have (that clients will volunteer such information) is not supported by relevant data. Clients seem reluctant to disclose their abuse experiences spontaneously for a number of reasons associated with their trauma and many clients expect someone to help them make such disclosure and empower them to discuss such issues by asking them directly about such experiences.

In terms of more reasons that professionals use for not enquiring Young et. al., (2001) reported that these include: fears that such enquiry would be suggestive and induce false memories. Other studies report fear of vicarious traumatisation (Eilenberg et. al., 1996). These arguments are not unreasonable and reveal professionals' self-awareness about issues that could arise throughout their practice. However, it seems that training on ways of enquiring and knowledge around the issue of false memory syndrome could help professionals overcome the first barrier. As far as vicarious traumatisation is concerned again this should not be used as a reason for avoiding enquiry because clinician's empathic engagement is an unavoidable part of doing trauma work. Perhaps educating clinicians on what resources are available as well as the importance of supervision and additional support, might help them overcome this fear.

Additionally, the ways of enquiring or even the criteria that therapists use to decide whether to enquire about sexual abuse or not also seem problematic. According to the

results of a study by Lab and his colleagues on this issue, the most frequently used methods by therapists of obtaining abuse history were either "to enquire when the client brings it up" or "to ask when it came to their mind" (Lab et al., 2000).

Furthermore, we now know that the gender of the client is a significant factor that influences professionals' decision to enquire, since research has shown that male clients are less likely to be asked compared to female clients (Lab et al., 2000, Read and Fraser, 1998). Also clients with a diagnosis of schizophrenia are less likely to be asked than other inpatients (Read and Fraser, 1998). Given the findings of a strong statistical relationship between CSA and psychosis (Beck et al., 1987, Goff et. al., 1991, Heins et. al., 1990, Ross et. al., 1994, Read and Frazier, 1998) such biases in assessment practices are worrying and result in loss of clinical data that might become crucial to treatment planning.

Therefore, although it seems encouraging that mental health professionals in the last few years acknowledge the importance of enquiry about sexual abuse, both the ways and the reasons that they use in making a decision of whether to ask, or not ask about a history of sexual abuse seem subjective, biased and based on first impressions. This study will explore psychologists' justifications and attitudes toward whether they routinely enquire or not about sexual abuse. This is important since as mentioned above most of the above studies were conducted on general mental health professionals and it might be that different professional groups present with different reasons for enquiring or not which would be important to explore.

Clients' opinions

Moreover, few studies have been identified that asked clients' opinions regarding sexual abuse enquiry (Josephson and Fong- Beyelle, 1987, Craine et al., 1988, Friedman et. al., 1992, Brabin and Berah, 1995). While there are a number of studies that reveal a reluctance of therapists to routinely enquire about sexual abuse there is no evidence in the literature that clients resent or object to being asked about a history of CSA (Gallop et. al., 1995, Dale, 1999, Bacchus, 2002). Josephson and Fong-Beyelle (1987) were among the few researchers that explored factors that facilitate disclosure of sexual abuse by conducting structured interviews with clients. Their findings suggested that among the important factors that relate to initial disclosure of the client is direct questioning by the therapist, client's readiness and positive reactions from the professional.

Craine et. al., (1988) found that many survivors did not disclose their abuse only because they were never asked. Shew and Hurst (1993) found that 99.5% of clients in a sexual health clinic did not mind being asked. Friedman et. al., (1992) found that the majority of both abused and non-abused clients do not mind being asked and that they favour routine enquiry of all clients. An important finding by Brabin and Berah, (1995) was that although many participants in their study found it distressing talking about their abuse it was very beneficial for them and that the distress was outweighed by the benefits for being able to discuss the trauma.

Moreover, a study examining women's perceptions of routine enquiry for domestic violence revealed that 718 women out of 771 found it acceptable to be asked and also most of those who had experienced domestic violence reported that this was very

beneficial in terms of their later well being (Bacchus et al., 2002). Such findings directly contrast with the failure of professionals to enquire about domestic violence and with the fear of many professionals of offending the women by asking. Clinical experience and research that has already been mentioned above suggests that a parallel issue exists in the case of sexual abuse.

However, little research has been found that includes clients' views regarding routine enquiry of sexual abuse and whether these contrast with therapists' current arguments against such routine enquiry, a gap that this study intends to fill.

One could ask though why routine enquiry of sexual abuse is so important after all? Some of the main reasons will be summarised below:

Why in particular routine enquiry of sexual abuse is important.

Following the review of some studies on practices on routine enquiry of CSA I would like to emphasise here the reasons that make such an enquiry important.

The link between sexual abuse and later psychopathology has been studied a great deal. In particular, more recent studies reveal that sexual abuse experiences are uniquely associated with psychiatric difficulties even after controlling for relevant background variables (e.g. age, race, marital status) and sexual abuse in particular seems to be the most powerful predictor of later psychiatric symptoms (Briere et. al., 1997). In an interesting study by Douglas (2000), it was found that mothers with a history of childhood sexual abuse had significant concerns regarding their own capacity to be parents and these concerns were associated with their experiences of childhood sexual abuse. In particular, the sexually abused mothers who participated in

the study expressed greater anxiety about intimate aspects of parenting like kissing, bathing or putting on nappy cream. Such results show the effects of sexual abuse not only on personal development but also across generations since it can affect parenting styles and the development of appropriate childcare. This further highlights the clinical implications for preventive work and early identification of sexual abuse through routine enquiry (Jones, 2000).

Additionally, the importance of sexual abuse enquiry is obvious if one considers the risks that exist when histories go undetected. In particular, Rose (1991) refers to a study by Gelinas (1983) who found that victims who have never disclosed the abuse, suffered persistent negative effects as long as the abuse remained undetected which were described by Gelinas as, "complicated depression with impulsive and dissociative elements". Craine et. al. (1988) reported that the longer the abuse goes untreated the greater the repression and the more ingrained the symptomatology since clients' attempts to deal with their distress might take indirect paths that lead to the development of confusing symptoms (e.g. feeling detached or estranged from others, hyperalertness, recurrent dreams etc) .

Other researchers support the above idea and argue that by not initiating a discussion about abuse clinicians might further confirm clients' denial of their experience (Bryer et. al., 1987, Figley, 1985, Pattern et. al., 1989 cited in Rose, 1991). Evidence suggests that victims of abuse are at risk for future abuse, (Browne and Finkelhor, 1986, Briere, 1997)) and may be at risk for being unable to protect their children from abuse (Alexander, 1990). Early identification appears crucial to reduction of

suffering, enhancement of psychological development and healthier adult functioning (Faulkner, 2003)

However, the importance of routine enquiry lies also in the fact that sexual abuse could predict risk behaviours such as suicidality. In particular, in a study by Lanktree et. al., (1991) in a child psychiatric outpatient clinic, children who reported sexual abuse were more likely to have attempted suicide, made more suicide attempts and had greater likelihood of being assigned a diagnosis of major depression compared to children with no molestation history. Interestingly enough, such relationships did not emerge for physical abuse (Lanktree et. al., 1991). Such results reveal the complex nature of child sexual abuse as a traumatic experience and how different such experience can be from physical abuse. Perhaps there is an important qualitative difference between physical abuse and sexual abuse like the secrecy involved in the latter or the lack of the obvious marks on the victim as in physical abuse (i.e. bruises, scratches etc), that interact with the shame and self blame of the victim and so contribute in the development of greater psychopathology and difficulty in later adjustment.

In addition to the above studies more research supports that link between a history of sexual abuse and suicidality. Kaplan et. al., (1995) found that a combination of childhood abuse and abusive experiences in adulthood was the strongest predictor of current suicidal ideation and past suicidal attempts. Moreover, a recent study Young and his associates (2001) found that current suicidality was better predicted by child sexual abuse (experienced on average 20 years previously) than by a current diagnosis of depression. These findings add weight to the recommendation of many researchers

and clinicians that a history of sexual abuse should routinely be taken from clients in order to ensure accurate formulation and treatment planning. It seems that the issue of enquiry becomes important since a history of sexual abuse according to the above researchers puts people at greater risk than the presence of depression, which for most of us has been synonymous with the notion of suicide. Thus without having taken a sexual abuse history, therapists trying to estimate suicide risk in adults may seriously compromise their assessment (Young et al., 2001). It is however important to clarify at this point that enquiry doesn't guarantee disclosure of abuse as was discussed earlier (page 29-30) but it does though facilitate it or rather increases the chances of a possible disclosure.

Furthermore, both clinical and counselling psychologists become almost certain to encounter cases of CSA in their caseloads, since prevalence rates among psychiatric populations are higher than rates among the general population (Wurr and Patridge, 1996, Price et al., 2001, Lombardo and Pohl, 1997). Therefore regardless of one's beliefs about the causal relationship between child abuse and a specific disorder, repeated findings that roughly half of all users of mental health services have been sexually abused suggest a professional obligation to offer appropriate treatment to those who feel they need it, and the only way to do this seems to be through routine enquiry (Young et. al., 2001).

In addition, therapists who work in adult mental health do not always know that clients that have been referred to them suffered childhood sexual abuse, because the referrals usually do not focus on such causative developmental factors, but rather highlight the symptomatology (i.e.: depression, anxiety, PTSD etc). As a result, it

seems that it has become common practice for therapists to start working with clients for symptoms such as depression or anxiety and end up dealing with issues of sexual abuse. This seems quite worrying if we think that therapists often lack conceptual frameworks and supportive environments for understanding the different issues that relate to them when working in this field (Pearlman and Saakvitne, 1995). As a result not all therapists feel confident and sufficiently well trained to deal with such cases (Day et al., 2003) and that raises many concerns regarding the treatment that is provided to these clients. It seems that therapists could prepare themselves better or refer clients to other professionals if they knew before the therapeutic work started whether the client had been sexually abused.

However, if by the time clients disclose the abuse to the therapist, therapy has progressed and a therapeutic alliance has been established, even if the therapist feels uncomfortable working with CSA cases, they will continue providing input to them and, as studies suggest, would not refer the clients to other professionals (Lab. et al., 2000). One hypothesis of why this might be happening could be that therapists feel obliged to go on and address the issue by themselves, without referring to another professional, because they might feel that if they do they will "betray their client's trust" or they might fear that they will be perceived as incompetent. In order to be able to further examine such hypotheses we need more studies to explore how therapists feel regarding such work and what are their current assessment practices. Therefore this study that will explore such feelings and practices among clinical and counselling psychologists, would contribute to a better understanding of professionals' needs when working in this field and assisting the improvement of current training and professional practices.

Finally, the issue of routine enquiry during an assessment seems vital since as discussed extensively previously, evidence shows that clients tend not to volunteer such information, unless someone asks them directly (Craine et.al., 1988, Cole, 1988, Jacobson and Herald, 1990, Lanktree, 1989). Although, clinical practice has revealed that there are clients who would disclose such information, research has also shown that there are a number of reasons that most sexually abused clients will not disclose such information. For all of the above reasons routine enquiry for sexual abuse seems to be a very important issue.

In conclusion, there have been studies revealing a lack of systematic enquiry about sexual abuse experiences. There are also some studies that explored professionals' reasons behind the lack of routine enquiry for sexual abuse experiences. Most of these reasons that professionals bring to our attention seem to be assumptions about the clients, and how they will feel regarding such enquiry. Some of professionals' arguments against routine enquiry, such as the fear of vicarious traumatisation and inducing false memories seem reasonable. However the question seems to be whether these concerns should be used as a reason to avoid enquiry in light of research showing the benefits of enquiry and how these outweigh the distress that such enquiry might create (Brabin and Berah, 1995, Pennebaker et al., 1988, Penebaker et.al., 1992). Also professionals' concerns seem to create barriers to routine enquiry that could be overcome through training. Finally, there seem to be few studies exploring clients' views about being asked about sexual abuse experiences and no study has been identified that focuses particularly on attitudes on enquiry during an initial assessment. Therefore, this study will try to explore further psychologists' attitudes on

that matter and directly contrast them with clients' views. This seems important in view of the fact that a lot of the reasons that have been reported by professionals refer to their worries regarding the impact of such enquiry on the client when in fact there is no empirical evidence to justify such worries as already mentioned above. Therefore a number of questions will be explored regarding clients' views on routine enquiry (please see page 61).

2) Professionals' feelings when working with CSA

Therapy in counselling psychology is about a therapeutic relationship that becomes the basis on which therapeutic techniques and psychological theories can be applied (Corey, 1996). What the therapist brings to this relationship is as important as what the client brings. According to literature personal reflection and awareness seems to be even more crucial when working with survivors of sexual abuse compared to other psychological difficulties (Pearlman and Saakvitne, 1995, Jackson and Nutall, 1997). One of the reasons is that therapists are social beings who have been part of society's denial and who grew up within the same societal rules, cultural beliefs, morals, fears, prejudices and taboos as their clients and therefore they need to become aware of these before they embark in such work (Pearlman and Saakvitne, 1995). Moreover, CSA is both a legally and morally condemned subject and touches upon various aspects of our being such as our values, our sexuality, our attitudes towards children, power issues and family dynamics (Sanderson, 1995). Also individuals who have been abused present particular challenges to the therapeutic alliance since relationships are perceived as a source of hurt, danger or betrayal (Courtois, 1999). A therapist must maintain ongoing awareness of these challenges since they often

manifest in transference reactions from the client and in countertransference reactions from the therapist (Pearlman and Saakvitne, 1995).

Pearlman and Saakvitne (1995) report that countertransference is part of every therapeutic relationship regardless of the therapist's theoretical orientation. According to them this is revealed in clinical errors, bodily sensations and in positive or negative thoughts about the client. There are more clinicians (Sanderson, 1995, Courtois, 1999, Fergasson, 1995) who highlight the importance of acknowledging countertransference phenomena during the work with sexual abuse survivors and who stress how these if not appropriately processed could infect the therapeutic process and impede the healing of the client (For a more detailed exploration of transference/ countertransference processes in CSA work please see extra literature review pages 231-238).

However, the above clinicians concentrate on professionals' feeling during therapy and demonstrate its importance but how therapists feel and think about that work outside of the therapeutic process seems equally vital. Day et. al., (2000) conducted a study exploring the views of 57 mental health professionals, mainly nurses, regarding the needs of clients who have experienced CSA. One of the most important finding of their study was that respondents reported not feeling comfortable, competent or supported in their work with this client group. These results are further supported by Gallop et al. (1995) who found that the majority of nurses who participated in their study avoid enquiring about sexual abuse because of their own discomfort around the issue, lack of support and confidence. Similar lack of training and competence in

dealing with abuse issues as well as discomfort discussing sex was also found by other researchers (Agar, 1998).

The above results contradict the results from one study by Mitchell et. al. (1996) who surveyed the opinions of 466 professionals who worked in acute short term psychiatric care settings (unit managers, head nurses, unit directors and supervisors of nursing). The majority of the respondents in this study (385 out of 460 who answered the question) reported feeling comfortable discussing sexual abuse with clients. In terms of their competence though most reported that they had not received any training in the care of sexually abused clients. The lack of training of professionals is also revealed in a study by Lab et. al., 2000. They found that 2/3 of all staff reported that received no training in the area of assessment and treatment of sexual abuse. However, we should be careful when interpreting these results and not infer that lack of training in the area of sexual abuse necessarily means that professionals feel a lack of competence since professionals who reported that they received no training might still feel competent due to being experienced therapists or due to the transferable skills learned on other types of training.

Most studies presented above indicate that the feelings and thoughts that a professional has about such work such as, how comfortable/competent or supported they feel, are not very positive and can affect their clinical practice. Although some studies have been identified that explore the feelings of professionals, these involved general mental health professionals and did not specifically explored psychologists'/therapists' feelings. Only a few studies reported psychologists did take part but still they were part of a larger sample of various professionals. This seems an

important gap not only because the prevalence of CSA has been shown to be higher in psychiatric populations (Bagley and Ramsay, 1985, Ainscough and Toon, 1996) but also because according to research (Price et al., 2001) talking therapies have become the main vehicle through which these clients can get help. As a result, this study would explore how comfortable/competent and supported clinical/counselling psychologists and psychotherapists feel regarding such work and since the few studies identified so far revealed that professionals felt a lack of competence and support, it was hypothesised that psychologists in this study will state that they do not feel competent/comfortable to work with sexually abused clients (please see hypothesis 4 on page 59).

3) Secondary Trauma and Vicarious Traumatisation

The topic of sexual abuse seems to generate many powerful and painful emotions. Clinicians are not immune to these and often become emotionally involved (Pearlman and Saakvitne, 1995, Etheringhton, 2000, Draucher, 2000, Sanderson, 1995, Dale, 1999). The exposure to traumatized material seems to be a specific stressor, which is different from other high demands of work (McCann & Pearlman, 1990, Figley, 1983). McCann and Pearlman (1990) postulated that being exposed to graphic details of human cruelty and participating in "traumatic re-enactments" with traumatised clients in therapy can have negative effects on the therapist that are qualitatively different than when working with other client populations. Research findings have shown that professionals working with survivors of trauma are susceptible to having personal emotional responses and suffer from symptoms such as crying, sleeplessness and feelings of horror, disruptions of beliefs, withdrawal, depression etc. (Pearlman and Saakvitne, 1995, Urquiza et al., 1997).

Literature on the impact of the work on professionals initially addressed attitudes and perceptions (Gore-Felton et al., 1999, Bolen, 2001, Wagner et al., 1993, Johnson et al., 1990, Hartman et al., 1994) whereas in the last 15 years there seems to have been greater focus on specific feelings and even symptoms that trauma work might trigger in therapists. As a result, many writers have used different terms to describe the effects of working with trauma. McCann & Pearlman (1990) have chosen the term, vicarious traumatisation (VT) and, based in constructivist self-development theory, described the disruptions that such work has on therapists' frames of reference about the world, to his/her sense of identity, control, safety, esteem and intimacy. These changes give rise to symptoms of intrusive imagery and painful affect. The construct was initially intended to describe the effects of working with survivors of sexual abuse.

Figley (1983) on the other hand used the term secondary trauma/compassion fatigue and defined it as "the emotional duress experienced by persons having close contact with trauma survivors". The topic of secondary trauma/compassion fatigue and vicarious traumatisation by Figley, (1995) and McCann and Pearlman, (1990) respectively has raised many concerns regarding the practice of trauma work (Collins and Long, 2003). According to Stamm (1997) the great controversy about helping induced trauma is not whether it can happen but how we should call it. A reading of the literature suggests that the problem of defining the impact of trauma work has huge implications in researching this field, as it will be explained later.

Defining terms: vicarious trauma and secondary trauma/compassion fatigue

Although secondary trauma/compassion trauma and vicarious trauma are similar in resulting from exposure to interpersonally demanding jobs, they do differ as constructs (Jenkins and Baird, 2002). Vicarious traumatisation is salient for therapists who help victims of sexual assault or survivors of child sexual abuse. It is founded within a constructivist personality theory, which emphasises the role of meaning and adaptation and contrasts with secondary trauma/compassion fatigue that focuses primarily on symptoms (Pearlman and Saakvitne, 1995). In particular, vicarious traumatisation refers mainly to disruptions in cognitive schemas such that represent psychological needs of safety, trust, esteem, intimacy and control (Pearlman, 2003). Whereas secondary trauma/compassion fatigue was first defined by Figley, 1983 (cited in Jenkins and Baird, 2002) as the "emotional duress experienced by persons having close contact with trauma survivors, especially concerned family members, a natural response to a survivor's traumatic material with which the helpers may identify and empathise" (Jenkins and Baird, 2002, pg 424). According to Figley (1995) the symptoms of secondary trauma are identical to PTSD symptoms. Although the term "secondary trauma" was initially used by Figley, it has now been renamed as compassion fatigue and a burnout aspect was more recently incorporated into its theoretical base (Jenkins and Baird, 2002) although it is not clear whether the construct of compassion fatigue is unitary or composed of two distinct domains (Figley and Stamm, 1996 cited in Jenkins and Baird, 2002).

Vicarious traumatisation differs from burnout since it is specific to trauma therapists and according to Pearlman and Saakvitne it is not simply "emotional exhaustion resulting from the stress of interpersonal contact" (Maslach, 1978). While burnout

involves exhaustion and emotional numbing, vicarious traumatisation is characterised by hyper vigilance, which may lead to an increased sensitivity to violence, cynicism or pervasive grief and sadness. According to the above authors its effects are specific, pervasive and predictable according to the psychology of the individual therapist. The effects of vicarious traumatisation seem extremely serious since they can affect a therapist's ability to live fully, to love, to work, to play, to create and can set the stage for burnout due to therapist's loss of sense of effectiveness as a helper and demoralisation (Pearlman and Saakvitne, 1995).

According to Pearlman and Saakvitne (1995) there are two components that make therapists vulnerable to vicarious traumatisation: their willingness to help and their empathic connection with trauma clients. However, they report that the actual impact of vicarious traumatisation will be determined by the unique interaction between the **situation** (i.e. number of clients, nature of trauma etc) and **the person of the helper** (i.e. professional identity, personal history, support etc).

As clinicians have become more aware of the impact of working with clients who have traumatic life experiences there is a need to develop instruments that would assess such impact. Among the number of trauma-specific instruments that were developed, two of them have been most popular in terms of measuring vicarious trauma and secondary trauma. The Trauma and Attachment Belief Scale (TABS), previously known as Traumatic Stress Institute Belief Scale (TSI) measures vicarious trauma (Pearlman, 2003) and the Compassion Satisfaction and Fatigue Scale (ProQol) that measures secondary trauma/compassion fatigue (Stamm, 1955-2002). These

scales were also used in this study and thus will be described in greater detail later in Chapter 3 (Method).

Empirical evidence on vicarious trauma, secondary trauma and sexual abuse

Several authors reported that human-induced trauma such as sexual abuse might be even more difficult for the clinician than naturally caused trauma (Herman, 1992, Janoff- Bulman, 1992). There is growing literature on the effects of vicarious traumatisation and secondary trauma on trauma therapists and specifically on therapists who work with survivors of sexual abuse (Follette et al., 1994, McCann and Pearlman, 1990, Shauben and Frazier, 1995, Pearlman and McIan, 1995, Neumann and Gamble, 1995, Shapiro et al., 1999, Lyndall and Downing, 1998, Bober and Regehr, 2006) as well as on the impact of CSA work on the professional and personal lives of practitioners who were abused as children (Elliot and Guy, 1993, Jackson and Nutall, 1994, Kassam-Adams's, 1995, Follette et. al., 1994).

For example, Pearlman and McIan (1994) conducted a study on 188 self-identified trauma therapists finding significant disruptions in their beliefs about self and others (as measured by TABS) as well as distressing psychological symptoms that resulted from their clinical work with trauma survivors. They also found that therapists with personal trauma histories reported more difficulties with client material than those without. Interestingly, among therapists with a personal history of abuse those who were more experienced in the field experienced less disruption than survivor therapists new to the field.

Follette et. al., (1994) surveyed mental health and law enforcement professionals who provided services to sexually abused individuals. They found that mental health professionals reported moderate levels of personal stress whereas law enforcement professionals reported higher levels of personal stress and unhelpful coping styles. In addition those who had a personal history of victimisation reported significantly higher levels of personal stress.

Also Shauben and Frazier (1995) found that female sexual violence counsellors with higher percentage of trauma survivors in their caseloads reported more disrupted beliefs in the form of higher ratings on five subscales of the Trauma and Attachment Belief Scale (TABS). In contrast to the previous two studies therapists with a victimization history did not show more signs of distress than those without such history. Bober and Regehr (2006) also found that the time spent with counselling trauma victims was the best predictor of trauma scores. Findings from Brady et al., (1999) are also consistent with findings from Shauben and Frazier's (1995) study since they found that women psychotherapists who had more sexually abused clients in their caseloads were more likely to exhibit trauma symptoms themselves.

Another study by Farrenkopf, (1992) exploring vicarious trauma and burnout among 94 Canadian therapists who worked with sex offenders reported no significant difference between participants on the TSI scale (which is the former version of TABS used in this study) and those of a criterion reference group of mental health professionals. Also no relationship was found between variables such as time working in the field and perceived exposure to graphic details of trauma with the measure of vicarious traumatisation, which contradicts results from the other studies such as

Pearlman and McIan, 1994, Shauben and Frazier, 1995 (http://www.fsu.edu/ trauma /v9/ vicarioustrauma.pdf.). Care must be taken, however before any firm conclusions are drawn from the results of this study since there seem to be limitations regarding the criterion group that was used. It is unclear if direct or indirect exposure to trauma among professionals in the criterion group was adequately controlled for. There seems to be a difference in the treatment of sexual offenders compared with victims of sexual abuse since the interactions between the therapist, offender client and society produce a unique pattern of empathic engagement and disengagement that may be somewhat different than with non- offender clientele (Farrenkopf, 1992).

According to a review by Pearlman, (2003), Cunningham, (1997), conducted a study in which TABS scores were compared between social workers working with sexual abuse survivors with those working with cancer patients. She found that the former group had more cognitive disruptions as shown by elevated scores on Safety, Other-Trust, Other-Esteem scores than the professionals who worked with cancer patients. Pearlman (2003) also reports similar results that were found by Lobel (1997) who assessed the impact on cognitive schemas on therapists who treated women raped in adulthood and by Simonds (1997) and Walton (1997), who also found elevated TABS scores in therapists working with sexual abuse trauma and general trauma respectively.

Rich (1997) conducted an investigation of vicarious traumatisation among therapists working both with survivors and perpetrators of sexually violent crime and found that sixty-two percent of participants identified themselves as suffering from vicarious trauma. However, the fact that therapists identified themselves as suffering from

vicarious traumatisation rather than using objective measures, limits conclusions and the validity of the results of this study, since each professional might perceive or experience vicarious traumatisation differently and since vicarious traumatisation is often confused with symptoms of burnout or secondary trauma.

Finally, one study was identified that focused on mediating variables between trauma work and the development of vicarious traumatisation. This was conducted by Brady et al., (1999) and examined the relation between vicarious traumatisation and spirituality in 446 female psychotherapists. Although they did not find a link between greater exposure to traumatic material and elevated TABS scores, they did find that higher TABS scores were related to a reduced sense of spirituality. Moreover, Regehr et. al., (2002) conducted a study on a convenient sample of paramedics (N= 86) within an emergency service organisation looking at exposure to traumatic events and levels of distress. The study included both quantitative (measures of exposure to traumatic events and level of distress) and qualitative components (semi-structured interviews with 18 paramedics). What was an interesting finding from the interviews with the paramedics was that the events that according to them had the greatest effect on them were those that the paramedic developed an emotional connection to the individual and thus moved beyond a cognitive understanding of the loss or suffering to experiencing empathy (Regehr et. al., 2002). If we are to think that empathy is almost one of the basic prerequisite in any type of psychological therapies including therapeutic work with traumatised individuals then there is a possibility that the levels of vicarious trauma in therapists might be determined or correlated with their levels of empathic connection to the traumatised clients. Such results show how important it is for researchers to examine other variables that could contribute to elevated TABS

scores rather than focus only on the exposure of the professional to traumatic material or to the type of traumatic material.

As far as secondary trauma/compassion fatigue is concerned most studies seem to describe symptoms of secondary trauma in various groups of trauma professionals and the effects of secondary trauma seem to have been examined in relation to trauma work generally rather than specifically to sexual abuse work. In particular, Cornille and Meyers (1999) report that 37% of 183 child protection service workers showed clinical levels of secondary traumatic stress. Lansen (1993) asked the directors of 25 treatment centres for torture victims to rate the frequency of PTSD like symptoms regarding their own staff and 10% of the professionals showed secondary trauma symptoms.

Another study was conducted on 25 professionals of the treatment centre for torture victims in Berlin in order to determine the severity of compassion fatigue and burnout symptoms as well as to examine the relationship between the kind of work (psychotherapy, administration etc) in relation to symptoms of compassion fatigue and burnout (Angelika Birck, 2002). The results of this study indicated a low risk for burnout whereas the risk for compassion fatigue was increased. It was also found that compassion fatigue increased with the number of years spent in trauma work and therapists showed higher compassion fatigue than other professionals. Surprisingly, long working hours did not seem to increase the risk for compassion fatigue as previous studies have showed (Cornille & Meyers, 1999, Kassam-Adams, 1995).

Collins and Long (2003) conducted a longitudinal study on 13 healthcare workers working for a trauma and recovery team set up to help those traumatised by the Omagh bombing (15 August, 1998). The analysis of the quantitative data they collected indicated that levels of compassion fatigue and burnout increased over the first year, while levels of satisfaction with life and life status decreased (Collins and Long, 2003).

Stamm (1997) offers a comprehensive review for work-related secondary traumatic stress in which he includes selected abstracts, comprehensive texts and additional citations on the topic. More reviews of relevant research and literature on secondary traumatic stress and related variables have also been published recently (Hesse, 2002, Salston and Figley, 2003). These reviews together with the studies presented above show that there are particular difficulties when researching the topic of the impact of trauma work as well as drawing conclusions from reviewing the relevant studies. Such difficulty seems to derive from a lack of differentiation in research studies of the various concepts proposed (i.e. secondary trauma, vicarious traumatisation, countertransference and burnout), term definition problems and also a huge overlap between different aspects of these concepts (Stamm, 1997, Hesse, 2002).

This review on the impact of CSA work on the worker would seem incomplete or even biased if the positive impact of this work is not mentioned. Although literature has highlighted the possible negative impact (vicarious trauma and secondary trauma) of working with survivors of sexual abuse that doesn't mean that there are no positive aspects of this work and a positive impact. Recent literature reviews have highlighted together with the negative impact of such work the positive aspects of sexual abuse

work, including the satisfaction of witnessing client resilience and personal growth as well as a great sense of the importance of the service provided (Salston and Figley, 2003). McCann and Pearlman (1990) discuss the positive impact of working with trauma survivors, which includes the depth of meaning given to one's life by being involved in such work, increased self esteem from helping survivors and hopefulness about the capacity of human beings to endure, overcome and transform traumatic experiences. Raphael et al., (1983-1984) examined disaster response workers attending the Granville rail disaster in Australia and they found that 33 out of 95 respondents reported feeling more positive about their lives as a result of their work.

Jennie Goldenberg, (2002) conducted an exploratory qualitative study on eighteen interviewers of Holocaust survivors regarding the impact of interviewing trauma survivors on the interviewer. She found that there was more positive than negative impact on the researchers and these included an increase in empathy and sensitivity towards others, gratitude for one's own good fortune and greater sensitivity to prejudice. However, this study examined the impact on the interviewer and not on the therapist, it was a small sample, consisting mostly of females and only one male interviewer and it involved interviews with Holocaust victims which could be different to other types of survivors, i.e. survivors of sexual abuse.

Another study by Linley et. al. (2005) was conducted in an international sample of 85 therapists. Participants completed measures of their trauma work experience (through a measure of their work with trauma clients), their sense of coherence (through a 29-item self report measure of one's general orientation in life) and positive and negative changes (through a 26 item self report measure) they experienced as a result of their

work. Their results showed that a greater sense of coherence (i.e. higher scores on Coherence scale) was significantly associated with higher scores on positive changes. These findings indicate that a sense of coherence may be a useful construct that helps the conceptualisation of factors that influence positive adaptation to trauma.

Some studies refer to positive effects of doing specifically work with sexually abused clients. Shauben and Frazier (1995) assessed the effects on female mental health professionals of working with sexual assault survivors and their results showed that over 45% reported enjoyable aspects of working with this population, which included witnessing client resilience and personal growth. Steed and Downing (1998) conducted semi-structured interviews, which explored therapists' responses to traumatic material and although they highlight the danger of vicarious trauma they also report that the work increased therapists' self -awareness and impacted positively on their sense of spirituality and meaning. Finally, Collins and Long (2003) conducted a longitudinal study examining the caregivers experiences on working with seriously traumatised people and reported that many participants gained great satisfaction seeing clients recover.

Generally there seems to be a growing interest in trauma literature on the positive effects of traumatic events on people and in particular on the experience of posttraumatic growth (Linley, 2003). Joseph and Linley, (2005) describe a positive psychological theory, the" Organismic Valuing Theory of Growth through Adversity" which talks about the ability of people to adapt positively following trauma. A key element of this theory is the extent to which our social environment determines our reactions to trauma. This theory is in accordance with what Christopher (2004)

postulates starting from the fundamental premise that the normal outcome of traumatic stress is growth rather than pathology and he says that psychopathology arises only when people are unable to deal properly with the stress responses (Christopher, 2004). Taking into account these positive psychological theories, one could wonder whether these also apply in the case of professionals who are indirectly exposed to traumatic material through their clients. This seems definitely a growing area within trauma literature and hopefully further studies will be conducted to shed some light on the positive side of doing trauma work.

In summary, there seem to be a number of studies that focus on the negative impact of working with survivors of trauma and specifically sexual abuse, which highlight the importance of good training, personal growth and protective mechanisms for the worker. As a result of such research on vicarious trauma and compassion fatigue/secondary trauma there is a danger of considering trauma work and sexual abuse work dangerous or too difficult to engage in and thus professionals might try to avoid it. However, there are studies (Steed and Downing, 1998, Goldenberg, 2002, Collins and Long, 2003, Shauben and Frazier, 1995, Linley et.al, 2005) and theories (Christopher, 2004, Joseph and Linley, 2005) that highlight the number of positive effects and levels of satisfaction that such work brings to the professional and so we need to be careful before we reach any conclusions. Perhaps more research is needed to explore the particular interpersonal variables that contribute to the development of vicarious trauma or secondary trauma. Also different types of traumas might create different dynamics in therapy and so one should be careful before generalising results that come from studies on trauma from natural disasters comparing to sexual abuse or physical abuse. The sample of the different studies play an important role as well

since different professional groups might respond differently according to their training or theoretical orientation.

In particular, from examining the literature, few studies seem to have focused on specific factors that could contribute to the development of vicarious trauma/secondary trauma such as the percentage of clients in caseload or the time spent in doing trauma work. This study will examine this. Since there is some evidence that the higher percentage of clients with CSA in ones caseload the higher the risk of vicarious traumatisation (Shauben and Frazier, 1995, Brady et. al., 1999, Bober and Regehr, 2006) it is hypothesised that professionals in this study with higher percentage of survivors of CSA in their caseload will be at more risk of both vicarious traumatisation and secondary trauna (please see hypothesis 6 on page 60).

Little attention has been paid to the individual characteristics of trauma work as well as to the characteristics of the professional (i.e. examining the mediating factors between trauma work and vicarious trauma, like therapists' feelings towards this work, the nature of trauma work, therapists' professional identity or other characteristics that make therapists vulnerable to vicarious traumatisation or secondary trauma). This seems to be very important since Pearlman and Saakvitne (1995) who first used the term of vicarious trauma, highlighted that it's the unique interaction between the personal characteristics of the therapist and the situation that would determine or contribute to the presence of vicarious trauma rather than the exposure to traumatic material alone. This study will address that need by examining professionals' feelings of comfort and competence in working with sexually abused clients and their relationship to TABS scores (Hypothesis 8, page 58-59). Although

there is no evidence from the scientific literature to show an association between feelings of comfort and competence with symptoms of vicarious traumatisation / secondary trauma it was considered interesting to test whether feelings of comfort and competence could play a protective factor for the professionals and as a result the professionals who feel more comfortable or competent would be less vulnerable to vicarious traumatisation (Hypothesis 8). In addition, following from the above it was thought that therapists who ask more frequently would be the ones who feel more comfortable and so they would be at less risk of vicarious trauma/secondary trauma (Hypothesis 7, page 60)

This study hopes to fill an additional gap in the literature by highlighting the distinction between vicarious trauma and secondary trauma through measuring these two concepts separately with valid and reliable scales (Pearlman 2003, Stamm, 1995-2002). Measuring both vicarious traumatisation and secondary trauma in psychologists/psychotherapists who work with adult clients particularly would help in distinguishing whether the former are struggling primarily with the cognitive impact of trauma work (vicarious trauma) or whether they suffer from PTSD symptoms (compassion fatigue/secondary trauma) and negative experiences with clients who have suffered a specific type of trauma-child sexual abuse.

Also, having as a sample participants who have exclusively trained in psychological therapies (i.e. clinical or counselling psychologists / psychotherapists / therapists) would give a clearer picture for this particular professional group. Finally, this study hopes to shed some light in terms of the impact of sexual abuse work when the worker does not exclusively engage in trauma work.

Aims and Hypotheses of this study following the review of literature

Working within the context described above and reflecting on my own work I have tried to develop a plan for an empirical study based on my initial questions, ongoing reflections and readings of the scientific literature. Reviewing the literature I identified studies that have researched three major issues separately (1. the issue of enquiring about sexual abuse, 2. how comfortable/confident professionals feel enquiring and 3. the impact of CSA work on the therapist in terms of the development of symptoms of Vicarious Traumatisation and Secondary Trauma). My study intends to examine the above in a combined way and identify possible links between them. Additionally, as was discussed in literature review an extended literature search in libraries including the British Library, the Institute of Psychiatry, City University Library as well as electronic databases has identified a few studies that refer to clients' experiences on the issue of enquiry or disclosure of abuse but which still don't address particularly the issue of initial enquiry during an assessment (Josephson and Fong-Beyelle, 1987, Etherington, 1995, Dale, 1999 and Devon, 2003). Therefore it is an important contribution of this study that clients will be asked to report their thoughts regarding being asked about CSA experiences during an initial assessment.

Aims of this study:

- To explore psychologists'/psychotherapists' views and practices regarding routine enquiry of CSA during an assessment.
- To explore how psychologists/psychotherapists feel working with CSA survivors as well as how comfortable, competent they feel enquiring/treating CSA.

- To explore clients' thoughts regarding being asked about CSA during an assessment.
- To examine the development of vicarious traumatisation, secondary trauma to psychologists/psychotherapists who work with survivors of CSA but who don't exclusively do trauma work or sexual abuse work.

Specific Hypotheses and Questions of this study

Although this is an exploratory study the following hypotheses that relate to the three main aims that were discussed above were formed as a result of the review of the literature on this topic. Each hypothesis is followed by a specific prediction or a number of specific predictions. A hypothesis about clients was not formed. Although clients' attitudes were considered a very important part of the research study, because the topic has not been explored extensively previously, it was thought that a number of questions rather than hypotheses would better assist the process of exploring clients' views on the specific topic (please see last paragraph of this section).

Enquiry of child sexual abuse

Hypothesis 1: Most professionals will report that the assessment of psychiatric patients should not include questions about sexual abuse or will report that they think the assessment of clients should include questions about child sexual abuse only sometimes.

Prediction 1: The highest percentage of professionals will choose the option "no" or "sometimes" on question 13 of the therapists' questionnaire (P-SQAPRESA, appendix C).

Hypothesis 2: Most professionals will report that they do not enquire about CSA or that they enquire only some of the time.

Prediction 2: The highest percentage of professionals will choose the option "sometimes" or "never" on question 17 of the therapists' questionnaire (P-SQAPRESA, appendix C).

Hypothesis 3: Most professionals who would report that they enquire about sexual abuse they would say they think it is best to do this during therapy.

Prediction 3: The highest percentage of professionals would circle the second choice of question 18 of the therapists' questionnaire, which is "later in therapy" (P-SQAPRESA, appendix C).

Hypothesis 4: A significant association will be found between professionals' levels of feeling comfortable/competent enquiring about CSA and the frequency in which they say they enquire.

Prediction 4: Scores from the Likert-scales of questions 22 and 24 of professionals' questionnaire (P-SQAPRESA) will be significantly associated with scores on question 17 of professionals' questionnaire (P-SQAPRESA).

Emotional responses to the work with CSA survivors.

Hypothesis 5: Most clinicians will state that they do not feel comfortable or competent enquiring about sexual abuse or treating sexual abuse clients.

Prediction 5: The largest proportion of clinicians will score 1 or 2 (1= not at all comfortable/competent and 4= extremely comfortable/competent) on the Likert scales

of questions 22, 23, 24 and 25 of the professionals' questionnaire (P-SQAPRESA, appendix C).

Impact of CSA work/enquiry in terms of Vicarious Traumatisation and Secondary Trauma

Hypothesis 6: Professionals who have more CSA clients on their caseloads will be at more risk of vicarious traumatisation and secondary trauma.

Prediction 6a: A significant association is expected between the percentage of CSA clients on professionals' caseload (question 10 of P-SQAPRESA) and the total score of TABS that measures vicarious traumatisation.

Prediction 6b: A significant association is expected between the percentage of CSA clients on professionals' caseload (question 10 of P-SQAPRESA) and the scores of the two subscales of ProQol that measure burnout and secondary trauma.

Hypothesis 7: A significant difference is expected between the frequency in which professionals enquire about sexual abuse and symptoms of vicarious trauma and compassion fatigue/secondary trauma.

Prediction 7: Professionals who would report that they "always" or "sometimes" enquire about CSA (question 17 of P-SQAPRESA) will have a significantly different total score on Vicarious Trauma scale (TABS) and on the two subscales of ProQol (burnout and secondary trauma) than those who would report that they "never" enquire (question 17 of P-SQAPRESA).

Hypothesis 8: A significant difference will be found between levels of comfort/competency professionals say they feel about enquiry/treatment of CSA and symptoms of Vicarious Trauma and Secondary Trauma.

Prediction 8: There will be significant differences on total scores of TABS and on the two subscales of ProQol (burnout and secondary trauma) between professionals who score 1,2,3 and 4 on Likert scales of questions 22,23,24 and 25 of P-SQAPRESA (score of 4= feel extremely comfortable/competent, score of 1= don't feel comfortable/competent at all)

In addition, how demographic variables impact on the above hypotheses will be further explored. Finally, the following questions will be examined: What ways therapists use to enquire about sexual abuse? How do they generally feel about CSA work? What reasons therapists give for enquiring or not enquiring about sexual abuse during an initial assessment? What do professionals believe regarding their training on sexual abuse work and the contribution of personal therapy to this type of work? What do clients believe about sexual abuse enquiry during an assessment? Do they mind being asked? How do clients prefer to be asked? Do they consider such an enquiry important for their therapeutic plan? Is there a difference on attitude about enquiry between abused and non-abused clients? These are points for exploration and no specific hypotheses are generated as already mentioned previously.

CHAPTER THREE: Method

This study was designed to explore the attitudes and practices of therapists regarding routine enquiry of sexual abuse during assessment, their feelings regarding such work and the impact of such work on them. This study also explored clients' attitudes regarding routine enquiry for sexual abuse and how they thought this should be done.

Participants

The sample consisted of two sets of participants: 72 therapists and 60 clients.

Sample of Therapists

Two hundred professionals were invited to participate. A list with all the names and addresses of the psychologists/psychotherapists who work in the Trust was used to assist this process. According to this list 200 professionals worked with adult clients in the Trust, after excluding the ones who worked within the child and adolescence services. Questionnaires were sent out to all of them (for details please see result section).

Inclusion criteria involved the following: professionals had to be either clinical or counselling psychologists/ psychotherapists or therapists who worked with adult clients both inpatients and outpatients and across different specialities (i.e. learning difficulties, addictions, forensic, older adults etc). The term "therapists" in this study was defined as mental health workers who have trained in one or more psychological therapies. Professionals who worked within the child and adolescent sectors were excluded from the study because the study focuses on practices and attitudes of professionals regarding the work with adult survivors of sexual abuse.

Sample of Clients

Sixty clients took part in this study. Sixty two percent (37/60) were female and thirty eight percent (23/60) were male. The age of the participants ranged from twenty years old to sixty years old with a mean age of thirty- five years. Since the researcher had access to one borough, clients from this particular borough were invited to participate and so the sample was one of convenience. Inclusion criteria for clients to participate in the study were: Clients had to be adult outpatients, already assessed and been put in a waiting list for talking therapy or already be in therapy. Clients who were in crisis or acutely psychotic were excluded from the study.

The recruitment of clients was different from that of therapists. Clients were identified through therapists. The initial step was that the researcher personally approached all psychotherapists/psychologists/therapists who worked in the borough. The researcher then asked for their permission to approach some of their clients and their advice as to which clients could be approached. Such advice was necessary from an ethical point of view since considering the questions there was a possibility for a client to become emotional and so the client needed to be in a stable condition and not currently suicidal or in crisis. After taking criteria of emotional vulnerability into account, therapists were requested to ask all their clients and instead of choosing who would be more suitable according to them (i.e. not to choose simply those who had PTSD diagnosis or those who had been sexually abused). The therapists, who gave permition for their clients to be approached, first asked the identified clients if they would be interested in participating in this study. The clients, who agreed to participate, were asked to attend the centre for their next therapeutic session fifteen minutes earlier in order to meet the researcher before the session. The psychologists then informed the

researcher and gave the dates and times that clients agreed to attend fifteen minutes earlier.

Measures

The study incorporated both standardised measures and questionnaires specifically designed to meet the aims of the study. Qualitative items (open-ended questions) were also included.

Professionals' questionnaire- P-SQAPRESA [Sotrillis Questionnaire on Attitudes and Practices of Routine Enquiry for Sexual Abuse **(appendix C)**].

The questionnaire (P-SQAPRESA) that was designed particularly for this study was based on previous work by Lab et al., (2000) who also designed a questionnaire on Attitudes to Assessment of Sexual Abuse for Male clients (APASAM). P-SQAPRESA was asking professionals about their attitudes and practices towards enquiring about sexual abuse in general (see appendix C). The P-SQAPRESA included some items that were also used in APASAM, adjusted to meet the needs of this study since Lab's et al. study referred mainly to routine enquiry of sexual abuse to male patients, whereas this study referred to both male and female clients. Therefore the adjustments that needed to be done on some of the items referred to the following: whenever the questions mentioned the word "male" this was omitted (i.e. the question " Do you feel that the assessment **of male** psychiatric patients should include questions about sexual abuse?" changed to "Do you feel that the assessment of psychiatric patients should include questions about sexual abuse?). P- SQAPRESA is comprised of 37 questions in total and is divided into three sections.

Specifically, the first part of P-SQAPRESA refers to demographic characteristics of the sample (q.1-11). Similar questions to those in APASAM (Lab et. al., 2000) were included in this section, which asked participants to state their profession (i.e. counselling psychologist, clinical psychologist, trainee etc) and the number of years they had worked in the mental health field. The questions that were added to P-SQAPRESA and were not included in APASAM, requested the gender of participant, the age, the specific area in which the participant worked (i.e. eating disorders, addictions, adult mental health etc), their theoretical orientation and whether the participant worked full-time or part-time. Also a question requesting the percentage of sexually abused clients in the participant's caseload was included. These questions were added since the researcher wanted to explore how such variables might affect professionals' practices or attitudes about CSA enquiry. Moreover, knowing the theoretical orientation of the participants was considered important, since that could influence participants' answers regarding assessment procedures (i.e. some models of therapy like psychodynamic psychotherapy an assessment is not conducted like in Cognitive Behavioural Therapy).

In addition, in the demographic section a question was included regarding the proportion of PTSD clients that respondents have in their caseloads. The rationale behind including such a question was the following: one of the aims of this study was to explore symptoms of secondary trauma/compassion fatigue (CF) and vicarious trauma (VT) and whether such symptoms were more evident in therapists who had higher number of sexually abused clients in their caseloads. Therefore knowing the proportion of PTSD cases for each therapist as well as the proportion of sexually abused clients would allow for a better understanding and differentiation of a

correlation between symptoms of vicarious trauma (VT) or compassion fatigue (CF) and the number of PTSD and a correlation between symptoms of VT or CF and the number of sexually abused clients that are seen by a therapist.

The second part of P-SQAPRESA includes questions regarding attitudes and practices on assessing child sexual abuse (q. 12-29). Similar to APASAM participants were asked to state whether they thought that sexual abuse questions should be included in an initial assessment, to state their reasons for agreeing or disagreeing with that, whether they do ask clients about CSA experiences, how often they ask and to report the ways that they use when they ask about CSA (i.e. give questionnaire, wait for the client to bring it up etc). The additional questions that were included in P-SQAPRESA and were not in APASAM requested professionals to state whether they preferred to enquire about CSA during an assessment or during therapy and what they thought was the most important thing when enquiring (i.e. the wording of the questions, the non-verbal communication etc). Also separate questions were included in this section to measure therapists' feelings regarding sexual abuse work, utilising Likert scales. (q.22-26 and q.29). Specifically these questions were designed to measure feelings of comfort and competence both in treating sexually abused clients and in enquiring about sexual abuse. Question 29 addressed general feelings on treating sexual abuse clients such as level of satisfaction, perceived difficulty etc.

Finally the third part of the questionnaire refers to attitudes about participants' training (q. 30-36). Like in APASAM, in P-SQAPRESA were also included questions that invited participants to report whether they had received any specific training on assessment or treatment of sexual abuse and whether they thought the topic of sexual

abuse was adequately covered in their training. However, additional questions were included in P-SQAPRESA that requested participants to state what they would regard as sufficient for therapists to gain skills in assessment and treatment of sexual abuse as well as questions on personal therapy and whether professionals considered them important when working with CSA clients.

In order to obtain participants' own insights and obtain a clearer picture of their answers, the following open-ended questions were included in the professionals' questionnaire (P-SQAPRESA). Questions 14, 15 and 16 requested participants to explain the reasons why they thought the assessment of adult clients should always include, should never include or sometimes include questions about sexual abuse. These questions were considered crucial for this study since they aimed to give an explanation and a better insight into the practices of professionals regarding enquiry of sexual abuse. Question 12 asked participants to write their own definition of sexual abuse. The term "sexual abuse" was not defined on the questionnaire by the researcher, since the whole questionnaire was about professionals' perspective on sexual abuse work and so it was thought that defining the term for them would automatically limit their perspective since their subsequent answers would be shaped through that definition. What was important for the researcher was to explore attitudes and practices regarding sexual abuse work as it is experienced and constructed from the participants' perspective and so it was their notion of sexual abuse that was important not the actual definition. Finally question 34 requested participants to write their thoughts in terms of how personal therapy of the therapist could be helpful or sometimes helpful to the work with sexually abused clients. Question 37 was the last

question in P-SQAPRESA and leaves a blank space for participants to include any additional thoughts or comments they had during the completion of the questionnaire.

A lot of time was devoted designing the questionnaire (2 and half months) since the validity of the method of the study depends on the type of questions asked and therefore suggestions that arose from research literature have been followed (Robson, 1994). Such suggestions included the use of specific rather than general questions, careful wording and question order and good design and layout. Moreover, an effort was made by the researcher to tackle the common problem of discrepancy between what people report they do and what they actually do by the use of asking multiple questions on a topic (Robson, 1994). For example there were three different questions on the topic of enquiry, one referring to attitudes and the other two to actual practices. For example q.13 says "Do you think the assessment of adult patients/clients should include questions about child sexual abuse?" and later on q.17 asks in a different way " during your work with adult patients/clients do you ask them about possible history of sexual abuse?" and q.18 "if you do enquire do you do this during assessment or later in therapy?".

<u>Additional scales used (see **appendix E** and **appendix F**)</u>

The Professional Quality of Life Compassion Satisfaction and Fatigue Subscales, (ProQol, Stamm, 1995-2002) and the Trauma and Attachment Belief Scale (TABS, Pearlman, 2003), which are described below were used to measure symptoms of compassion fatigue/secondary trauma and vicarious traumatisation respectively. These particular scales were chosen because the concept of the impact of trauma work on the worker is quite recent and these two scales seem to have developed as a result

of the paucity of measures that addressed the possibility of such impact on the worker. In particular, Figley (1983) was the first who defined secondary trauma and who later introduced the term "compassion fatigue" in relation to PTSD, whereas Pearlman and her colleagues on the other hand were the ones who defined Vicarious Trauma (VT) using constructivist self-development theory and are the main and most frequent contributors in relation to the impact of patient trauma on general health care providers. Moreover, these scales were chosen since most of previous studies that explored the impact of trauma work on the therapist have also used them and so comparisons between the results of this study and those of previous research would be possible.

The **Compassion Satisfaction and Fatigue Scale,** was first published 12/02 and was shortened and improved on 4/03. It was later named ProQol, **the Professional Quality of Life Compassion Satisfaction and Fatigue Subscales, R-III (Stamm, 1995-2002) (see appendix F)**. The shorter version of the scale was used in this study, which has 30 items (Stamm, 1995-2002). The scale comprises of three subscales, *the Secondary Trauma/Compassion Fatigue* subscale, *the Burnout* subscale and the *Compassion Satisfaction* subscale. *The Secondary Trauma/Compassion Fatigue* subscale refers to the risk of the worker to develop PTSD like symptoms as a result of indirect exposure to traumatic material in work. The average score of this subscale is 37. A score that exceeds 40 means that the risk to develop compassion fatigue is high whereas a score below 32 means that the risk is low (Stamm, 1995-2002). *The Burnout* subscale reflects feelings of hopelessness or difficulties in dealing with work effectively, feelings that your efforts make no difference and can be associated with very high workload or non-supportive work-environment. The average score of this

subscale is 23 and a score that falls below 19 reflects positive feelings about work and the ability to be effective whereas a score above 28 reflects the presence of burnout (Stamm 1995-2002). Finally, the *Compassion Satisfaction* subscale was added to the new version based on developing theory of positive effects of caring and refers to the pleasure that professionals derive from being able to do their job well and contribute to the work setting and to society. The average score of this subscale is 37 and scores higher than 41 reflect good deal of professional satisfaction whereas scores below 32 reflect less job-satisfaction (Stamm 1995-2002).

The psychometric properties of the revised, shorter version are Compassion Satisfaction alpha=.82, Burnout alpha=.71 and Compassion Fatigue alpha=.78. While these are somewhat lower than the original test (Comp.Sat. alpha=.87, Burnout alpha =.90, Comp.Fat. alpha=.87) given that the scales are shortened by half in length, these scores are actually more reliable than the longer form (according to Spearman Brown Formula if original reliability was.82 a comparable reliability on a shortened scale would be .69). The measure has considerable improvement on the item to scale statistics, due to increased specificity and reduced collegiality (Larsen et al., 2002, www.isu.edu/~bhstamm/tests.htm). For the sample of this particular study a reliability test was performed providing the following results for the total score alpha= .75, N=72. Particularly for the subscales Cronbach's alpha for compassion satisfaction was .86, for burnout was .74 and for compassion fatigue/secondary trauma was .81.

The **Trauma and Attachment Belief Scale** (TABS, Pearlman, 1996) (see appendix E) previously known as the Traumatic Institute Belief Scale (TSI) is an 84-item, 6-point Likert scale (1=strongly disagree, 6=strongly agree) and measures disruptions in

five need/schema areas for self and others (safety, trust, esteem, intimacy, and control), yielding a total score and ten subscales. In terms of the individual subscales these refer to *Self-Safety* (high scores indicate that people might worry that they will be victimised or harmed by another person), *Other-Safety* (elevated scores mean that people are worried about the safety of loved ones), *Self-Trust* (high scores indicate that people struggle to trust their own judgments and might heavily rely on others), *Other-Trust* (elevated scores show difficulties forming trusting relationships and suspect others' motives at every turn), *Self-Esteem* (high scores indicate disruptions in the sense of self-worth and experiencing a sense of shame), *Other-Esteem* (people who score high might view others with disdain and disrespect and expecting a negative evaluation from others), *Self-Intimacy* (people who have an elevated score cannot spend time alone and have difficulties with self-reflection), *Other-Intimacy* (high scores indicate that one is disconnected and isolated from others), *Self-Control* (high scores indicate fears of loosing control over one's emotions or behaviours) *and Other-Control* (elevated scores indicate the need to be in charge and cannot allow others to have autonomy). Generally a higher score on the above subscales indicates greater disruption. In particular, a score between 45-55 is considered average, between 56-50 is considered high average and between 60-69 very high, whereas a score within the range 40-44 is considered low average and between 30-39 very low (Pearlman, 2003).

Pearlman's review of unpublished studies reported overall internal consistency reliability (Cronbach's alpha) of .91 (Jenkins and Baird, 2002). Jenkins and Baird, in their study reported, Cronbach's alpha for the total score .95 and for the subscale alphas varied from .62 to .83 (Jenkins and Baird, 2002). In this study, Cronbach's

alpha for the total score (N=72) was .93 and for the 10 subscales, alphas varied from .52 to .84.

Clients' Questionnaire: C- SQACRESA (Sotrillis Questionnaire on Attitudes of Clients on Routine Enquiry of Sexual Abuse), (see **appendix D)**

A separate questionnaire (C-SQACRESA), which included questions regarding perceived acceptability and relevance of therapists enquiring about sexual abuse, was constructed following the suggestions from the research literature in which it is suggested the use of specific questions, careful wording and good layout (Robson, 1994). The C-SQACRESA was designed to be very brief (5 minutes completion time) and comprised of 12 questions in total (see appendix D). The first three questions referred to demographic characteristics of the respondent (i.e. gender, age, ethnicity) and the rest of the questions (4- 12) referred to attitudes and feelings on being asked about experiences of sexual abuse during an initial assessment apart from q.4 that referred to other enquiries as well as sexual abuse. Specifically, the fourth question asked respondents to state whether they would or would not mind being asked questions about their family, their relationships, illicit drugs, sexual abuse etc. The reason that the C-SQACRESA started with such a type of general question was to compare whether sexual abuse enquiry would create different feelings than the rest of the enquiries.

Questions 5 and 8 of the C-SQACRESA are the same as questions 28 and 27 of the P-SQAPRESA questionnaire and refer to how the respondent thinks an enquiry of sexual abuse should be done as well as what is important when such an enquiry takes place (i.e. is it the way the therapists asks, the way the therapist responds, etc). The

reason for including the same questions in both questionnaires was that this would allow comparisons between clients' and therapists' beliefs and also it would allow us to see whether current practices are consistent with clients' needs.

The clients' questionnaire (C-SQACRESA) included two open -ended questions one of which is question 9. Question 9 invited participants to state whether a psychologist had ever asked them about experiences of sexual abuse and if that was done appropriately. In case clients said this was not done appropriately the researcher asked them to explain in what way it was not appropriate. Question 11 of the C-SQACRESA asks participants to state whether they have ever disclosed sexual abuse experiences to a therapist and therefore in an indirect way the question reveals whether the person who completed the questionnaire was sexually abused or not. Discussing the inclusion of such a question with both my internal and external supervisor, the discussions paralleled interestingly enough the initial general dilemma and research question that this study wished to address (should we ask people whether they had experiences of sexual abuse or not?). Since this study was initiated because it was felt therapists should routinely ask clients about sexual abuse experiences and since literature suggests that we should not treat such enquiry any different to the rest of enquiries we make (i.e. suicide risk, drug and alcohol history, family history etc) it was decided to include such a question in the clients' questionnaire (C-SQACRESA).

Finally, the last question on C-SQACRESA, is the second open ended question and requests participants to write their own definition of sexual abuse. While it might be argued that this should be the first question it was put last for two reasons: 1) First I thought it might be distressing for clients to start describing sexual abuse at the

beginning and might have prevented them from completing the rest of the questionnaire. 2) Second although I was interested in exploring how each client defines sexual abuse this was not the focus of the study. What mattered was that while clients completing the questionnaire they needed to think things that for them consisted sexual abuse regardless of what that meant for each client.

Piloting the questionnaires of the study

Piloting the questionnaire was important to ensure good comprehension, structure, clarity of wording, simplicity of design and right timing (Robson, 1993). The therapists' questionnaire (P-SQAPRESA) together with the two scales described above (TABS and ProQol) were attached together and given to six counselling psychologists known to the researcher. These therapists didn't work in the same trust where the packets were subsequently distributed. The psychologists were asked to time themselves and note down any difficulties they encountered during completion. No specific problems were noted in the questionnaires themselves, apart from minor changes in the way some questions were worded. Subjects were able to understand directions clearly and according to their feedback the time it took them to complete the surveys ranged from 15 to 25 minutes. After piloting the questionnaire the appropriate amendments were made and so the survey packets were sent to 200 professionals within the Trust.

In terms of the clients' questionnaire (C-SQACRESA) this was given to four people known to the researcher who were not psychologists. They were also asked to time themselves and note any difficulties they encountered while they were completing the questionnaire. The possibility of using colleague's clients or the researcher's clients

was not considered appropriate for ethical reasons (i.e. dual/multiple relationships). By definition, multiple relationships involve at least two roles for the therapist and two for the client (in this case therapist and researcher). The 2002 APA ethics code outlines four domains of potential harm to the client that, if present, would define the multiple relationships as unethical. First is the impaired objectivity of the therapist. Second, the multiple relationships may impair the competency of the therapist. For instance, the addition of a second relationship may add to the therapist's sense of involvement with and responsibility for the client's life. The third domain of potential harm is that the secondary relationship may threaten the client's confidentiality. The last domain of potential for harm is the exploitation of the client by the therapist (2002 APA ethics code).

Procedure

Before the study begun ethical approval was sought from the Trust's ethical committee. An application form was completed and sent to the ethical committee and approval was given three months later (see appendix H). An initial contact was made through a pre-survey e-mail addressed to all psychologists within the Trust, through which the researcher informed therapists and consultants about the study. Moreover, written approval was requested and given by the director of the Borough where the researcher works, in order to allow for clients to be recruited from this borough (appendix I).

Therapists' questionnaires were sent out internally to all psychologists / psychotherapists in the trust. A detailed information letter was attached to both therapists' (appendix A) and clients' questionnaires (appendix B). This indicated the aims of the survey, conveyed its importance, assured confidentiality, encouraged

reply and it was tailored to the target population (Robson, 1994). The information letter explicitly stated that all data collected was voluntary and would be kept confidential and anonymous. Anonymity was essential to ensure an honest response. The cover letter included all the names and details of the people who were involved in this research study and it was attached to the questionnaire and sent to therapists. Participants' consent to participate was confirmed by completing and returning the questionnaire.

The envelope that was sent out to professionals included the information sheet, the questionnaires and a return envelope addressed to the researcher. A smaller envelope was included in which people could write their names and addresses if they wanted to receive feedback on the results of the study (see instructions included in the information sheet). The use of anonymous postal questionnaires for therapists was decided upon to reduce issues of social desirability and the possibility of them faking competence and comfort in working with CSA clients in a face-to-face encounter.

In terms of clients' recruitment, following clients' permission to participate in the study, the researcher attended the different outpatient centres of the borough on the agreed dates that therapists provided and approached clients while they were waiting in the waiting area for their appointment. In particular, when clients arrived in the resource centre and reported to the reception, the researcher approached them, introduced herself and invited the client to follow her in the room that was booked by the client's therapist for the session that was going to follow. The researcher then explained the study to the client privately and highlighted its voluntary nature as well as confidentiality issues. The researcher also stressed to the participants that they

could change their mind at any point during the completion of the questionnaire and simply withdraw from the study without giving a reason and without this affecting their care. The information sheet that was given to them attached to the questionnaire (appendix B), further explained the aims of the study and the voluntary nature of the participation. The client was then left to complete the questionnaire and the researcher let them know where she was in case they wanted to ask any further questions. The researcher was not present while clients completed the questionnaires in order that clients did not feel pressurised to take part in the study. Instead they were instructed to give the questionnaire sealed in the addressed envelopes given to them, back to reception. People in reception of the different resource centres were informed about the study and so when clients were giving questionnaires back to them they were directly putting them in internal mail. This way all questionnaires received were sent to the researchers' work address anonymously through internal mail.

Ethical considerations

The researcher followed the ethical principles for conducting research with Human Participants (BPS, 1991) and covered the main areas of Consent-Confidentiality-Deception-Withdrawl-Debriefing and Protection of Participants. As a result, the researcher ensured that the relevant persons, committees and authorities were consulted and informed and the necessary approval was obtained before the start of the study (Robson, 1993). As already mentioned before, participants were **informed** regarding the nature and aims of the study through an information sheet that was attached to the questionnaires that were given to them (clients were informed both through the information sheet and verbally). Their **voluntary participation** was highlighted and **confidentiality** was stressed. Return of the questionnaires indicated

consent of participation. Additionally, participants were assured that the questionnaires were anonymous and that no identifying information would be used in writing up the research.

In terms of protection of the clients that agreed to take part, they were assured that their participation or refusal to complete the questionnaire would not affect their therapeutic work and since the questionnaires were anonymous there was no way their therapist would know how they answered. Finally, the clients' questionnaire addressed a sensitive issue that could bring up upsetting memories (child sexual abuse) for some clients. Therefore, it was decided that the questionnaire would be given to clients while they were waiting for their therapeutic session in order for any concerns to be addressed and contained immediately in therapy if needed. Clients were advised both verbally and through the information sheet to discuss any concerns or issues that arose from the completion of the questionnaire with their therapist or they could also contact the researcher.

Method of analysis

Combinations of quantitative (i.e. for the scales and closed questions) and qualitative methods (i.e. for the open-ended questions) of analysing data were used. Quantitative data were analysed using the Statistical Package for Social Sciences (SPSS) for Windows (version 13). Analysis concerned itself with descriptive and inferential statistics. Categorical data were analysed using crosstabulations and chi-squared analysis. Continuous data were analysed using Pearson correlation and analysis of variance (ANOVA).

In addition, qualitative open-ended data were gathered (open-ended questions) for which an inductive method of coding and creating categories was used. The procedure that was followed and which is the one proposed by Robson (1993), was to copy all the responses that fell under each question to a sheet of paper headed by the question. Then each answer was given a number which was the code given to this person's questionnaire (please see Appendix G: Participants' responses to open-ended questions). Following consultation with the two thesis supervisors a smallish set of categories was developed into which these responses could fall under.

CHAPTER FOUR: Results

The results of this study will be reported separately for therapists and clients. Initially there will be a presentation of the data from therapists, then the data from clients and in the end there will be a section presenting the results from the analysis of questions that were common for both therapists and clients. The implications of the following results will be discussed in detail in the following chapter (Chapter 5, "Discussion").

Moreover, the tables that are presented in the result section show only the observed values obtained during the statistical analysis and not the expected. It is therefore important to say that according to Field (2000) for all the chi-squared analyses in 2x2 tables the expected frequencies in the cell counts should be greater than 5 but in larger contingency tables it is acceptable to have up to 20% of expected frequencies below 5 but none below 1. As a result in this study whenever a crosstabulation is performed a chi-squared result is reported only if all the expected values of large contingency tables are above 1 and if a maximum of 20% are less than 5. Otherwise, if more than 20% are less than 5 or if there are some that are less than 1, a Fisher's exact is conducted and reported instead of a chi-squared value (Field, 2000). Two-tailed tests were used throughout regardless of the direction of differences predicted or not. Finally, for multiple comparisons the Bonferoni correction method was used.

RESULTS FROM THERAPISTS' DATA

Demographics

Eighty- seven out of the 200 survey packets that were sent out to therapists were received back resulting in 43.5% response rate. This response rate is similar to that reported in previous studies (Brandy et al., 1999, Follette et. al., 1994, Shauben and Frazier, 1995, Pruitt et. al., 1992). However, out of the eighty -seven packets, eleven were returned incomplete and four respondents reported that they did not work with adults and so did not fulfil the criteria to participate in the study. As a result, fifteen respondents in total were excluded from the study, leaving seventy- two valid survey packets for the analysis (36%).

Table 1 shows the breakdown of percentages of participants according to their gender and professional title.

Table 1: Gender and Professional title of participants

Gender	N	Percentage
Male	20	27.8
Female	52	72.2
Total	72	100.0

Professional Title	N	Percentage
Counselling Psychologist	21	29.2
Clinical Psychologist	33	45.8
Psychotherapist	8	11.1
Therapist	3	4.2
Trainee Psychologist	4	5.6
Assistant Psychologist	3	4.2
Total	72	100.0

From table 1 we can see that the majority of participants (72%, 52/72) were female. Regarding participants' professional title the highest percentage of professionals (46%, 33/72) reported being clinical psychologists and the second highest (29%, 21/72) counselling psychologists. The term "therapists" on the table refers to mental health professionals who haven't got a psychology degree (i.e. nursing background) but who have been trained in one or more psychological therapies. The term differs from the term "psychotherapists" which refers to professionals who are trained specifically in psychoanalytic/psychodynamic psychotherapy.

Participants were also asked about the clinical area in which they worked and 24% (17/72) reported working with adult inpatients, 6% (4/72) within forensic inpatient units, 1% (1/72) reported working within inpatient addictions, 3%(2/72) inpatient older adults, 1%(1/72) inpatient learning disabilities service, 79% (57/72) reported working within adult outpatient services, 4% (3/72) within outpatient forensic services, 4% (3/72) outpatient addiction services, 3% (2/72) outpatient older adults, 3% (2/72) outpatient learning disabilities services and 1% (1/72) within an outpatient eating disorders service. (Percentages sum to more than 100% because of multiple ticks in the same question and not a different participant, e.g. one participant could work part-time in inpatient forensic services and part-time in adult outpatients).

Participants were also asked to report the number of years they worked in the field they had stated previously since they qualified. Table 2 below shows the percentages of not yet qualified participants, of the newly qualified, of the experienced and the very experienced. These categories were taken from clusters that were constructed

during Agenda for Change and were communicated to clinicians through internal e-mails and letters within South London and Maudsley NHS Trust.

Table 2: Percentages of professionals according to years working since qualified

Months of experience since qualified	N	Percentage
Not yet qualified	3	4.2
Newly Qualified= up to 60 months	26	36.1
Experienced= 61-132 months	24	33.3
Very experienced= 133 months and above	19	26.4
Total	72	100.0

Table 2 shows that the highest percentage of participants who took part in this study fall within the "newly qualified" range (26/72, 36%) whereas the second higher percentage (24/72, 33%) of participants falls within the "experienced" range.

Moreover, the time participants reported working in the field they stated they worked in, ranged from 5 months to 25 years (mean= 8 years, sd= 6) and the time spent in the field since they were qualified ranged from 2 months to 31 years (mean= 9 years, sd= 7). The year participants reported to have completed their training ranged from 1969 to 2004.

Table 3 below shows the breakdown of percentages of participants according to their theoretical orientation and working hours.

Table 3: Theoretical orientation of professionals and working hours

Theoretical Orientation	N	Percentage
CBT	42	58.3
Psychodynamic	11	15.3
Humanistic	1	1.4
Existential	2	2.8
Integrative	16	22.2
Total	72	100.0

Working hours	N	Percentage
Full-time	41	56.9
Part-time	31	43.1
Total	72	100.0

From table 3 it is apparent that the majority of participants (42/72, 58%) reported Cognitive Behavioural Therapy (CBT) as their theoretical orientation whereas the second higher percentage of participants (16/72, 22%) reported using Integrative approach. Moreover table 3 shows that the majority of participants (41/72, 57%) reported working full time.

Table 4 below shows the responses regarding the percentage of sexually abused clients in participants' caseload.

Table 4: No of sexually abused clients in caseload

Percentage of CSA clients in caseload	N	Percentage of professionals
Up to 10%	19	26.4%
20% to 40%	33	45.8%
50% to 70%	17	23.6%

80% or more	3	4.2%
Total	72	100.0%

In total the number of clients that participants reported seeing in a week ranged from two to twenty eight (mean=11, sd=6). As shown from Table 4, the highest percentage of professionals (46%, 33/72) said that the number of sexually abused clients in their caseload ranged from 20% to 40%.

Finally, as far as supervision is concerned, 24% (17/72) reported receiving weekly supervision, 36% (26/72) twice monthly, 31% (22/72) once in a month and the remaining 9% (7/72) once in three months or when requested.

ATTITUDES AND PRACTICES ON ASSESSING AND TREATING SURVIVORS OF CHILD SEXUAL ABUSE

Do professionals believe that the assessment of adult clients should include questions about child sexual abuse?

Hypothesis 1: Most of professionals will report that the assessment of psychiatric patients should not include questions about sexual abuse or will report that they think the assessment of clients should include questions about child sexual abuse only sometimes.

Prediction 1: The highest percentage of professionals will choose the option "no" or "sometimes" on question 12 of the professionals' questionnaire (P-SQAPRESA, appendix C).

Table 5a below shows the percentages of professionals regarding their beliefs about inclusion of sexual abuse questions during an assessment.

Table 5a: Do professionals believe that the assessment of adult clients should include questions about child sexual abuse?

Yes	Sometimes	No	Not Sure	Total
27 (38%)	34 (47%)	9 (13%)	2 (3%)	72 (100%)

Table 5a shows that the highest percentage of professionals (47%, 34/72) said that the assessment of adult clients should "sometimes" include questions about child sexual abuse. Therefore hypothesis one was confirmed.

Table 5b below shows the breakdown of participants' responses on the question for each professional group separately.

Table 5b: What each professional group believes in terms of whether the assessment of adult clients should include questions about child sexual abuse.

	Yes	Sometimes	No	Not sure	Total
Counselling	9 (42.9%)	6 (28.6%)	6 (28.6%)	0 (0%)	21(100%)
Clnical	11 (33.3%)	21 (63.6%)	0 (0%)	1 (3.0%)	33 (100%)
Psychotherapist	4 (50%)	2 (25%)	2 (25%)	0 (0%)	10 (100%)
Therapist	0 (0%)	2 (66.7%)	1 (33.3%)	0 (0%)	3 (100%)
Trainee psychologist	2 (50%)	2 (50%)	0 (0%)	0 (0%)	4 (100%)
Other	1 (33.3%)	1 (33.3%)	0 (0%)	1 (33.3%)	3 (100%)
Total	27 (37.5%)	34 (47.2%)	9 (12.5%)	2 (2.8%)	72 (100%)

From table 5b its apparent that the highest proportion of therapists (67%, 2/3) and clinical psychologists (64%, 21/33) reported that only "sometimes" questions of

sexual abuse should be included in an assessment whereas the highest proportion of counselling psychologists (43%, 9/21) reported "yes", meaning that they thought that the assessment of adult clients should include questions about sexual abuse. Moreover, although there were a number of counselling psychologists, psychotherapists and therapists who believed that the assessment of adult clients should not include CSA questions, none of the clinical psychologists believed that.

In order to explore whether professionals' answers on the question were significantly related to their professional title (professional group) a chi-squared analysis was performed. However since some of the cells have expected counts less than 1 a Fisher's exact test was performed and results showed that participants' answers were significantly correlated to their professional group: Fisher's exact test = 25.68, p= < .01

Table 6 below shows the breakdown of answers of professionals on the above question for the different variables separately including professionals' gender, working hours, level of experience and professional group.

Table 6: Do professionals believe that the assessment of adult clients should include CSA questions?

Gender	Yes	Sometimes	No	Not Sure	Total
Male	9 (45%)	10 (50%)	1 (5.0%)	0 (0%)	20 (100%)
Female	18 (34.6%)	24 (46.2%)	8 (15.4%)	2 (3.8%)	52 (100%)
Total	27 (37.5%)	34 (47.2%)	9 (12.5%)	2 (2.8%)	72 (100%)
Working hours					
Full-time	12 (29.3%)	25 (61%)	2 (4.9%)	2 (4.9%)	41 (100%)
Part-time	15 (48.4%)	9 (29%)	7 (22.6%)	0 (0%)	31 (100%)
Total	27 (37.5%)	34 (47.2%)	9 (12.5%)	2 (2.8%)	72 (100%)
Level of experience					
Not yet qualified	1 (33.3%)	2 (66.7%)	0 (0%)	0 (0%)	3 (100%)

Newly qualified	9 (34.6%)	10 (38.5%)	6 (23.1%)	1 (3.8%)	26 (100%)
Experienced	11(45.8%)	11 (45.8%)	1 (4.2%)	1 (4.2%)	24 (100%)
Very Experienced	6 (31.6%)	11 (57.9%)	2 (10.5%)	0 (0%)	19 (100%)
Total	27 (36.8%)	34 (47.2%)	9 (12.5%)	2 (2.8%)	72 (100%)

Professional group

Couns. Psychol.	9 (42.9%)	6 (28.6%)	6 (28.6%)	0 (0%)	21 (100%)
Therapists	0 (0%)	2 (66.7%)	1 (33%)	0 (0%)	3 (100%)
Clinical Psychol.	11 (33.3%)	21(63.6%)	0 (0%)	1 (3%)	33 (100%)
Trainee Psychol.	2 (50%)	2 (50%)	0 (0%)	0 (0%)	4 (100%)
Psychotherapists	4 (50%)	2 (25%)	2 (25%)	0 (0%)	8 (100%)
Other (assistants)	1 (33.3%)	1 (33.3%)	0 (0%)	1 (33.3%)	3 (100%)
Total	27 (37.5%)	34 (47.21%)	9 (12.5%)	2 (2.8%)	72 (100%)

As one can see from table 6 that the highest percentage of both male (50%, 10/20) and female (46%, 24/52) professionals believes that the assessment of clients should include CSA questions only sometimes. The table also shows that there was a difference between full-timers and part-timers since the highest percentage of full-timers (61%, 25/41) reported that they believed that the assessment of clients should include CSA questions only sometimes compared to the highest percentage of part-timers (48%, 15/31) who reported that they believed that the assessment should include CSA questions. Across levels of experience, the highest percentage of not yet qualified professionals (67%, 2/3), newly qualified (38%, 10/26) and very experienced (58%, 11/ 19) reported that they believed the assessment should include CSA questions only sometimes whereas experienced professionals were equally divided between those who said that the assessment should include CSA questions (46%, 11/24) and those who reported that CSA questions should be sometimes included in the assessment (46%, 11/24). Finally, table 6 shows that the highest proportion of therapists (67%, 2/3) and clinical psychologists (64%, 64%, 21/33) reported that they believed that the assessment of adult clients should sometimes

include CSA questions. On the other hand the highest percentage of counselling psychologists (43%, 9/21) and psychotherapists (50%, 4/8) reported that they believed that the assessment of adult clients should include CSA questions.

In order to explore whether there were any significant associations between the variables that are shown in table 6 and professionals' belief about routine enquiry a series of chi-squared analyses were performed. However where the cells had expected counts less than 1 Fisher's exact tests were conducted. Results showed that at significance level of $p < 0.0125$ (Bonferoni correction due to multiple comparisons) that professionals' belief about routine enquiry regarding sexual abuse is significantly associated to whether they work full-time or part-time (Fisher's exact= 10.91, $p < .01$) and is significantly associated to their professional group (i.e. counselling psychologist, psychotherapist etc) Fisher's exact= 25.68, $p < .01$. Moreover professionals' belief about routine enquiry of sexual abuse is not significantly associated to their gender (Fisher's exact= 1.94, $p = .58$) or level of their experience (Fisher's exact= 7.28, $p = .65$).

Do professionals ask their clients/patients about possible experiences of sexual abuse?

Hypothesis 2: Most professionals will report that they do not enquire about CSA or that they enquire only some of the time.

Prediction 2: The highest percentage of professionals will choose the option "sometimes" or "never" on question 17 of the clinicians' questionnaire (P-SQAPRESA, appendix C).

The majority of professionals (69%, 50/72) reported that they enquired sometimes compared to 17% (12/72) who said that they always enquired and to 14% (10/72) who said that they never enquired. Therefore the initial hypothesis that the highest percentage of professionals would say that they enquire only some of the time was confirmed.

Table 7 below shows the breakdown of professionals' answers for the different variables (gender, working hours, level of experience and professional group).

Table 7: Do professionals ask their adult clients about sexual abuse during an assessment?

Gender	Always	Sometimes	Never	Total
Male	4 (20%)	15 (75%)	1 (5.0%)	20 (100%)
Female	8 (15.4%)	35 (67.3%)	9 (17.3%)	52 (100%)
Total	12 (16.7%)	50 (69.4%)	10 (13.9%)	72 (100%)
Working hours				
Full-time	4 (9.8%)	31 (75.6%)	6 (14.6%)	41 (100%)
Part-time	8 (25.8%)	19(61.3%)	4 (12.9%)	31 (100%)
Total	12 (16.7%)	50 (69.4%)	10 (13.9%)	72 (100%)
Level of experience				
Not yet qualified	0 (0%)	3 (100%)	0 (0%)	3 (100%)
Newly qualified	5(19.2%)	17 (65.4%)	4 (15.4%)	26 (100%)
Experienced	5(20.8%)	15 (62.5%)	4 (16.7%)	24 (100%)
Very Experienced	2 (10.5%)	15 (78.9%)	2 (10.5%)	19 (100%)
Total	12 (16.7%)	50 (69.4%)	10 (13.9%)	72 (100%)
Professional group				
Couns. Psychol.	3 (14.3%)	14 (66.7%)	4 (19%)	3 (100%)
Clinical Psychol.	6 (18.2%)	23 (69.7%)	4 (12.1%)	24 (100%)
Therapists	0 (0%)	3 (100%)	0 (0%)	26 (100%)
Psychotherapists	2 (16.7%)	5 (62.5%)	1 (12.5%)	72 (100%)
Trainee Psychol.	1 (10.5%)	3 (75%)	0 (0%)	19 (100%)
Other (assistants)	0 (0%)	2 (66.7%)	1 (33.3%)	3 (100%)
Total	12 (16.7%)	50 (69.4%)	10 (13.9%)	72 (100%)

From table 7 we can see that the highest proportion of both male and female professionals, full-timers and part-timers, across all levels of experience and across all professional groups, answered that they "sometimes" asked their clients about CSA experiences during assessment.

In order to explore whether any of the above variables were significantly associated with the frequency that professionals reported asking their clients about CSA experiences, a chi-squared analysis was performed for each variable separately. However because some of the cells had expected counts less than 1 a Fisher's exact test was performed. The results of the analysis showed that at a significance level of $p < 0.0125$ there were no significant associations between the different professional groups and their answers to this question (Fisher's exact = 4.20, $p = .98$). Moreover, no significant associations were found between how participants answered this question and their gender ($\chi^2(2) = 1.88$, $p = .39$), level of experience (Fisher's exact= 2.25, $p = .93$) and working hours ($\chi^2(2) = 3.29$, $p = .23$).

Do professionals prefer to enquire about sexual abuse during assessment or during therapy?

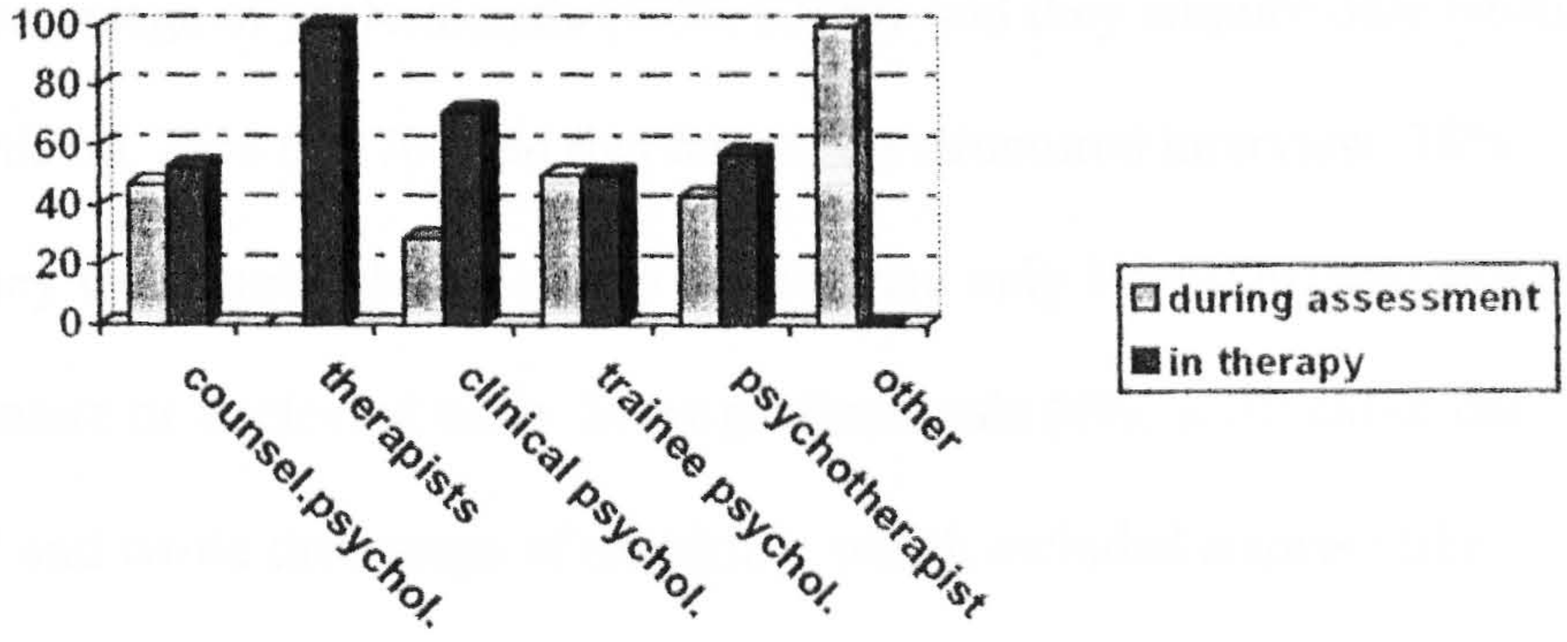
Hypothesis 3: Most professionals who would report that they enquire about sexual abuse they would say they think it is best to do this during therapy.

Prediction 3: The highest percentage of professionals would circle the second choice of question 18 of the professionals' questionnaire, which is "later in therapy" (P-SQAPRESA, appendix C).

Of 72 participants, 8 (11%) did not answer this Question, (two of whom said that the question was not valid for them since they never ask clients about sexual abuse, also see page 147 in the discussion part for reflections on why 11% of participants didn't answer this question). The responses of the remaining 64 professionals confirmed the above hypothesis since the majority (56%) reported that they thought is best to enquire during therapy, whereas the rest 33% reported that they thought is best to enquire during assessment.

Figure 1 below shows how each professional group answered this question and it is apparent that in most professional groups the highest percentage of professionals seems to think that it is best to ask CSA questions during therapy.

Figure 1: Do professionals ask about sexual abuse during assessment or therapy?



In order to explore if there were any significant associations between the gender of professionals, their level of experience, professionals' working hours, their professional group and their preference of asking CSA questions during therapy or during assessment, chi-squared analysis was performed for each of the above variables separately. Following a Bonferoni correction for multiple analyses the significance level was set at 0.0125. Therefore there were no significant associations

(Fisher's Exact= 6.43, p= .23) between the professional groups of participants and whether they thought is best to ask CSA questions during assessment or therapy. No other significant associations were found between professionals' thoughts regarding when is the best time that clients should be asked about CSA -during assessment or therapy and their gender, (χ^2 (1) = .52, p= .47), their level of experience (Fisher's Exact= 3.51, p= .31) and working hours (χ^2 (1) = .004, p= .95).

If professionals enquire about sexual abuse how do they go about it?

In this question participants were asked to circle one or more of five choices given to them ("enquire when clients bring this up", "use a structure interview", "ask when it comes to mind", "use a questionnaire" and "other"). Two participants (3%) did not answer this question. The remaining 70 participants gave the following responses: The highest percentage of professionals (46%, 33/70) said they enquire only when clients bring this up, 26% (19/70) said that they use a structured interview, 18% (13/70) said they would ask when it comes to mind and only 3% (2/70) said would use a questionnaire or a relevant scale. Some professionals (4%, 3/70) chose the option "other" and wrote their ways of enquiring, which included answers like "asking when there is indicative presentation", "when good rapport has been established", "when the client is ready to cope" etc.

Did professionals have any specific training in assessing and treating sexual abuse?

The majority of participants, 72% (52/72), said they had no specific training **in assessing** adults for child sexual abuse and no specific training **in treating** survivors of sexual abuse (63%, 45/72).

Table 8 below shows the breakdown of answers of each professional group on this question.

Table 8: Did professionals receive any specific training in the assessment and treatment of adult survivors of sexual abuse?

Counselling Psychologists	**Received Training**	**Did not receive training**	**Total**
Assessment	2 (9.5%)	19 (90.5%)	21 (100%)
Treatment	5 (23.8%)	16 (76.2%)	21 (100%)
Therapists			
Assessment	1 (33.3%)	2 (66.7%)	3 (100%)
Treatment	1 (33.3%)	2 (66.7%)	3 (100%)
Clinical Psychologists			
Assessment	12 (36.4%)	21 (63.6%)	33 (100%)
Treatment	13 (39.4%)	20 (60.6%)	33 (100%)
Trainee Psychologists			
Assessment	0 (0%)	4 (100%)	4 (100%)
Treatment	2 (50%)	2 (50%)	4 (100%)
Psychotherapists			
Assessment	5 (62.5%)	3 (37.5%)	8 (100%)
Treatment	6 (75%)	2 (25%)	8 (100%)
Other (Assistants)			
Assessment	0 (0%)	3 (100%)	3 (100%)
Treatment	0 (0%)	3 (100%)	3 (100%)

What stands out from table 8 is that almost all counselling psychologists (91%, 19/21) reported that they had no training in assessing sexual abuse, compared to a lower percentage of clinical psychologists 64% (21/33) and 67% (2/3) of therapists. Moreover, table 8 shows that the group of psychotherapists was the only group within which the majority (63%, 5/8) said they had received specific training in assessing adults for sexual abuse. Similar to the above results regarding the assessment of sexual abuse were also the results regarding the training professionals said they received for treating sexual abuse. A smaller percentage 24% (5/21) of counselling psychologists said they had received specific training compared to 39% (13/33) of clinical psychologists and 33% (1/3) of therapists. The group of psychotherapists were

again, as with the training for assessment, the only group from which the majority 75% (6/8) reported that they had received specific training for treating sexually abused clients.

In order to explore whether the above differences between professional groups in terms of receiving specific training for assessing and treating CSA were significant, crosstabulations were performed followed by chi-squared analysis for each professional group separately. In terms of the individual groups of professionals significant differences were found regarding whether they received specific training for **assessing** sexual abuse, Fisher's Exact= 11.163, p= .025, whereas no significant differences were found between professional groups in terms of the training they received for the **treatment** of sexual abuse (Fisher's Exact= 8.111, p= .119).

Table 9 below shows the breakdown of answers of professionals in terms of their level of their work experience.

Table 9: Have participants received training in treating and assessing CSA?

Assessment	**Received Training**	**Did not receive training**	**Total**
Not qualified yet	0 (0%)	3 (100%)	3 (100%)
Newly qualified	3 (11.5%)	23 (88.5%)	26 (100%)
Experienced	9 (37.5%)	15 (62.5%)	24 (100%)
Very.experienced	8 (42.1%)	11 (57.9%)	19 (100%)
Total	20 (27.8%)	52 (72.2%)	72 (100%)
Treatment			
Not qualified yet	2 (66.7%)	1 (33.3%)	3 (100%)
Newly qualified	4 (15.4%)	22 (84.6%)	26 (100%)
Experienced	11 (45.8%)	13 (54.2%)	24 (100%)
V.experienced	10 (52.6%)	9 (47.4%)	19 (100%)
Total	27 (37.5%)	45 (62.5%)	72 (100%)

Table 9 shows that in most categories of each level of experience of professionals the highest percentage reported that they didn't receive any specific training in neither assessing or treating adults for child sexual abuse. Table 9 also shows that as the level of professionals' experience increases, the number of those who reported that they received training increases as well.

In order to explore whether there is an association between the levels of experience and whether participants received training, a chi-squared analysis was performed both between levels of experience and whether received training for assessment as well as between level of experience and whether they received training for treating CSA clients. A marginally significant association was found between the level of experience and whether participants had received specific training for assessment, (Fisher's Exact= 7.307, p= .054) and a significant association between the level of experience and whether participants had received training for treatment, (Fisher's Exact= 9.48, p= .017).

Further analysis was performed in order to explore whether any of the following variables (working hours and gender) were significantly associated to whether professionals received any training in **assessing** and **treating** CSA. Results showed that there were no significant associations between working hours such as part-timers/ full-timers, (χ^2 (1)= .04, p= .84) and received training **in assessment** and no significant associations between professionals' gender- males and females, (χ^2 (1)= .07, p= .79) and the training they received **in assessing** CSA. Additionally, no significant associations were found between the specific training that professionals

received for **treating** sexually abused clients and their gender-male/females (χ^2 (1)= .07, p= .79) and their working hours- part-timers/full-timers (χ^2 (1)= .03, p= .85).

Hypothesis 4: A significant association will be found between professionals' levels of feeling comfortable/competent enquiring about CSA and the frequency in which they say they enquire.

Prediction 4: Scores from the Likert-scales of questions 22 and 24 of professionals' questionnaire (P-SQAPRESA) will be significantly associated with scores on question 17 of professionals' questionnaire (P-SQAPRESA).

Table 10 below shows the percentages of professionals according to how frequent they say they enquire about CSA and to how competent/comfortable they report they feel enquiring.

Table 10: How comfortable/competent professionals feel and frequency of enquiry

	Always	Sometimes	Never	Total
Not at all comfortable enquiring	0 (0%)	0 (0%)	4 (40%)	4 (5.6%)
Not at all competent enquiring	0 (0%)	1 (2%)	2 (20%)	3 (4.2%)
A little bit comfortable enquiring	0 (0%)	15 (30%)	3 (30%)	18 (25%)
A little bit competent enquiring	1 (8.3%)	17 (34%)	2 (20%)	20 (27.8%)
Quite comfortable enquiring	6 (50%)	25 (50%)	3 (30%)	34 (47.2%)
Quite competent enquiring	2 (16.7%)	23 (46%)	6 (60%)	31 (43.1%)
Extremely comfortable enquiring	6 (50%)	10 (20%)	0 (0%)	16 (22.2%)
Extremely competent enquiring	9 (75%)	9 (18%)	0 (0%)	18 (25%)
Total	12 (100%)	50 (100%)	10 (100%)	72 (100%)

What is shown from the table is that the more comfortable/competent psychologists feel to ask about child sexual abuse the more likely they "always" or "sometimes" enquire.

In order to test hypothesis 5 a crosstabulation was performed between levels of comfort/competency as measured by the Likert scale of Question 22 and 24 (i.e. 1= not at all and 4= extremely) and frequency of enquiry (i.e. always, sometimes, never) followed by a chi-squared analysis to test its significance. The results showed significant associations between how comfortable professionals feel enquiring and the frequency of enquiry about sexual abuse, Fisher's exact= 23.79, $p < .001$ and how competent they feel enquiring and the frequency of enquiry, Fisher's Exact= 21.42, $p < .001$.

No significant associations were found between how **comfortable,** Fisher's Exact= 9.10, p= .13, and how **competent,** Fisher's Exact= 10.48, p= .07, professionals feel **treating** sexually abused clients and the frequency with which they enquire about sexual abuse experiences.

Hypothesis 5: Most clinicians will state that they do not feel comfortable or competent enquiring about sexual abuse or treating sexual abuse clients.

Prediction 5: The largest proportion of clinicians will score 1 or 2 (1= not at all comfortable/competent and 4= extremely competent/comfortable) on the Likert scales of questions 22, 23, 24 and 25 of the professionals' questionnaire (P-SQAPRESA, appendix C).

How comfortable/competent professionals feel *asking* clients about sexual abuse?

Figures 2 and 3 illustrate the percentages of professionals and how **comfortable/competent** they feel **enquiring** about sexual abuse at a scale of one to four, where one is not comfortable at all/not competent at all and four is extremely comfortable/extremely competent.

Figure 2: How comfortable professionals feel enquiring for sexual abuse

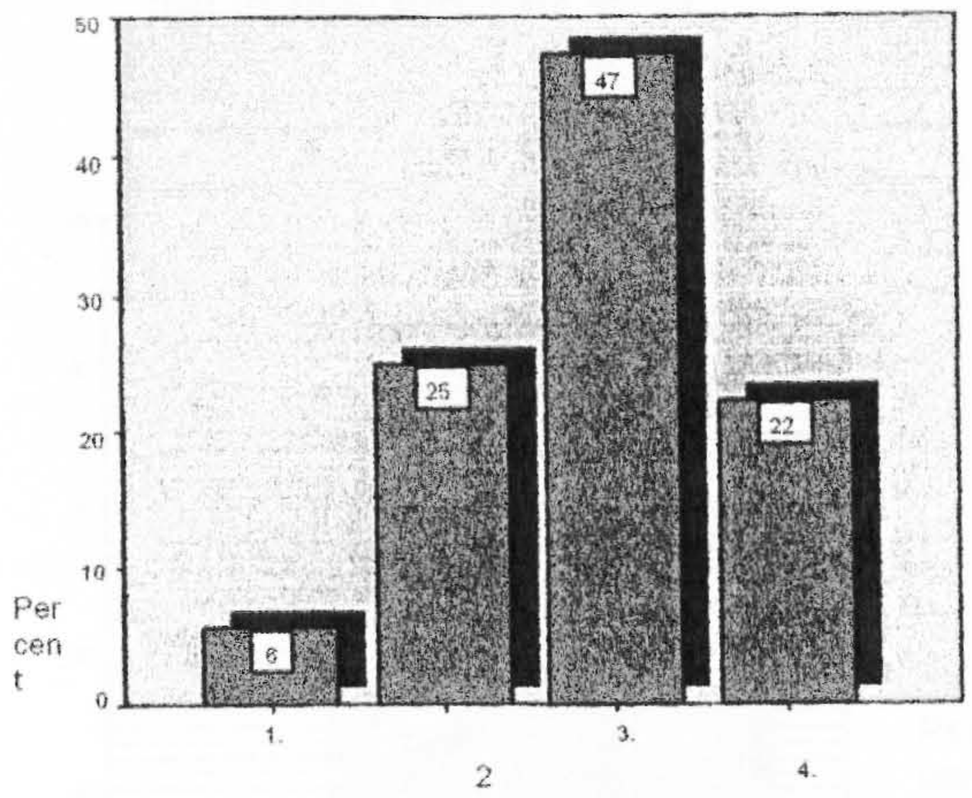


Figure 3: How competent professionals feel enquiring for sexual abuse

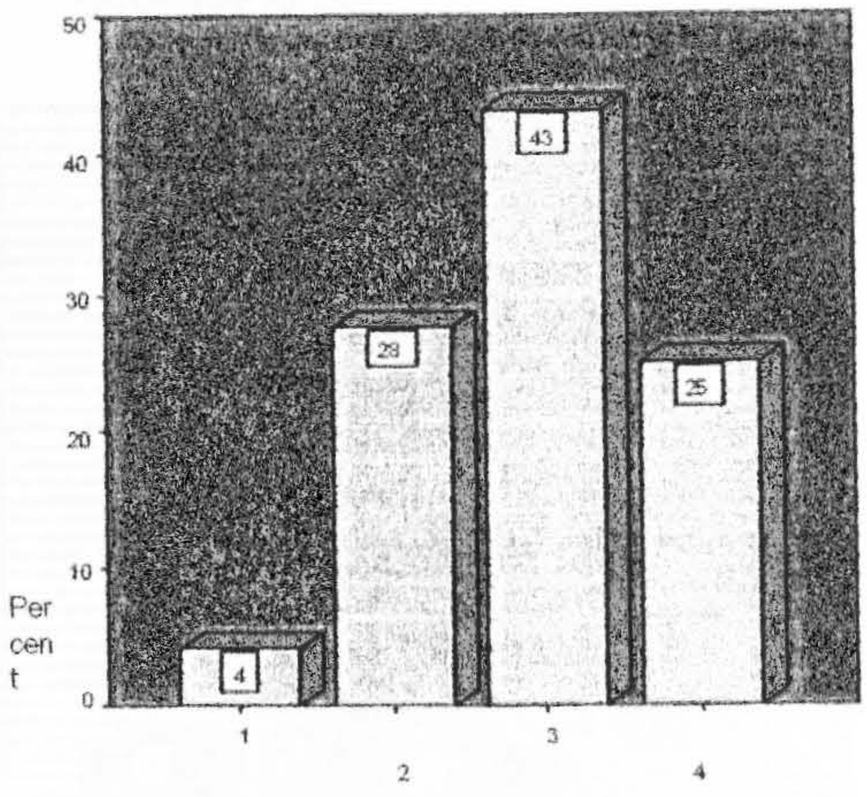


Figure 2 shows that the highest proportion of professionals (69%) rated 3 and 4 on the scale for comfort, meaning that most of them feel either close to extremely or extremely comfortable asking their clients about sexual abuse experiences. Moreover, figure 3 shows that the highest proportion of professionals (68%) rated 3 and 4 also on the scale for competency meaning that most of them reported feeling close to extremely and extremely competent asking clients about sexual abuse compared to only 32% who rated 1 and 2. Therefore the first part of the above hypothesis regarding how professionals feel **enquiring** for sexual abuse was not confirmed.

How comfortable/competent professionals feel *treating* survivors of sexual abuse?

Figures 4 and 5 illustrate the percentages of professionals and how **comfortable/competent** they feel **treating** sexual abuse at a scale of one to four, where one is not comfortable at all/not competent at all and four is extremely comfortable/extremely competent.

Figure 4: How comfortable professionals feel treating survivors of csa.

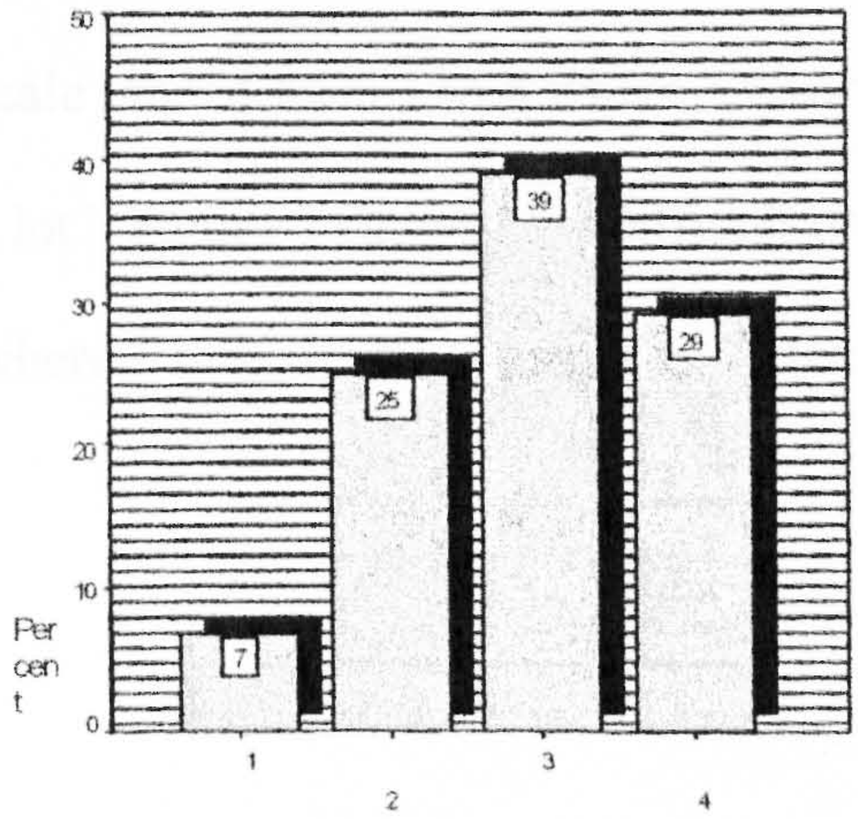
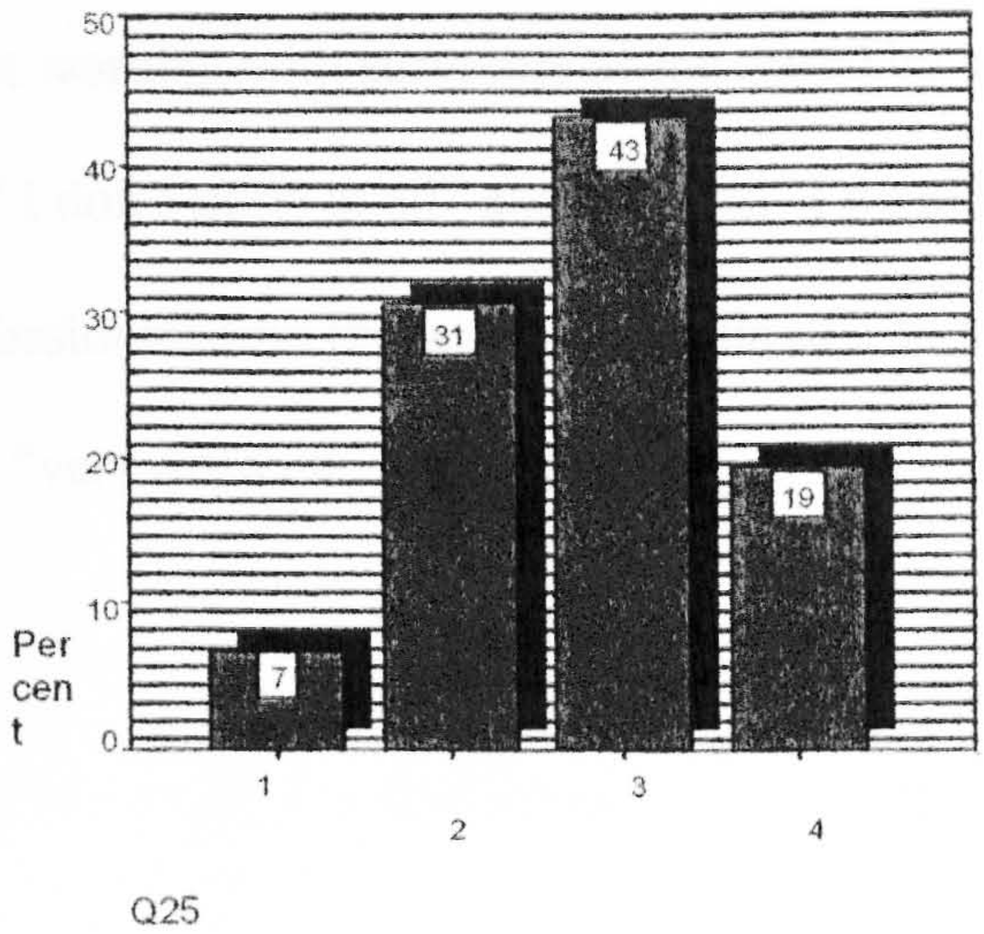


Figure 5: How competent professionals feel treating survivors of csa.



In terms of how **comfortable/competent** professionals feel **to treat** survivors of sexual abuse, figure 4 and 5 illustrate that on a scale of one to four, most professionals (68%) rated themselves as 3 or 4 on the scale of comfort, meaning that most of them said that they feel close to extremely and extremely comfortable compared to 32% who rated 1 and 2. Also the highest proportion of professionals (62%) rated themselves 3 and 4 on the scale of competency, meaning that they feel close to extremely and extremely competent. Therefore the second part of hypothesis 4 regarding how professionals feel **treating** sexually abused clients was not supported either.

How do professionals generally feel about the work with survivors of sexual abuse?

Participants were initially asked to rate themselves in a scale of one to four 1) whether they minded working with survivors of sexual abuse or not, 2) how difficult they find the work, 3) how stimulating, 4) whether they enjoy it, 5) whether they find it

draining, 6) satisfying and 7) whether if they had the choice they would choose not to work with survivors.

Figure 6 below shows people mind or not working with survivors as measured by a scale ranged from 1 to 4 where 1 means "I don't mind at all" and 4 means "I do mind a lot". Figure 7 shows how difficult professionals find the work on a scale of 1 to 4 where 1 means "very easy" and 4 means "very difficult"

Figure 6: Do professionals mind working with sexually abused clients?

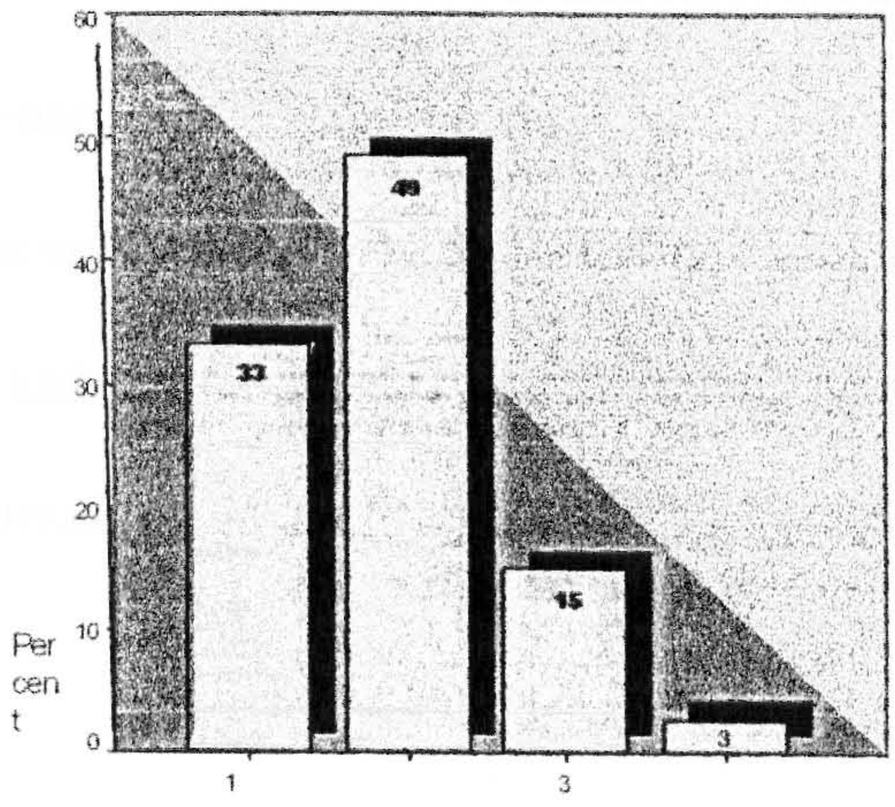
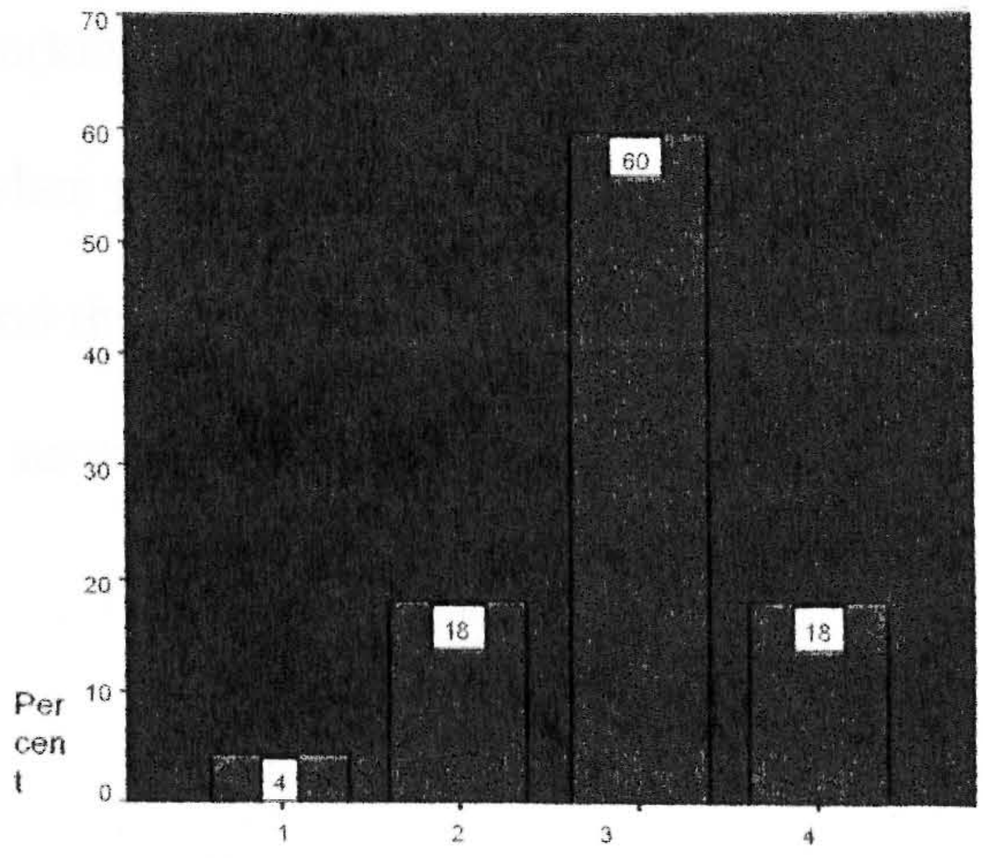


Figure 7: How difficult professionals find the Work with sexually abused clients?



According to figure 6 the highest percentage of professionals (82%) said "they do not mind so much" and "do not mind at all" working with survivors of sexual abuse. Figure 7 shows that the majority of professionals (78%) said they found that work "very difficult" or close to "very difficult".

Figure 8 and 9 below show how much professionals enjoy the work with CSA clients and how stimulating they find it respectively.

Figure 8: How much professionals enjoy the work with sexually abused clients?

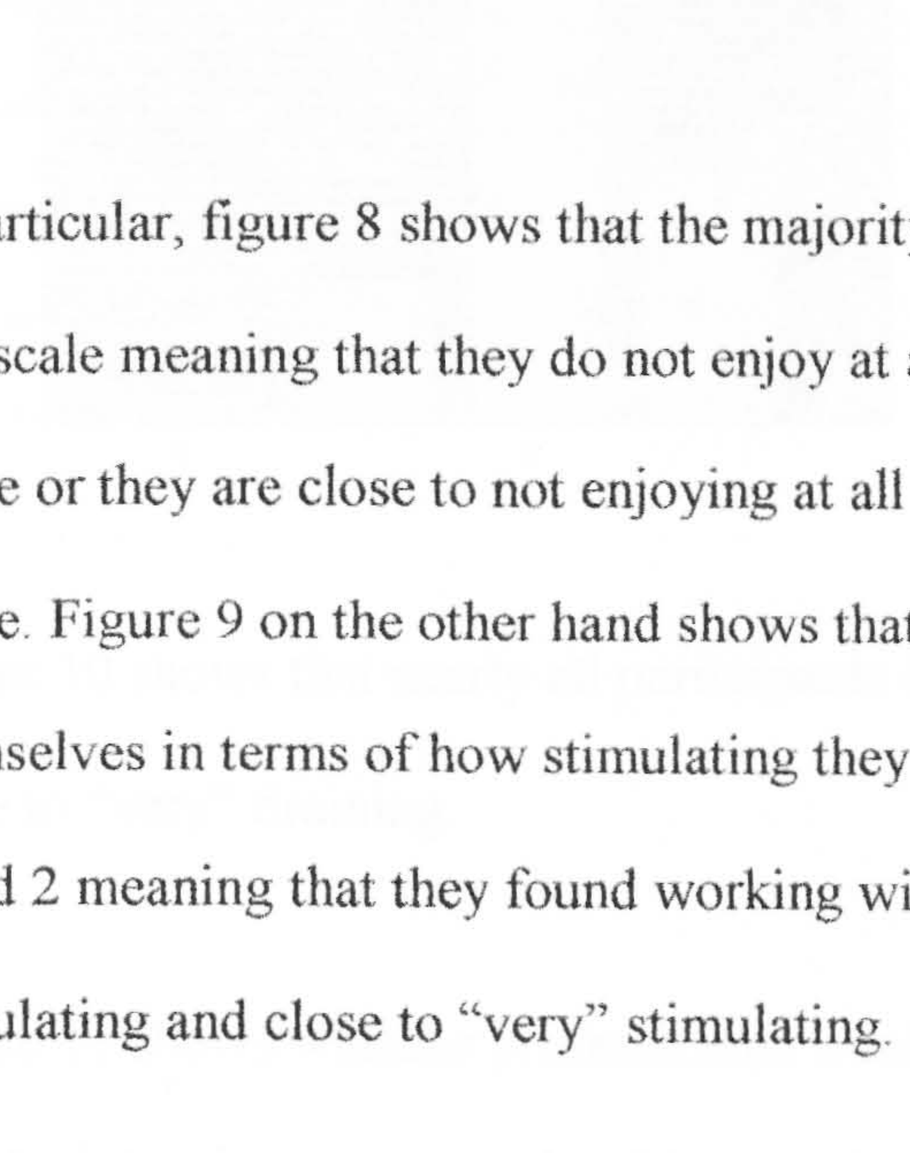
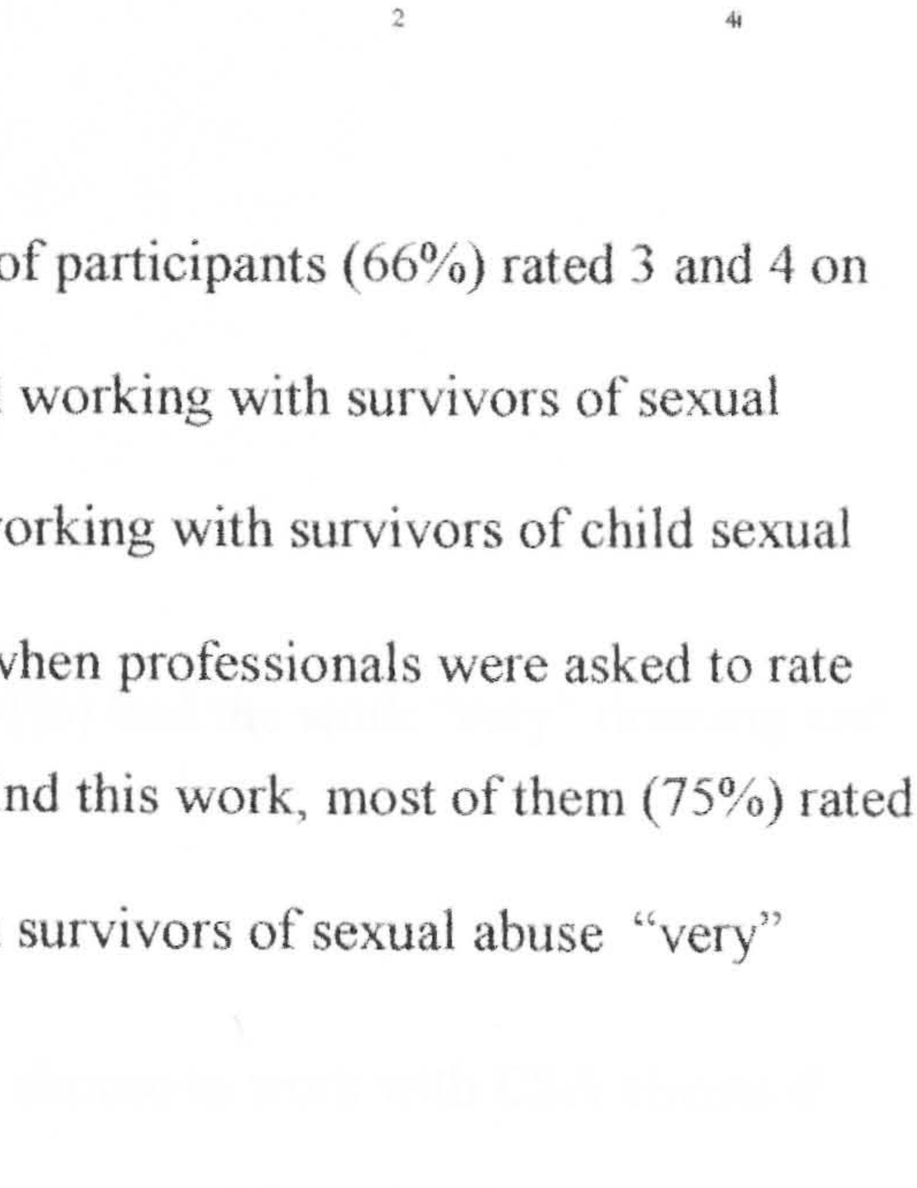


Figure 9: How stimulating professionals find the work with sexually abused clients?



In particular, figure 8 shows that the majority of participants (66%) rated 3 and 4 on that scale meaning that they do not enjoy at all working with survivors of sexual abuse or they are close to not enjoying at all working with survivors of child sexual abuse. Figure 9 on the other hand shows that when professionals were asked to rate themselves in terms of how stimulating they find this work, most of them (75%) rated 1 and 2 meaning that they found working with survivors of sexual abuse "very" stimulating and close to "very" stimulating.

Figure 10 below shows how draining professionals find the work with CSA survivors on a scale of 1 to 4 where 1 means "I don't find such work draining" and 4 means "I find such work very draining".

Figure 10: How draining professionals find the work with sexual abuse survivors?

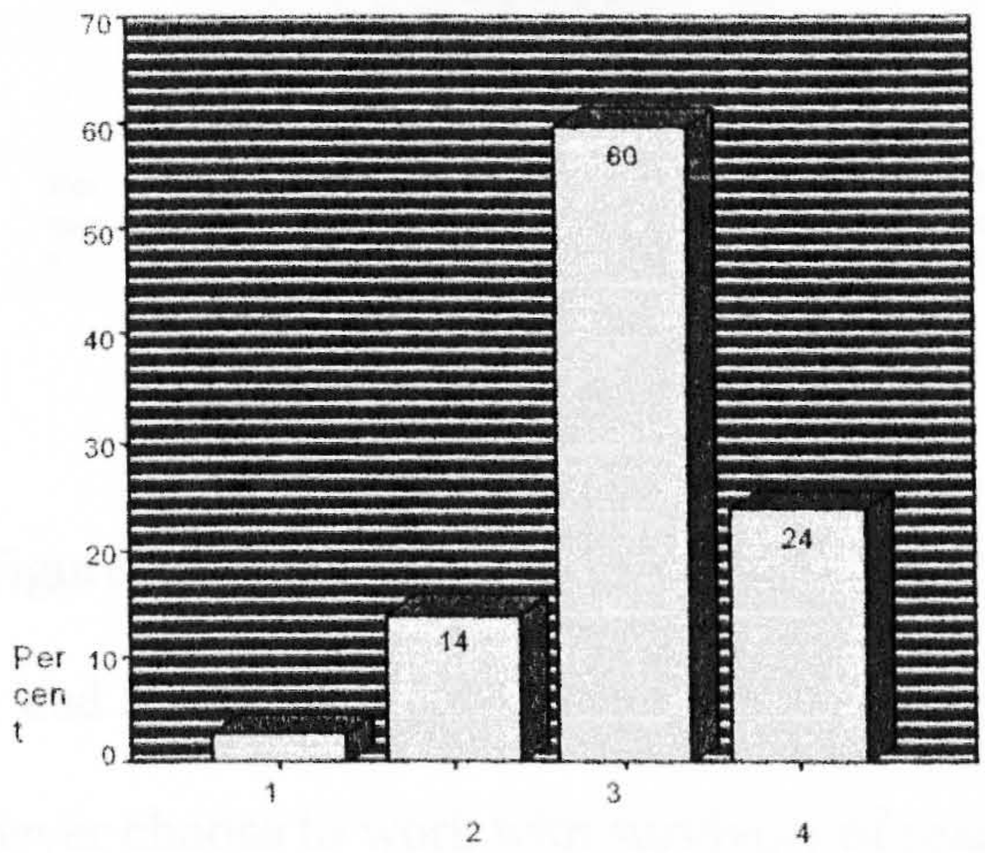


Figure 10 shows that nearly all participants (84%) find the work "very" draining and close to "very" draining.

Figure 11 shows whether professionals would choose to work with CSA clients if they had the choice on a scale of 1 to 4 where 1 means "if I had a choice I would often choose to work with survivors of sexual abuse" and 4 is "I would never choose to work with CSA survivors". Figure 12 shows how satisfying professionals find CSA work again on a scale of 1 to 4 where 1 means "I find this work very satisfying" and 4 "I don't find such work satisfying at all".

Figure 11: If professionals had a choice would they choose to work with survivors of sexual abuse?

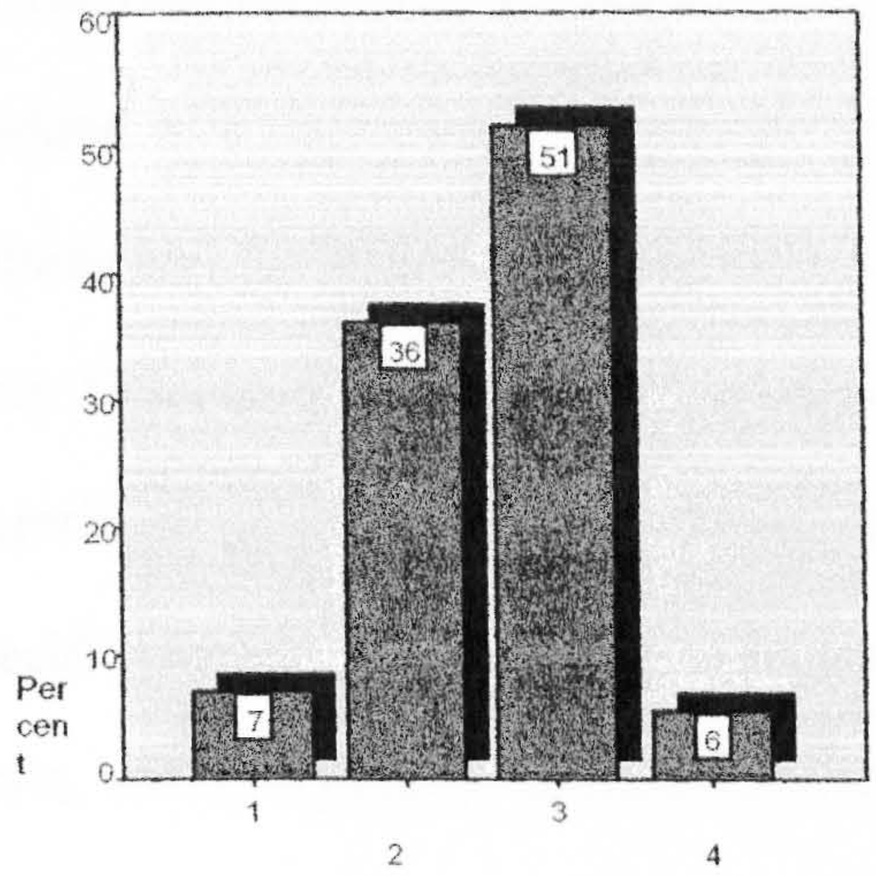


Figure 12: How satisfying professionals find CSA work?

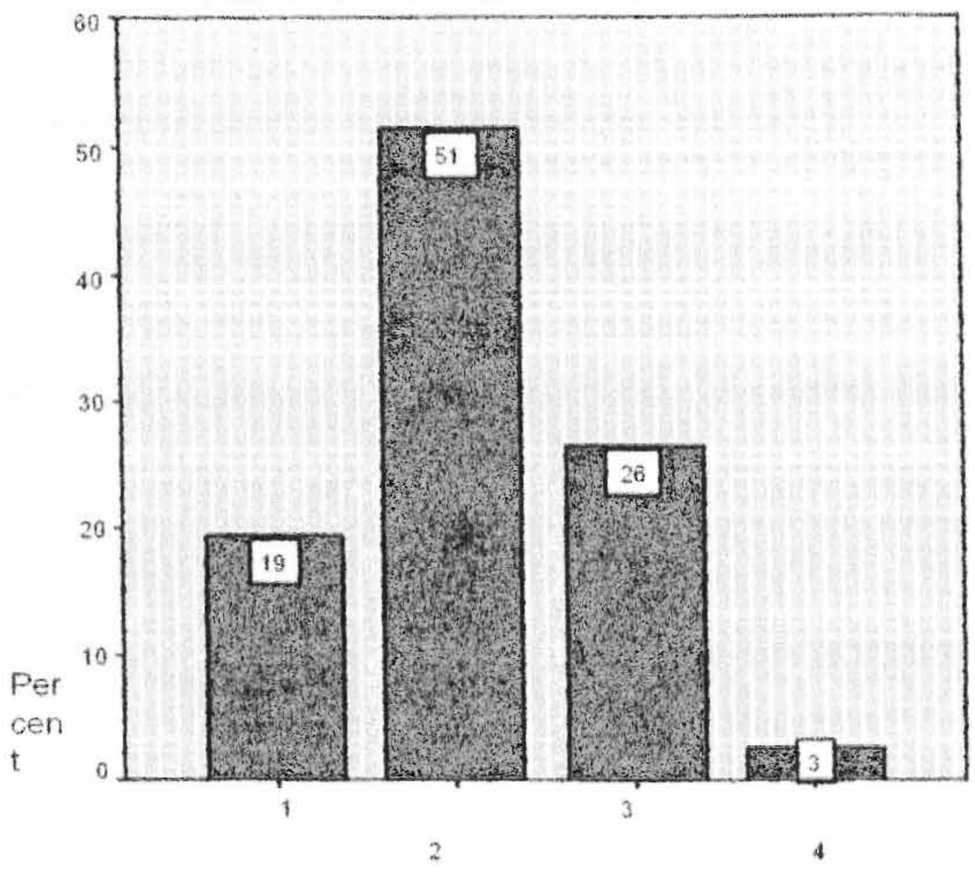


Figure 11 shows that 57% of professionals rated 3 and 4 compared to 43% who rated 1 and 2 meaning that the highest percentage of professionals said that they would never choose to work with survivors of sexual abuse and close to never choosing to work with CSA survivors. Interestingly figure 12 shows, that the percentage of those who rated 1 and 2 (70%) was higher than the percentage of those who rated 3 and 4 meaning that the highest percentage of professionals found this work very satisfying and close to very satisfying.

ATTITUDES OF PROFESSIONALS ON THEIR TRAINING

A) Do professionals think that their training equipped them with skills to work with survivors of child sexual abuse?,

B) Do they believe training programmes should address both assessment and treatment of CSA? ,

C) What do they think would be sufficient to equip them with skills for assessing and treating survivors of sexual abuse?

A) The majority of professionals (58%, 42/72) reported feeling that the topic of working with survivors of sexual abuse was inadequately addressed during their training and further 19% said the topic was not addressed at all during their training. Only 22% (16/72) said they thought the topic was adequately addressed. B) Also the majority of professionals 89% (64/72) said that professional programmes should offer specific training on the assessment of sexual abuse and the majority of professionals (88%, 63/72) supported specific training on the treatment of CSA.

C) At the same time the majority of professionals (67%, 48/72) reported that they believed that a combination of professional training, attendance of seminars, workshops, readings and supervision are needed in order to give them the appropriate skills to assess and treat survivors of sexual abuse compared to a smaller percentage (29%, 21/72) of professionals who said they thought supervision would be sufficient to equip them with the appropriate skills. In addition 28% (20/72) of professionals said that they believed that it would be enough if the topic of assessing and treating survivors of sexual abuse was to be included in therapists' professional training and 7% (5/72) believed that it would be sufficient for each professional to pursue such training through seminars, workshops and own reading. (The above percentages do not add up to 100 since participants could tick more than one of the options offered)

Did participants receive any personal therapy?

The majority of all participants, 65% (47/72) reported that they have received personal therapy. The majority of counselling psychologists, 91% (19/21), all therapists (100%, 3/3) and the majority of psychotherapists (88%, 7/8) reported that they had received personal therapy compared to a smaller percentage 49% (17/33) of clinical psychologists. It is interesting to note that more males (75%, 15/20) than females (61.5%, 32/52) said that received personal therapy. Moreover the majority of the newly qualified 77% had received therapy compared to 58.3% of the experienced and to 63% of the very experienced who did.

In order to explore whether there were any associations between participants' professional group, gender, level of experience and whether they received personal therapy or not, chi-squared analysis was performed. Results showed a significant association between professional group and whether participants received personal therapy, χ^2 (5)= 19.38, p< .01. No other statistically significant associations were found between whether professionals received personal therapy and professionals' gender (χ^2 (1)= 1.16, p= .28) and level of experience (χ^2 (3)= 3.45, p= .33).

Do professionals believe that personal therapy of the therapist could help him/her to work more effectively with clients who have been sexually abused?

The highest percentage of participants (46%, 33/72) said that personal therapy would be helpful for the therapist who works with survivors of sexual abuse, 38% (27/72) said that it would be helpful only sometimes and 17% (12/72) said it would not be helpful. In particular, the majority of counselling psychologists (57%, 12/21), psychotherapists (88%, 7/8) and therapists (100%, 3/3) said that personal therapy is

helpful when working with survivors of sexual abuse compared to a lower percentage (24%, 8/33) of clinical psychologists who supported the same. The largest proportion of clinical psychologists (49%, 16/33) said personal therapy is only sometimes helpful. Also the majority of newly qualified professionals (58%, 15/26) supported that personal therapy could help the professional to work more effectively with CSA clients compared to 33% (8/24) of the experienced and 47% (9/19) of the very experienced.

A chi-squared analysis was performed in order to explore whether there were significant associations between the sub-groups of professionals and their beliefs about personal therapy. The analysis showed significant associations Fisher's Exact= 18.047, p= .02. A significant association was also found between professionals beliefs about personal therapy and their level of experience, Fisher's Exact= 13.51, p= .02. No significant associations were found between professionals beliefs about therapy and professionals' gender, $\chi^2(2)= 3.71$, p= .16 and working hours (part-timers/full-timers) $\chi^2(2)= 3.28$, p= .19.

Vicarious Traumatisation/Secondary Trauma

In terms of how professionals scored on vicarious traumatisation scale (TABS), table 11 gives the total scores given by TABS.

Table 11: Percentages of participants on each range of total scores of TABS

Range of T-scores	N	Percentages
60-69: Very high	4	5%
56-59: High average	8	11%
45-55: Average	38	53%
40-44: Low average	15	21%
30-39: Very low	7	10%

Table 11 shows that most of the professionals' mean scores for most of the subscales fall within the average limit (45-55) (Pearlman, 2003). In terms of the total score on TABS, table 11 also shows the number and percentage of participants who scored below and above average. It is worth noting that the majority of professionals fall within the average range and that there was a percentage of 16% who scored above average (either high average or very high) compared to 31% who scored below average (either low average or very low).

Table 12 below shows the mean scores for each subscale. What each subscale represents was explained in a previous section (please refer to Chapter Three, under measures).

Table 12: Mean scores of all TABS subscales

	N	Minimum	Maximum	Mean	Std. Deviation
SELF-SAFETY	72	15.00	65.00	44.40	10.35
SELF-TRUST	72	19.00	69.00	50.64	7.57
SELF-ESTEEM	72	32.00	64.00	48.03	6.82
SELF-INTIMACY	72	10.00	67.00	51.61	7.70
SELF-CONTROL	72	25.00	61.00	47.14	8.95
OTHER-SAFETY	72	24.00	89.00	43.60	12.69
OTHER-TRUST	72	19.00	61.00	42.36	10.14
OTHER-ESTEEM	72	27.00	75.00	48.19	9.83
OTHER-INTIMACY	72	28.00	69.00	49.56	10.41
OTHER-CONTROL	72	31.00	68.00	46.15	8.34
TOTAL	72	30.00	64.00	48.06	7.39
Valid N (listwise)	72				

Moreover the mean score for each of the three subscales of ProQol, that measure burnout, secondary trauma and compassion satisfaction are shown in the table 13 below.

Table 13: Mean Scores on ProQol subscales

	N	Minimum	Maximum	Mean	Std. Deviation
COMSAT	72	19.00	50.00	34.69	5.97
BURNOUT	72	8.00	35.00	21.38	6.42
SECTRAUM	72	.00	20.00	8.79	4.95
Valid N (listwise)	72				

As we can see from table 13 the mean score for burnout and compassion satisfaction is quite high whereas the mean score of the secondary trauma subscale is low (Stamm, 1995-2002).

Exploring specific questions and hypotheses related to vicarious and secondary trauma.

Hypothesis 6: Professionals who have more CSA clients on their caseloads will be at more risk of vicarious traumatisation and secondary trauma.

Prediction 6a: A significant association is expected between the percentage of CSA clients on professionals' caseload (question 10 of P-SQAPRESA) and the total score of TABS that measures vicarious traumatisation.

Prediction 6b: A significant association is expected between the percentage of CSA clients on professionals' caseload (question 10 of P-SQAPRESA) and the scores of the two subscales of ProQol that measure burnout and secondary trauma.

A Pearson Correlation analysis was performed to explore the above hypothesis. Table 14 shows the results of the Pearson correlation analysis between the percentage of CSA clients on professionals' caseload and the three subscales of ProQol (Compassion satisfaction, Burnout, Secondary trauma) and the subscales of TABS (Self-safety/Other-safety, Self-Trust/Other-Trust, Self-Esteem/Other-Esteem, Self-Intimacy/Other-Intimacy and Self-Control/Other-Control) that measure vicarious trauma.

Table 14: Correlation between sexual abused clients on caseload and scores of VT and ST

ProQol	PEARSON CORRELATION	SIG. (2-TAILED)	N
COMSAT	.09	.43	72
BURNOUT	.30**	.01	72
SECTRAUM	.42**	.00	72
TABS			
SELFSAFE	.15	.21	72
SELFTRUST	-.06	.63	72
SELFESTEEM	.02	.85	72
SINTIMACY	.09	.47	72
SCONTROL	.15	.22	72
OTHERSAFETY	.17	.16	72
OTHERTRUST	.22	.07	72
OTHERESTEEM	.25*	.03	72
OTERINTIMACY	.22	.06	72
OTHERCONTROL	.26*	.03	72
TOTAL	.25*	.04	72

* Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed)

From table 14 we can see that a significant correlation was found between the percentage of sexually abused clients on caseload and the two subscales of Pro Qol (burnout and secondary trauma subscale) and a positive significant correlation was also found between the percentage of sexually abused clients and the total score of the

TABS scale that measures vicarious traumatisation. Therefore the above hypothesis was confirmed which means there is an association between the number of CSA clients on ones caseload and the risk for the development of vicarious trauma and secondary trauma.

In terms of the specific subscales of Vicarious Traumatisation Scale, table 14 also shows that the number of sexually abused clients on the caseload affect mainly cognitive disruptions that refer to "others" than the "self". In particular, the cognitions that are significantly affected as the number of CSA clients increases in ones caseload, are cognitions that refer to "other-esteem" and "other-control" (please refer to discussion for the meaning and implication of this result).

Is there an association between percentage of clients who suffer from PTSD (as a result of trauma other than sexual abuse) and levels of vicarious traumatisation (TABS) and secondary trauma (ProQol)?

A Pearson correlation analysis was performed between percentage of PTSD clients (given by Question 11 of P-SQAPRESA) and scores from TABS subscales and scores of the two subscales of ProQol (burnout and secondary trauma). Results showed that no significant correlation was found between percentage of PTSD clients in professionals' caseload and symptoms of Vicarious Traumatisation as measured by the total score of TABS scale, $r = .16$, $p > .05$. Results showed no significant correlation with any of TABS subscales as well (SS $r = .13$, ST $r = -.23$, SE $r = -.004$, SI $r = -.06$, SC $r = .01$, OS $r = .12$, OT $r = .20$, OE $r = .23$, OI $r = .16$, OC $r = .22$).

Moreover, no significant correlation was found between percentage of PTSD clients in a professional's caseload and symptoms of secondary trauma as measured by the two subscales (burnout and secondary trauma) of ProQol scale. In particular for burnout subscale r= .06, p>05 and for secondary trauma subscale r= .14, p>.05.

Hypothesis 7: A significant difference is expected between the frequency in which professionals enquire about sexual abuse and symptoms of vicarious trauma and compassion fatigue/secondary trauma.

Prediction 7: Professionals who would report that they "always" or "sometimes" enquire about CSA (question 17 of P-SQAPRESA) will have a significantly different total score on Vicarious Trauma scale (TABS) and on the two subscales of ProQol (burnout and secondary trauma) than those who would report that they "never" enquire (question 17 of P-SQAPRESA).

In order to examine any differences between frequency of enquiry and scores of vicarious traumatisation (VT) as measured by TABS and scores of secondary trauma (ST) as measured by the three subscales of ProQol (burnout, secondary trauma and compassion satisfaction) an ANOVA was performed and the results can be seen on the table 15.

Table 15: Frequency of enquiry and symptoms of VT (TABS) and ST (ProQol)

Vicarious traumatisation (TABS)	**N**	**Mean**	**SD**	**F value**
Always enquire	12	45.33	10.91	F(2,69)=1.20
Sometimes enq.	50	48.32	6.32	
Never enquire	10	50.00	7.27	p= .31
Total	72	48.06	7.39	p> .0125
Compassion Satisfaction (ProQol)				
Always enquire	12	39.25	5.53	F(2,69)=5.55**
Sometimes enq.	50	34.20	5.46	

Never enquire	10	31.70	6.50	p=.006
Total	72	34.69	5.97	p< .0125

Burnout (ProQol)

Always enquire	12	20.83	8.03	F(2,69)=.10
Sometimes enq.	50	21.36	6.25	
Never enquire	10	22.10	5.78	p=.90
Total	72	21.37	6.42	p> .0125

Secondary trauma (ProQol)

Always enquire	12	11.17	5.67	F(2,69)=1.70
Sometimes enq.	50	8.50	4.56	
Never enquire	10	8.28	5.62	p=.19
Total	72	8.79	4.95	p> .0125

****Bonferoni Correction (0.05/4= 0.0125). Differences are significant at 0.0125 level**

The mean scores on table 15 indicate that professionals who enquire more frequent about sexual abuse have higher scores of compassion satisfaction. Table 15 also shows that the mean scores of vicarious traumatisation and burnout of professionals who always enquire are lower compared to those who never enquire whereas the mean scores of secondary trauma of professionals who always enquire are higher than those who never enquire.

Results from the ANOVA showed that the differences between frequency of enquiry and vicarious traumatisation as well as the two ProQol subscales-burnout and secondary trauma- were not found to be significant and so the above hypothesis was not confirmed. However, a significant difference was found between frequency of enquiry and the third subscale of ProQol, the compassion satisfaction subscale.

Hypothesis 8: A significant difference will be found between levels of comfort/competency professionals say they feel about enquiry/treatment of CSA and symptoms of Vicarious Trauma and Secondary Trauma.

Prediction 8: There will be significant differences on total scores of TABS and on the two subscales of ProQol (burnout and secondary trauma) between professionals who

score 1,2,3 and 4 on Likert scales of questions 22,23,24 and 25 of P-SQAPRESA (score of 4= feel extremely comfortable/competent, score of 1= don't feel comfortable/competent at all)

In order to explore the above hypothesis and test for any existing significant differences a number of ANOVA were conducted between 1) how **comfortable** professionals feel about **enquiring** for sexual abuse on a scale of 1 to 4 and the risk of vicarious traumatisation (measured by total score of TABS) and secondary trauma (measured by the scores on two subscales of ProQol, burnout and secondary trauma). 2) How **comfortable** professionals feel about **treating** sexual abuse on a scale of 1 to 4 and the risk of vicarious traumatisation (measured by total score of TABS) and secondary trauma (measured by the scores on two subscales of ProQol, burnout and secondary trauma). 3) How **competent** professionals feel about **enquiring** about sexual abuse on a scale of 1 to 4 and the risk of vicarious traumatisation (measured by total score of TABS) and secondary trauma (measured by the scores on two subscales of ProQol, burnout and secondary trauma) and finally 4) how **competent** professionals feel about **treating** sexual abuse on a scale of 1 to 4 and the risk of vicarious traumatisation (measured by total score of TABS) and secondary trauma (measured by the scores on two subscales of ProQol, burnout and secondary trauma)

Table 16 below shows the mean scores of vicarious traumatisation, burnout and secondary trauma for each level of competence and comfort as well as the F scores of the ANOVAs conducted.

Table 16: Mean scores of Vicarious Traumatisation in relation to feelings of comfort/competency

	1=Not at all	2	3	4=Extremely	F	Sig.
Comfortable asking	46.75 N=4	49.33 N=18	48.32 N=34	46.37 N=16	**.50**	**.68**
Comfortable treating	43.80 N=5	46.33 N=18	50.82 N=28	46.85 N=21	**2.53**	**.07**
Competent asking	45.33 N=3	48.30 N=20	48.22 N=31	47.94 N=18	**.15**	**.93**
Competent treating	43.80 N=5	48.22 N=22	49.16 N=31	46.86 N=14	**.91**	**.44**

Mean scores of Burnout in relation to feelings of comfort/competency

Comfortable asking	21.50 N=4	22.38 N=18	20.76 N=34	21.50 N=16	**.25**	**.86**
Comfortable treating	14.00 N=5	22.00 N=18	22.46 N=28	21.14 N=21	**2.71**	**.05**
Competent asking	18.67 N=3	19.15 N=20	22.58 N=31	22.22 N=18	**1.47**	**.23**
Competent treating	14.00 N=5	22.64 N=22	21.87 N=31	20.93 N=14	**2.75**	**.05**

Mean scores of Secondary Trauma in relation to feelings of comfort/competency

Comfortable asking	11.75 N=4	9.00 N=18	7.71 N=34	10.13 N=16	**1.45**	**.24**
Comfortable treating	6.40 N=5	9.89 N=18	8.89 N=28	8.29 N=21	**.75**	**.52**
Competent asking	10.00 N=3	7.55 N=20	9.00 N=31	9.61 N=18	**.65**	**.58**
Competent treating	6.40 N=5	10.04 N=22	8.77 N=31	7.71 N=14	**1.08**	**.36**

lBonferoni Correction (0.05/4= 0.0125). Differences are significant at 0.0125 level**

Table 16 shows that most of the Vicarious Traumatisation mean scores of the professionals who said they don't feel at all comfortable/competent asking about sexual abuse or treating sexual abuse (i.e. scored 1) are slightly lower than of the professionals who said they felt extremely competent/comfortable asking or treating CSA (who scored 4 on the scale of comfort/competence).

In addition table 16 shows that the mean scores for Burnout of the professionals who said they didn't feel at all comfortable/competent asking/treating sexual abuse (scored

1) are much lower than the mean scores of professionals who said they felt extremely comfortable/competent asking/treating (scored 4).

Finally table 16 shows that in terms of the secondary trauma subscale, the mean scores of professionals who said they didn't feel at all comfortable/competent treating CSA (those who scored 1 on the scale) are lower than the scores of professionals who said they felt extremely comfortable/competent treating CSA (who scored 4). On the other hand the secondary trauma mean scores of professionals said they didn't feel at all comfortable / competent asking clients about CSA (who scored 1) are higher than the scores of the professionals who said they felt extremely comfortable/competent asking about CSA (the ones who scored 4).

The results of the ANOVAs (shown on table 16) conducted showed that the above differences were not significant.

QUALITATIVE DATA ON PROFESSIONALS' QUESTIONNAIRE

In addition to gathering quantitative data, participants were asked to complete some open -ended questions in the therapists' questionnaire. The individual answers of each participant in each of these questions were collected (please see **appendix G**). In order to make sense of the answers that participants gave the answers were coded and grouped into different categories as explained previously in the method section.

Definition of sexual abuse

It is well known in the literature that the definition of child sexual abuse is quite problematic (Jackson and Nutall, 1997). The researcher was interested to examine whether there were differences between the participants since they all come from

similar professional groups, since the sample consisted of psychologists /other-therapists / psychotherapists and not from totally distinct professional groups as in studies conducted previously. In this study 68 professionals gave their individual definitions and the following categories emerged. Under each category one can see the number of participants' answers that reflected the particular category.

1.Engagement in sexual acts/behaviours/physical contact

All 68 definitions agreed on the fact that any sexual act/behaviour or physical contact is considered sexual abuse. There was no disagreement in terms of the extent of these sexual acts (i.e., watching, touching only, full intercourse etc) (see appendix G). Specifically, some of the responses included "any kind of interference with a child which aims at the sexual gratification of the perpetrator" or "anything that introduces a child to the sexual behaviour of adults" and "any sexual relationship between a child and an adult".

2. Victim's age

Almost all definitions (except 5 responses) highlighted the victim's young age, either by referring to it using the word "child" or by particularly defining the age of the victim (i.e. child under 16 or under 17 years old), "sexual advances towards children under 16", "sexual actions that happen to someone below 17 years old", "sexualised behaviour experienced at an inappropriate developmentally age". The definitions that professionals gave in this study reflect the general problem that exists in the area of child sexual abuse regarding the age of the victim which results in different studies using definitions of sexual abuse that include different age limits.

3.Perpetrator's age

Thirty -three out of the sixty -eight responses given refer to the age of the perpetrator by including the word "adult". The rest of the definitions do not mention the age of

the perpetrator. Some examples that refer to perpetrator's age are: "sexual activity carried out by an adult to a child", "someone who is older interferes sexually with a child".

4.Power issues

Five definitions mention power issues i.e. the perpetrator needs to be in power or forcing the victim, "forcing or persuading a child to perform sexual acts", "an experience of a youngster or a child where a person in power inflicts sexual acts on them" (see answers 3, 38, 39,14, 70 in appendix G).

5.Were the acts wanted or unwanted?

Five definitions refer to sexual abuse as being an unwanted experience (see answers 1, 10, 16, 17, 41) whereas one definition refers to it as both "wanted or unwanted" (see answer no 37).

6. Consent issues

Nine definitions refer to consent in terms of the victim being in a position that consent cannot be taken i.e. "inappropriate sexual contact with a minor where consent cannot be taken"(see answers 24, 25, 30, 35, 37, 42, 43, 58, 67,68).

7.Developmental issues

Three definitions mention developmental issues "sexualised behaviour experienced at an inappropriate developmentally age" (see answers 12, 3, 45)

8. Creation of distress

One definition refers to sexual abuse as an act that needs to have caused distress to the client (see answer 31).

Why psychologists think that an initial assessment should include questions about sexual abuse.

Twenty – three out of the seventy two professionals said that they routinely enquire about sexual abuse experiences (see individual answers in appendix G). The categories that emerged from their justifications were the following:

1. Validates clients' experience and sends the message to clients that this is not a taboo to keep it a secret.

Eleven professionals gave that justification "gives clients permition to talk about it", "clients need to feel they have permition to disclose such experiences and therapists have to give that opportunity" (please see individual answers, 1,2,4,14, 29, 38,47, 52, 60,61,66).

2. Due to the effects of child sexual abuse and in order to provide better treatment.

Eleven answers from professionals echo that category that refers mainly on formulation and treatment reasons "in order to obtain complete history", "important for formulation", " very important factor in psychopathology" (see answers 3,5,6,16,20,24,26,40,56,60,65).

3. Child sexual abuse is so common

Two professionals referred to the prevalence of sexual abuse as a reason to enquire (please see 19,20 individual answers).

4. Common practice

Only one professional gave that justification for a routine enquiry (answer 22).

<u>Why psychologists think that an assessment should never include questions about sexual abuse.</u>

Thirteen professionals out of the seventy -two in total said that they do not enquire about sexual abuse experiences during an initial assessment (see individual answers in appendix G). The categories that emerged from their justifications are the following:

1. Could be abusive/traumatic to client or put them at risk. Four people used this argument, "it might feel abusive to client, it should be the client's choice to disclose otherwise it could be traumatic to them" (see answers 10,53,62,63).

2. Could mislead clients, force their attention somewhere that did not intend to and distract them from what they really want to address in therapy. Three participants answered like that (please see answers 8,9,50).

3. Timing issues and fear of premature termination. Three professionals referred to this argument, " the client might feel pressurised and terminate therapy if asked such a thing" (see individual answers 15,39,43).

4. By asking you assume it is traumatic. Two professionals supported this argument (see individual answers 18, 44).

5. Assessment is about suitability to therapy. Only one participant used this argument against routine enquiry (answer 32).

<u>Why professionals think that only sometimes an assessment should include questions about sexual abuse.</u>

The majority of participants thirty- six out of the seventy- two, said that they only sometimes enquire about sexual abuse experiences during an initial assessment with a client. They were then asked to explain when they decide to ask and when they do not. Individual answers are shown in **appendix G**. The following categories summarize their answers both for the times they enquire and the times they don't.

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2. When client is in distress or psychotic: Eight professionals gave this answer, "do not ask if client is in distress during assessment", "do not ask if client is psychotic or is likely to relapse" (see answers 4,13,22,45,51,57,64,69).

3. When enquiry is irrelevant to presenting problem/there is no indication: Seven professionals justified their answer like that, "do not ask if there is no suspicion due to client's presenting problem", "do no ask if there is no indication" (see answers 2,16,25,30,31,34,46).

4. When relationship has not been established: Six participants gave this justification, "do not ask if it is too early because it can damage the relationship", "do not ask if I feel it will damage the therapeutic relationship" (see answers 11,28,48,54,55,59).

5. When the presenting problem is about the here and now: Three professionals gave this answer (see individual answers 12,36,58).

<u>Does personal therapy of the therapist help professionals to work better with sexually abused clients?</u>

Fifty- one out of the seventy- two participants said that personal therapy of the therapist is helpful or is sometimes helpful (see individual answers in **appendix G**).

The categories that emerged from participants' answers were the following:

1. Personal therapy helps in terms of exploration of oneself/acknowledging limitations: Sixteen professionals gave an answer that reflects the above category, "recognise own blind spots and limitations", "therapy helps all therapists and makes them more sensitive to client's needs", "knowing one self is always helpful" (see answers 4,10,16,19,27,32,33,34,35,36,38,40,53,57,62,65).

2. Personal therapy helps the therapist to process difficult emotions or attitudes around the work of sexual abuse: Thirteen professionals answered like this, "if the therapist has difficulties in this area of work", "it helps process difficult thoughts and feelings", "csa work can trigger chords to therapists that need processing", "helps explore attitudes around sexual abuse" (see answers, 2,8,15,17,18,22,41,44,45,56,64 66).

3. Personal therapy can help when the therapist has experienced sexual abuse as a child: Twelve participants justified personal therapy as positive due to the above category, "depends on therapist's own history", "if therapist has gone through similar experiences", "if therapist is a survivor it helps understand countertransference" (see answers 11,13,21,29,30,42,46,47,52,55,58,60,68).

4. Personal therapy helps because of countertransference issues and the danger of vicarious traumatisation: Ten professionals answered like this, "to prevent over identification with the victim and process feelings around abuse", "prevents vicarious trauma", "to work through emotional response of therapist", "therapy helps to understand therapist's sexualised feelings when working with CSA clients" (see individual answers 3,12,14,26,51,54,59,61,67).

RESULTS FROM CLIENTS' DATA

Demographics

Sixty adult clients participated in this study. Sixty two percent (37/60) were female and thirty eight percent (23/60) were male. The age of the participants ranged from twenty years old to sixty years old with a mean age of thirty- five years. In terms of the participants' ethnic origin the majority (51%) reported being "White- British". Other ethnicities included, Asian, Black African, Black Carribean, British Indian,

White European, Irish, Kenyan. However, exact percentages cannot be reported here, since the section where clients had to report their ethnicity had a blank space that people needed to complete. As a result many people were not specific and wrote i.e. Black, White, English, British and so where somebody reports "White" it is not clear if it is White-British or other.

Finally, fifty two percent of the sample (31 clients), reported having been sexually abused. From the fifty-two percent who had experienced child sexual abuse, twenty eight percent had disclosed that to a therapist.

Would clients mind being asked about experiences of sexual abuse during an initial assessment?

Table 17 below shows that the majority of clients (85%, 51/60) reported that they wouldn't mind being asked about experiences of abuse during an initial assessment, 7% (4/60) said they wanted to be asked, 3% (2/60) said they didn't want to be asked and 5% (3/60) reported that they had no opinion.

Table 17: Do clients mind being asked about experiences of sexual abuse?

Gender	Do not mind	Do not want	Do want	No opinion	Total
Male	21 91.3%	1 4.3%	0 (0%)	1 4.3%	23 100%
Female	30 81.1%	1 2.7%	4 10.8%	2 5.4%	37 100%
Total	51 85.0%	2 3.3%	4 6.7%	3 5.0%	60 100%
Abused/non abused					
Abused and disclosed abuse	13 76.5%	2 11.8%	2 11.8%	0 0%	17 100%
Abused but did not disclose abuse	12 85.7%	0 0%	1 7.1%	1 7.1%	14 100%
Not abused	26	0	1	2	29

	89.7%	0%	3.4%	6.9%	100%
Total	51 85.0%	2 3.3%	4 6.7%	3 5.0%	60 100%

As is summarised on the table 17 both males and females seem to have answered similarly this question since the majority of both genders said they didn't mind being asked. In addition table 17 shows that the higher percentage for all three categories of participants (those who had no experiences of abuse, those who did not disclose experiences, those who disclosed experiences) said they would not mind being asked about such experiences during an initial assessment.

In order to explore whether there was an association between the gender of participants and the way they answered the above question a chi-squared analysis was performed. The result showed that there was no significant association (Fisher's Exact = 2.85, p= .48). Moreover, no significant association was found (Fisher's Exact= 6.24, p= .30) between possible experiences of abuse (i.e. clients who had/had not disclosed sexual abuse experiences and clients who said they had no sexual abuse experiences) and the way they answered the above question.

Participants were also asked a question similar to the previous one later on in the questionnaire. In particular, they were asked to hypothesise that a psychologist had never asked them about sexual abuse experiences and to report whether they would have liked it instead. Participants had to choose one of three given options "yes", "no", "I would not mind" (question 10 from client's questionnaire, see appendix D).

Table 18: Would clients have liked to be asked about CSA experiences?

Gender	**Would have liked to have been asked**	**Would not have liked to have been asked**	**Would not mind to be asked**	Total
Male	3 (13%)	1 (4.3%)	19 (82.6%)	23 (100%)

Female	4 (10.8%)	3 (8.1%)	30 (81.1%)	37 (100%)
Total	7 (11.7%)	4 (6.7%)	49 (81.7%)	60 (100%)

Abused/non abused

Disclosed abuse	4 (23.5%)	0 (0%)	13 (76.5%)	17 (100%)
Did not disclose	3 (21.4%)	2 (14.3%)	9 (64.3%)	14 (100%)
Not abused	0 (0%)	2 (6.9%)	27 (93.1%)	29 (100%)
Total	7 (11.7%)	4 (6.7%)	49 (81.7%)	60 (100%)

Table 18 shows the breakdown of percentages of clients who said they would have liked to be asked about sexual abuse, would not have liked to have been asked and of those who said that they would not mind to be asked. Table 18 also shows the breakdown of participants' answers according to their gender (male/female) and to whether they said they were abused/not –abused. From the table it is shown that the majority of both males (83%, 19/23) and females (81%, 30/37) reported that they would not mind being asked about sexual abuse experiences. Moreover, the highest percentage of those who said that they disclosed their abuse (76.5%, 13/17), of those who said they did not disclose their abuse (64.3%, 9/14) and of those who said they were not abused (93.1%, 27/29) reported that they would not mind to be asked about CSA.

In order to explore whether there was any significant association between the gender of participants and whether they would mind/wouldn't mind been asked about CSA a chi-squared analysis was performed. The result of the analysis showed no statistically significant associations between the gender of participants and whether they minded being asked about CSA (Fisher's Exact= .44, p= 1.00).

Another chi-squared analysis was performed in order to explore whether there was any significant association between abused/non -abused participants and whether they would have liked or not to be asked about CSA experiences. The result of the chi-

squared analysis showed a significant association (Fisher's Exact= 10.62, p= .01). Specifically, participants who reported that they would have liked to have been asked about such experiences during their assessment were all sexually abused compared to those who said they wouldn't mind of which the majority (55%) were not abused. Moreover, from the participants who said they would not have liked to be asked none of them had disclosed their abuse.

According to clients what is the best way a psychologist could ask them about experiences of child sexual abuse?

Table 19 below shows the breakdown of clients' answers on the above question. From the table we can see that the highest percentage of clients (48%, 29/60) reported that the psychologist should ask about possible experiences of sexual abuse but leave the details and address them later in therapy. Moreover, 37% (22/60) ticked the option "a psychologist should initiate such a topic and ask about experiences of sexual abuse rather than wait for the client to disclose it". Only 10% (6/60) of the clients ticked the option " the psychologist should wait for the client to talk about it" and 5% (3/60) reported "not sure".

Table 19: What is the best way to ask about CSA experiences?

Gender	Psychologist to initiate topic rather than wait for client	Psychologist should wait for the client to bring it up	Psychologist should ask but discuss details during therapy	Not Sure	Total
Male	11 47.8%%	2 87%	10 43.5%	0 0%	23 100%
Female	11 29.7%	4 10.8%	19 51.4%	3 8.1%	37 100%
Total	22 36.7%	6 10%	29 48.3%	3 5.0%	60 100%
Abused/non abused					
Disclosed abuse	10 58.8%	1 5.9%	5 29.4%	1 5.9%	17 100%
Did not disclose abuse	2 14.3%	3 21.4%	9 64.3%	0 0%	14 100%
Not abused	10 34.5%	2 6.9%	15 51.7%	2 6.9%	29 100%

Total	22 35.7%	6 10%	29 48.3%	3 5.0%	60 100%

Table 19 also shows the breakdown of participants' answers according to their gender and to whether they reported being abused/non abused. In particular, the table shows that the majority of males (47.8% or 11/23) believe that the psychologist should initiate the topic of possible experiences of sexual abuse whereas the majority of females (51.4% or 19/37) believe that the psychologist should ask about possible experiences of sexual abuse but leave the details to be explored later in therapy. Moreover, table 19 shows that the highest percentage of clients who disclosed their abuse experiences (58.8%, 10/17)) believed that the psychologist should initiate the topic of sexual abuse during an assessment whereas the majority of clients who had no experiences of sexual abuse (51.7%, 15/29) or who had not disclosed their experiences (64.3%, 9/14) believed that although the psychologist should ask he/she should address the details of the abuse later in therapy.

In order to explore whether there was any significant association between the gender of participants and what they thought was the best way to ask about CSA experiences a chi-squared analysis was performed. No significant association was found (χ^2 (3)= 3.38, p= .34).

In order to explore whether there was any significant association between participants who have disclosed abuse/not disclosed abused or never been abused and what they thought was the best way to ask about CSA experiences, another chi-squared analysis was performed. The chi-squared analysis showed that there was no significant association (Fisher's exact= 9.08, p= .11).

Would participants prefer to be asked about CSA during an assessment 1)directly by the psychologist? 2)to be given a relevant questionnaire to complete by themselves? Or 3) to complete a relevant questionnaire with the psychologist's help?.

The majority of participants, (65%, 39/60) prefer to be asked directly by a psychologist regarding CSA experiences, compared to 22% (13/60) who prefer to be given a questionnaire to complete with the help of the therapist and 12% (7/60) who prefer to be given a relevant questionnaire to complete by themselves. There was one participant who chose the option "other" and explained that she would prefer to be asked about CSA experiences gradually during treatment.

In terms of how each gender answered this question, the majority of both males (74%, 17/23) and females (60%, 22/37) reported that they preferred to be asked directly. In addition how participants who had/had not disclosed abused or who had no abused experiences answered this question it was found: the majority of those who disclosed abuse (77%, 13/17), 50% (7/14) of those who did not disclose their abuse and the majority of those who said they had not experienced any abuse (66%, 19/29) reported that they preferred to be asked directly about sexual abuse experiences.

In order to explore whether there were any significant associations between the gender of participants and how they answered the question and between disclosures of abuse and their answers to this question, a chi-squared analysis was performed. Neither gender of participants (Fisher's Exact= 2.38, p= .55) nor whether they had revealed/not revealed experiences of abuse (Fisher's Exact= 4.39, p= .67).

was significantly associated with how they answered this question.

Is it important for a psychologist to know whether you have been sexually abused?

Seventy one percent (43/60) of the participants said "yes", 22% (13/60) said "not sure" and only 7% (4/60) "no".

The majority of both males (65% or 15/23) and females (76% or 28/37) reported that it would be important for their therapeutic plan for the psychologist to know whether they had experiences of sexual abuse compared to 22% of males (5/23) and 22% of females (8/37) who reported that they were not sure whether such knowledge would be important and to 13% (3/23) of males and 3% (1/37) of females who reported that such information would not be useful for their therapeutic plan. In order to explore whether there was any significant association between participants' gender and the answers that gave to this question a chi-squared analysis was performed. Results from the analysis showed that the answers that people gave were not significantly associated with their gender (χ^2 (2)= 2.49, p= .29).

Moreover regarding the answers of participants who have disclosed/not disclosed sexual abuse and of those who said they never had experiences sexual abuse, in all three groups of participants the highest percentages, 88% (15/17) of those who disclosed abuse, 64% (9/14) of those who did not disclose their experiences of abuse and 66% (19/29) of those who said they had no experiences of abuse, said they thought it would be important for their psychologist to know whether they had been sexually abused or not. To explore whether there was any significant association

between the answers that participants gave and whether they had disclosed/not disclosed or never experienced sexual abuse a chi-squared analysis was performed. Marginally significant associations were found between participants who had/had not disclosed sexual abuse, the ones who said that they had no CSA experiences and the way participants answered this question, (Fisher's Exact= 8.76, p= .04).

Has a psychologist asked participants about experiences of sexual abuse? If Yes, When? Was it done appropriately?

The majority of the clients (55%, 33/60) said they were asked about CSA experiences. From the 33 clients who said they were asked about CSA, 55% (18/33) said this was done during an assessment and 46% (15/33) said they were asked during therapy. Also 52% of participants (31/60) said they were asked about CSA experiences in an appropriate way, only one participant (2%) said this was not done appropriately and one (2%) circled the "not sure" option.

Table 20 below shows the breakdown of participants' answers on the above question in terms of their gender and in terms of whether they had disclosed abuse experiences or not.

Table 20: Did a psychologist ask participants about sexual abuse?

Gender	Clients were asked about CSA			Were not asked about CSA	Total
	Assessment	Therapy	Total		
Male	6 (50%)	6 (50%)	12 (52%)	11 (47.8%)	23 (100%)
Female	12 (57.1%)	9 (42.9%)	21 (56.8%)	16 (43.2%)	37 (100%)
Total	18 (54.5%)	15 (45.5%)	33 (55.0%)	27 (45.0%)	60 (100%)
Abused/non abused					
Disclosed abuse	6 (42.2%)	7 (53.8%)	13 (76.5%)	4 (23.5%)	17 (100%)

Did not disclose abuse	1 (50%)	1 (50%)	2 (14.3%)	12 (85.7%)	14 (100%)
Not abused	11 (61.1%)	7 (38.9%)	18 (62.1%)	11 (37.9%)	29 (100%)
Total	18 (54.5%)	15 (45.5%)	33 (55.0%)	27 (45.0%)	60 (100%)

In particular, table 20 shows that the majority of both males 52% (12/23) and females 57% (21/37) reported that a psychologist had asked them about experiences of sexual abuse. In addition, 77% (13/17) of clients who said they had disclosed their abuse experiences, had been asked about CSA experiences by a psychologist compared to 24% (4/17) who disclosed their sexual abuse without being asked. Also 14% (2/14) of clients were asked but did not disclose their experiences compared to a larger percentage of 86% (12/14) who were not asked and did not disclose their sexual abuse experiences.

In order to explore whether there was any significant association between the gender of participants and whether they have been asked about sexual abuse experiences a chi-squared analysis was performed. The results showed no significant associations (χ^2 (1)= .12, p= .73). A chi-squared analysis was performed also to check for a possible significant association between disclosures of abuse or not and whether participants have been asked about it. The chi-squared analysis showed a significant association between disclosure of sexual abuse from participants and whether they have been asked or not (χ^2 (2)= 13.13, p= .001).

Results from common questions asked to both professionals and clients

What is most important when a psychologist asks about experiences of sexual abuse?

The participants had to put a tick to one or more of the following options: 1.the exact words the professional chooses in order to ask, 2. the way the professional asks (tone of voice etc), 3. the way the professional responds to such enquiry, 4. other.

The majority of both clients and therapists selected the second and the third option of this question, which says that it is the way the professional asks (i.e. tone of voice, nonverbal communication) as well as the way the professional responds to such enquiry that is most important when asking a client about sexual abuse experiences.

In the same question there was an option where respondents could write their own thoughts about it. Not many clients chose this option apart from one who wrote that is important for the psychologist to nod the head in a comforting way. Seven therapists on the other hand wrote their own thoughts, which included the following: "level of rapport", "timing is important when you ask" and "what the patient perceives".

What method should be used when a psychologist wants to enquire about experiences of sexual abuse?

Participants had to tick one of the following four options: 1. the therapist should directly ask the client, 2. The therapist should give a questionnaire to the client, 3. the therapist should help the client to complete a questionnaire on the topic, 4. other.

The first choice for both clients and therapists was that a psychologist should directly ask the client whether he/she had experiences of sexual abuse. In particular, 67%

(48/72) of professionals and 65% of clients (39/60) chose this option. The second highest percentage (22% for clients and 11% for therapists) was again on the same choice for both clients and therapists and that was "client to complete a relevant questionnaire with the help of the therapist".

CHAPTER FIVE: Discussion

This chapter will present a discussion of the results generated by this study. The results from therapists' data will be discussed in relation to the results from clients' data. This chapter will also include a discussion of the implications for practice and training and the strengths and limitations that the researcher sees in the study as it was completed. Recommendations for future research and practice will also be made.

Attitudes towards enquiry

What do professionals think regarding routine enquiry of sexual abuse and what are their practices?

One of the aims of this study was to examine professionals' attitudes and practices on the issue of enquiry. Previous studies have shown that professionals are reluctant to ask clients about experiences of sexual abuse (Mitchell et. al., 1996, Lab et. al., 2000) and that such data is often missed from clients' medical files (Jacobson and Richardson, 1987, Jacobson et. al., 1987, Lanktree et. al., 1989). As a result, it was hypothesised that the participants of this study would believe that clients should only sometimes or never be asked about sexual abuse during an initial assessment and that they would be reluctant to enquire.

The majority of professionals in this study reported they believed clients should be asked about sexual abuse some of the time and the majority of them said they actually enquired about sexual abuse some of the time. This reveals a more positive attitude and practice towards sexual abuse enquiry than results from older studies (Richardson, 1987, Craine, 1988, Cole, 1988, Rose, 1991, Mitchell et al., 1996) and is more consistent with results from more recent studies conducted in this area which

show that professionals do enquire some of the time (Lab et al., 2000, Young et. al., 2001). However, although professionals' attitudes towards enquiry have been more positive it seems that professionals prefer to ask only some of the time which still, as in previous research (Rose et al., 1991; Mitchell et al., 1996), shows some reluctance about such enquiry being done routinely during an assessment. Such reluctance of therapists to routinely ask about experiences of sexual abuse was also highlighted from the results of the clients' data that showed that although 55% of clients reported that a psychologist had asked them about experiences of sexual abuse during an assessment almost an equal percentage of clients (45%) said they were never asked. One could argue that clinicians base their decision to enquire about sexual abuse on their clinical judgement and therefore that justifies the fact that they are reluctant to enquire routinely. However, the results of the qualitative part of this study showed that professionals' criteria on which they base such decision are many times subjective and biased. These criteria will be discussed in detail later in this section.

Furthermore, it seems that there are significant differences in the attitudes and practices of the various groups of participants. Although the majority of clinical psychologists and therapists reported that they believed clients should be asked only sometimes, the majority of counselling psychologists reported that they believed clients should be always asked about sexual abuse during an initial assessment. Such difference can be explained perhaps by differences in training but this is a hypothesis that would need to be tested further. What is interesting though is that looking at each category of professionals, although the majority of counselling psychologists believed that they should always enquire about sexual abuse during an initial assessment, when they were asked what they actually did the majority of them said that they only

enquired some of the time, similar to the rest of the professional groups. Pruitt & Kappious (1992) in their study found similar discrepancies where although the majority of therapists endorsed the belief that clients should be directly asked about sexual abuse only half of them reported they actually did that. Such discrepancies indicate that although therapists acknowledge the need for routine enquiry of sexual abuse for some reason they decide not to do it.

What was also interesting though in terms of enquiry was that no significant difference was found between female and male clients in terms of whether they were asked about CSA. Such a finding contradicts previous findings that male clients are less likely to be asked about experiences of sexual abuse compared to female clients (Lab et. al., 2000). One possible explanation could be that since the clients' sample was a convenience sample, clients were recruited only from the borough in which the researcher worked and so psychologists of the borough might have been influenced by recent discussions with the researcher about her study. Therefore therapists might have increased their rate of asking people about sexual abuse experiences or they might have become more aware of such enquiry and were more careful in terms of not being biased against male clients.

This finding could also be explained by the fact that this study referred to assessment procedures done by psychotherapists/psychologists only and not by different mental health workers (nurses, psychiatrists, social workers etc) as in previous studies. Thus, this could mean that for psychologists it might not be the client's gender that prevents them from enquiring about CSA but other factors. Some speculations about this include the fact that they might decide whether to ask or not on the basis of the

client's presenting problem, client's distress or they could even base their decision to ask or not on whether they feel adequately equipped and competent with such an enquiry. Future research on this is important

What are the arguments that participants brought to support or not support routine enquiry of sexual abuse?

The majority of professionals in this study did not support routine enquiry during an initial assessment, instead they argued that professionals should only sometimes enquire about sexual abuse. There were some participants though who supported routine enquiry and some who were totally against it.

The following three paragraphs present participants' arguments for the need of routine enquiry as well as evidence from the scientific literature.

Examining these arguments of the professionals who supported routine enquiry it seems that these were well justified and supported by the scientific literature. In particular, half of those reported that by enquiring the professional sends the message to the client that the issue of sexual abuse is not a taboo and they therefore do not need to keep it a secret anymore. Such justification is also reported by many authors and studies in the area of sexual abuse that highlight the difficulty clients have in disclosing such information spontaneously (Rose, 1991, Lister, 1982, Jacobson et. al., 1987, Pruitt and Kappious, 1992, Courtois, 1998). It is also supported by the results of this study that showed that the majority of clients who disclosed sexual abuse experiences were those who were directly asked about it.

Moreover, another argument that professionals who supported routine enquiry reported in this study referred to the effects that sexual abuse has on the person and therefore to the importance of such information to the formulation and the client's treatment plans. This seems again to be a valid argument in light of recent studies that reveal sexual abuse to be the most powerful predictor of later psychiatric symptoms (Briere et. al., 1997) especially since studies support the link between sexual abuse and suicidality (Kaplan et. al., 1995, Young et. al., 2001). Thus the argument that professionals brought here supporting routine enquiry is actually very important since risk assessment is a vital part of an initial assessment. If sexual abuse is linked with suicide risk then not knowing about a possible history of sexual abuse could seriously compromise an assessment procedure. It is however important to say that enquiring about sexual abuse experiences doesn't guarantee a disclosure by a client and therefore it doesn't resolve the problem of non disclosure completely, but it seems from this data that enquiry may at least assist the process of disclosure.

There were also two participants supporting routine enquiry by saying that sexual abuse is very common. This is a very realistic argument, since the prevalence of sexual abuse particularly within clinical populations has been found to reach levels of 70% (Wurr and Patridge, 1996, Price et. al., 2001).

In terms of the professionals who said they didn't enquire routinely but only some of the time, their criteria on which they based such decision seem to be quite problematic. In particular, the majority reported that they would ask when clients bring it up or give a hint, which is similar to what other researchers reported in their studies (Lab et. al., 2000, Pruitt and Kappious, 1992). The next two most common

criteria for asking about sexual abuse experiences were if a sexual abuse history was noted in the referral letter or case notes and when the presenting problem indicates such possibility. In light of evidence that most clients would not volunteer such information unless asked (Rose et al., 1991, Lanktree et. al., 1989, Bagley, 1992, Mitchell et. al., 1996, Jacobson and Herald, 1990, Jacobson and Richardson, 1987, Eilenberg et. al., 1996, Pruitt and Kappious, 1992, Briere and Zaidi, 1989, Craine et. al., 1988) and that most professionals would not record a history of sexual abuse on patients' charts (Read and Frazer, 1998) then professionals' practices towards identifying sexual abuse do not seem very helpful.

Moreover, the fact that professionals rely on the client to bring such a topic up is an important finding that contradicts the results from the clients' data. Results from clients' data showed that from the clients in this study who reported they had disclosed experiences of sexual abuse the majority said they had been asked directly by a psychologist. Whereas from the clients who reported that they had not disclosed their experiences of sexual abuse the majority said they were not asked about such experiences during an assessment. Such a finding further stresses the fact that clients who have been sexually abused are more likely to reveal this, if a psychologist asks them directly.

Another criterion that clinicians use, according to their reports in this study, in order to decide whether to ask or not about CSA experiences was that clients needed to present with symptoms that indicated sexual abuse history. This is an argument documented by other studies as well (Pruitt and Kappious, 1992). Such an argument is quite subjective since according to literature there is no single set of symptoms that is

considered characteristic of a history of sexual abuse. Literature suggests that there are some presenting difficulties such as post traumatic stress symptoms, sexual dysfunctions, eating disorders, self-harming behaviour, feelings of guilt, self-hatred, mistrust of others that have been highly linked with a history of sexual abuse but the conclusion from research is that childhood sexual abuse does not cause specific problems and therefore we cannot infer that a person has been abused just because they are presenting with some of the above difficulties (Kennerley, 2000, Smucker, 2005). It is generally agreed that sexually abused clients usually manifest a high variety of symptoms (anxiety, depression, psychosis) but these do not necessarily indicate a history of sexual abuse (Finkelhor, 1990).

In addition to this qualitative data that revealed some of the criteria on which professionals base their decision to enquire about CSA, clinicians were also asked to choose one of several options to indicate when they usually ask their clients about sexual abuse. Their answers were consistent with their open -ended answers since the majority of professionals reported that they enquire about sexual abuse only when clients bring it up or when it comes to mind. Only some professionals (26%) reported using a structured interview. These results further confirm the fact that most professionals use non-pragmatic methods (i.e. when it comes to mind) for such an enquiry, a finding confirmed by other studies as well (Lab et. al., 2000, Young et. al., 2001).

Finally there were some professionals who argued that clients should never be asked about experiences of sexual abuse during an initial assessment because enquiry could distract clients from what they really want to discuss in therapy, that it could be

abusive and traumatic to clients, that it could put them at risk or cause premature termination of therapy. Moreover, some other professionals reported that they would avoid such enquiry on occasions when clients do not feel comfortable disclosing such information, when the presenting problem is irrelevant to a history of sexual abuse, when clients are in distress or psychotic and when a therapeutic relationship has not been established.

Considering the above it seems that professionals' decisions to proceed in sexual abuse enquiry often seem to be subjective and based on first impressions. Questions like how does the therapist know that the client feels uncomfortable to disclose such information and when does the presenting problem relate to a possible history of abuse easily challenge such arguments. We now know that there are a lot of biases such as the gender of the client (Agar, 1998, Lab et al., 2000) or the diagnosis of schizophrenia (Read and Frazer, 1998) that influence professionals on their decision to ask or not to ask a client about a history of sexual abuse. And although it would be unproductive to ask a client about a history of sexual abuse when they are acutely psychotic or in crisis, it seems equally problematic not to ask clients on the basis of a particular diagnosis (i.e. psychosis) or on the basis of their gender. Unfortunately according to research, a diagnosis of schizophrenia and the client's gender are the two most popular biases against a sexual abuse enquiry (Read et al., 1998, Lab et al., 2000).

The above arguments against routine enquiry seem to reveal a concern about how the client might react to such an enquiry. The results of this study agree with results from previous studies that also report similar arguments from professionals who had

reservations about routine enquiry of sexual abuse (Young et al., 2001; Pruitt and Kappious, 1992; Mtchell et al., 1996) and although one could say that these concerns that clinicians have are understandable, however, no evidence in the literature appears to justify them. In particular, there seems to be no clinical evidence to support the notion that asking about sexual abuse could distract clients from the real issues they want to discuss in therapy and there is no evidence to support the idea that asking about sexual abuse gives the message that such an experience is always traumatic. Moreover, clients' responses make an original contribution and add to previous findings since these indicate that professionals' arguments against enquiry are not always valid. In particular, the majority of clients reported that they wouldn't mind being asked questions about sexual abuse during an initial assessment by a psychologist. What was more interesting was that both females and males gave similar answers to this question and, moreover, answers were independent from whether clients had been abused or not. In addition, the majority of clients reported that they thought it was important for their therapeutic plan for the psychologist to know whether they had been abused or not and this was true for both male and female clients.

These results are very important since the arguments professionals gave against routine enquiry, was that clients might feel uncomfortable, that they might terminate therapy prematurely or that it would be too early for a client to disclose such information during an assessment and so, by asking, it would be abusive for the client. Previous studies have not reported clients' beliefs about enquiry and so professionals in these studies were only assuming how clients might feel. The results of this study

clearly reveal that there is a high possibility that professionals' assumptions are erroneous.

Looking more closely at professionals' arguments against enquiry, one could say that perhaps what they are mostly concerned about is not routine enquiry itself but the way such an enquiry is made. As discussed earlier, most clinicians report that the therapist should directly ask the client about sexual abuse but in practice, most report that they usually wait for the client to bring this up. This suggests that although psychologists are probably aware of the need to directly ask their clients and facilitate the disclosure of a possible sexual abuse there are barriers that hold them back from doing so.

One hypothesis is that professionals lack appropriate training and support and so do not feel competent with how such an enquiry should be made. If we were to accept that explanation, then it becomes easier to understand the above arguments against enquiry. The above hypothesis is not however supported by the results of this study since professionals reported that they feel competent asking and treating survivors of sexual abuse despite reporting they didn't receive any specific training on enquiry.

Both professionals and clients did acknowledge that what was more important in sexual abuse enquiry was the way the professional asks the question in terms of nonverbal communication (body language, tone of voice etc) and also the way the professional responds to such enquiry which is valid in light of recommendations that are made by practitioners in the field and researchers in the area of sexual abuse who highlight the importance of knowing how to make such an enquiry (Jacobson et. al., 1990, Young et al., 2001, Briere, 1997, Dill et. al., 1991, Mahala, 2001) and also

agrees with what has been suggested so far in literature in terms of professional guidelines for enquiring (Gelinas, 1983, Read and Lindsey, 1997, Courtois, 1999, Draucker, 2000). However this is the first study in which clients also confirm the importance of knowing how to enquire about possible sexual abuse experiences.

As a result one speculation regarding the possible existing barriers that prevent routine enquiry of sexual abuse is that therapists might not feel competent with how to respond when a client discloses experiences of sexual abuse as a child during an initial assessment and so even if they feel competent/comfortable to ask they may still avoid it because of not feeling comfortable/competent with how to respond to a positive answer. Although the results of this study do not provide any evidence to support this speculation since therapists have reported feeling quite competent and comfortable both asking and treating sexual abuse survivors, therapists were not asked specifically regarding their **responses** to an early disclosure of CSA during an assessment and whether they felt equally comfortable and competent **to respond** to a possible disclosure which is something that could be addressed in future studies.

The issue of appropriate response to an initial sexual abuse disclosure is important especially during an assessment procedure where therapy has not yet started. A therapeutic relationship might not have been established and therefore inappropriate responses might easily lead to premature termination, retraumatisation of the client or even an increase in dissociative symptoms (Draucker, 2000, Pearlman and Saakvitne, 1995, Everill & Waller, 1995). It would therefore be understandable for therapists who lack appropriate training or who don't feel competent, comfortable or adequately supported to respond to a disclosure of sexual abuse to prefer not to address the issue

at all. However the hypothesis that participants of this study might not enquire systematically because of not feeling competent to respond to such enquiry is not supported by results of this study.

One interesting result of this study on the other hand concerned the right timing that an enquiry of sexual abuse should be made. The majority of professionals reported that if they were to enquire about sexual abuse they would prefer to do it during therapy compared to a smaller percentage who said they would enquire during an initial assessment. A study by Young et al. (2001) showed similar results. When professionals were asked to identify "the best time to enquire" the majority selected "once rapport has been established". The problem with this argument is that such enquiry could be deferred indefinitely and result in the loss of important clinical data (Young et. al., 2001).

If according to professionals the establishment of rapport is a precondition to sexual abuse enquiry then it is natural for them to prefer to wait until that time. Although this is understandable other issues addressed during assessment like suicidal thoughts or drug abuse might be equally sensitive. If professionals address these during assessment why, in particular, should sexual abuse enquiry be postponed?

Moreover, taking into account clients' responses in this study and from previous studies (Devon, 2003) that they do not mind being asked about sexual abuse during an initial assessment, one could question the assumption that clients need to feel safer before they are asked. What is suggested in literature is that clients who have been abused have great difficulties with trust and find it very difficult to open up in therapy

(Sanderson, 1995, Draucher, 2000, Courtois, 1999). It is also suggested by clinicians that clients do need to feel safe before exploring their abuse with a therapist. However, exploration of an abuse history is different from an initial enquiry and this doesn't necessarily imply that professionals should not ask about sexual abuse experiences during an assessment. Asking about sexual abuse experiences professionals do not force a disclosure but rather they give a choice to the client to disclose or not. Therefore maybe the results of this study regarding the professional's decision to enquire about sexual abuse during the therapeutic process rather than during the assessment, reflect the fact that clinicians are so aware of the need of clients to feel safe and protected that they have generalised that rule and extended it to their assessment practices. This seems quite possible since it reflects the fact that the scientific literature has focused very much on the therapeutic work with sexually abused clients and not so much on the issue of an initial enquiry, which might have influenced professionals' practices.

It is also important to say that 11% of the participants did not answer this question, which was an interesting finding since the percentage of non response was quite high compared to other questions. The 11% who didn't answer this question were from all three professional groups (4 were counselling psychologists, 2 were clinical psychologists and 1 was psychotherapist). One possible explanation for such high non response rate is that since the question was posed in a hypothetic way "if you enquire...when do you prefer to do it, during assessment or during therapy?" it is possible that participants who don't enquire about CSA skipped that question thinking that this was not relevant to them. Moreover, just by the fact that the nature of this question is hypothetical participants might have been put off by the complication.

An additional finding of this study was about clients' responses regarding how they would prefer to be asked about sexual abuse. Many clients (37%) reported that a psychologist should actually initiate the topic instead of waiting for the client to do so. Also the highest percentage of clients (48%) reported that the psychologist should ask about sexual abuse but leave the details to be addressed later in therapy. These results indicate that a high percentage of clients want the therapist to take the lead and help them make such a disclosure. This was further supported by the fact that when were asked about the method with which such enquiry should be made the majority of clients reported no reservations about being asked directly and there were some who reported that if therapists decide to give a questionnaire to explore a possibility of sexual abuse, they would prefer to have the therapist's help on its completion and didn't choose the option of completing a questionnaire by themselves. This indicates that many clients come to therapy expecting that professionals are responsible for addressing these issues or that maybe the clinician would be able to help them answer sensitive personal questions.

There were though a small percentage (10%) of clients who reported that a psychologist should wait until the client himself talks about sexual abuse experiences. Also in another question a small percentage of clients reported that they would not have liked to be asked at all. So what about them? First of all it is essential to say that out of the sixty clients who took part in this study only four (three women and one man) said they would not have liked to be asked which is a very small percentage of all participants. Findings from previous studies (Lister, 1982; Jacobson et al., 1987; Fong-Beyette, 1987; Courtois, 1988) suggest that clients are reluctant to disclose

sexual abuse experiences unless they are asked directly (due to embarrassment, guilt, stigma or even loyalty to their families). Thus it was expected in a way that some clients in this study would report that they don't want to be asked probably for similar reasons. We therefore have to take into account the fact that some clients might not be willing to be asked about CSA experiences for reasons that have been discussed earlier in this study such as the need to feel safe, a possible fear of their sexual abuse being written in their notes, because of fear that if it comes out they will lose control (Cole, 1988) due to the fact that they kept it secret for so long or even because they feel scared, guilty and embarrassed about it as many studies have revealed (Jacobson et al., 1987, Eilenberg et al., 1996). Also there are some sexually abused clients who have tried to make a disclosure in the past and the reaction of others re-traumatised them to the point that they cannot anticipate acceptance from a therapist (Cole, 1988).

All these barriers and concerns that clients might have when asked about sexual abuse do not necessarily indicate that clinicians should not routinely enquire about sexual abuse. On the contrary these need to be taken into account before such an enquiry is made because these will determine the way that a professional will pose such a question and the way the professional will respond to a positive answer in order to help the client to feel contained and understood and prevent any retraumatisation.

It is also important to highlight that the concerns that some clients might have regarding sexual abuse enquiry do not necessarily mean that because they are worried about such enquiry or reluctant to disclose that they would necessarily be harmed in any way if they are asked or that they would not want to continue therapy. Indeed, it might mean that clients who are more reluctant to be asked about sexual abuse might

be those who have kept such information undisclosed for years and so they might benefit most from disclosing it to a professional who is going to be understanding and empathic to what they have been through. Although the above hypothesis was not explored in this study there is evidence in scientific literature that supports the fact that supportive professional responses to sexual abuse disclosures and validation of victims' experiences of sexual abuse seem to mitigate the negative effects of abuse (Devon, 2002). Pennebaker's well documented studies have clearly shown the benefits of disclosing traumatic experiences (Pennebaker, 1992; Pennebaker, Mayne and Francis, 1997). His research has shown that the inhibition of emotions surrounding an upsetting or traumatic experience can lead to negative health consequences as well as psychological distress and that people who disclose their traumatic experiences demonstrated enhanced immune functioning as well as drops in physician visits (Pennebaker, Kiecolt-Glaser & Glaser, 1988).

It is however acknowledged that there may be cases where the enquiry of sexual abuse is not always possible and needs to be deferred. Nevertheless it would be helpful if, for whatever reason a professional does not enquire about sexual abuse, he/she records this in the notes in order to ensure that an abuse history is taken as soon as the inhibiting circumstances have passed.

Finally, it is also important to acknowledge that professionals with different therapeutic orientations (i.e. psychodynamic, person-centred) might not ask clients any questions at the beginning of therapy or might conduct an assessment in a different way than the direct approaches (e.g. CBT). That means that some professionals might not enquire about sexual abuse not because of concerns around

such enquiry but because its part of their standard practice to leave clients to determine the content of each session. However, as discussed at the beginning of this study (under the "context" section) the researcher was interested in this topic as part of her clinical work that involves regular assessments based on Cognitive Behavioural Principles for the therapeutic work of adult clients. As such these results might be more relevant to CBT therapists or to any professionals who do lots of generic assessments within their clinical work or within the National Health System (NHS).

What are participants' attitudes towards their training on sexual abuse work and the role of personal therapy?

The majority of professionals said they had no specific training in assessing and treating sexual abuse. Specifically, the majority of participants thought the topic of sexual abuse was inadequately addressed during their professional training. Such information becomes more important considering that the majority of professionals in this study believe that professional training programmes should offer training on both assessment, and treatment of sexual abuse. These results could explain the fact that in this study most professionals reported that they do not routinely enquire about sexual abuse during an assessment, and when they do, their methods are non-pragmatic and subjective.

Professionals in this study also believe that the topic of sexual abuse is a complicated and difficult one that needs to be addressed through several sources (supervision, workshops, training, own reading) to feel ready to work in this area. The fact that most reported that they did not receive specific training raises questions regarding professionals' practices when they encounter sexually abused clients. One could

speculate though that therapists who have been working for many years have gained enough experience that has equipped them with the necessary skills and knowledge in order to work with this client group.

What is also interesting and consistent with the above argument regarding years of experience is that most professionals in this study reported feeling competent and comfortable working in this area and yet most of them did not feel they had adequate training and support. Such conflicting results could be explained either by social desirability and the need of professionals to portray themselves as competent workers or by the fact that professionals truly feel comfortable and competent because as mentioned above it is possible that clinical experience in itself might have equipped therapists with the appropriate transferable skills and knowledge that are required for sexual abuse work. Professionals may have even gradually gained experience in this area by pursuing short courses, seminars and supervision over the years. Another possibility is that professionals have read on the topic quite a lot and so a combination of all these could have compensated for the lack of specific training during their courses. If that is the case then the lack of training and support that professionals reported in this study might be of concern mainly for newly qualified professionals and not so much for more experienced therapists.

Professionals in this study consider personal therapy of the therapist very important and they argue that when working with survivors of sexual abuse the need of self - awareness is great (Pearlman and Saakvitne, 1995). In particular, participants seem to be aware that survivors might trigger a number of difficult emotions within the therapist, which could be processed through personal therapy. Moreover, participants

seem to value personal therapy in terms of addressing vicarious traumatisation and countertransference phenomena that are common when working with sexual abuse survivors and can highly affect and disrupt the therapeutic process (Pearlman and Saakvitne, 1995). Personal therapy has a special place in that case for the treatment of vicarious trauma (Salston and Figley, 2003). The fact that the participants of this study seem aware of all these issues is encouraging and shows how many professionals try to keep up to date with current literature in order to continue to provide an ethical and professional service to clients.

Significant differences were found between clinical psychologists who reported that personal therapy might help only sometimes and counselling psychologists and psychotherapists who stated that personal therapy of the therapist is always helpful in sexual abuse work. Such differences possibly reflect a different training ethos since in both counselling psychology and psychotherapy training personal therapy is a course requirement whereas it isn't in clinical courses.

Nevertheless, it is interesting that in this study the majority of participants including a high percentage of clinical psychologists had undergone personal therapy. Thus even if not a requirement for training, and even if not exclusively working with survivors of sexual abuse professionals still seem to value personal therapy and find it useful. However, care should be taken when interpreting such results since the reasons that the participants of this study pursued personal therapy in the first place are not known. It might be that they did so to address personal issues rather than because they thought it would enhance their therapeutic skills.

The issue of whether therapists should participate in personal therapy is a debate in the literature (Corey, 1996; Mace, 2001). However, the results of this study regarding personal therapy seem to reflect a general agreement that when it comes to working with trauma and specifically with issues of sexual abuse, self-exploration and self-awareness seem vital for the therapist and are considered an important component of a successful therapeutic outcome (Sanderson, 1995; Pearlman and Saakvitne, 1995; Draucker, 2000). The question probably is whether personal therapy is the only or the most important mean to achieve such self-awareness or whether supervision could play an equally significant role as will be further discussed below under the "implications for practice and training" section.

How do professionals feel about CSA enquiry and treatment and how is frequency of enquiry influenced by that?

Contrary to what was initially hypothesised and the results of previous research (Day et al., 2003) the majority of professionals reported feeling comfortable and competent enquiring and treating sexual abuse. It is important to mention here that the different result compared to what previous studies have found could be explained also by the sample of this study that included only psychologists/psychotherapists rather than a variety of mental health professionals (i.e. nurses, social workers, psychiatrists etc) as in previous studies. An argument around professionals feeling competent and comfortable working with CSA has also been included in the previous section (page 153).

In terms of professionals' general feelings about CSA work it was found that professionals chose scores (3 and 4) that reflected the negative side of specific

emotions and negative feelings towards this work rather than positive. In particular, clinicians had to rate their feelings about CSA work on scales from 1 to 4 where 1 indicated very positive feelings (i.e. I do not mind at all working with sexually abused clients, I very much enjoy working with CSA clients, I don't find at all working with sexually abused clients draining, I find working with CSA clients very satisfying etc) and 4 indicated the exact opposite of the positive feeling that each scale represented (i.e. I do mind CSA work a lot, I don't enjoy such work at all, I find such work very draining, I don't find such work satisfying at all etc). The majority of participants (82%) on the first scale circled options 1 and 2, which represent the positive end of the scale meaning that they did not mind such work or were closer to not minding this work. However, at the same time the majority of participants (78%) circled options 3 and 4, which is the negative side of the scale on the scale of difficulty, meaning that they find such work very difficult or are closer to finding this work difficult. In addition the majority (66%) of participants chose option 3 and 4 on the scale of enjoyment meaning that they said they don't enjoy such work. On the other hand 70% of professionals chose option 1 and 2 on the scale of satisfaction meaning that the majority find the work satisfying. Finally 84% chose the options on the negative side of the scale that refers to how draining they find the work meaning that the majority said they find it draining and the 57% of professionals scored 3 and 4 meaning that if they had a choice they would not choose to work with sexually abused individuals.

Following the above, it is worth noting that the negative feelings that professionals reported had to do mainly with the nature of CSA work, such as being difficult and draining. Since professionals also said that they found the work satisfying and didn't particularly mind working with sexually abused clients, this might mean that

professionals would be more willing to work within this area if they knew how to protect themselves and if they were better trained in order to deal with the difficulties of the work. This argument is further supported by Shauben and Frazier (1995), who asked psychologists about the most difficult and enjoyable aspects of working with survivors of sexual trauma. The results of their study revealed that professionals do enjoy being part of the healing process of survivors and they find it very rewarding to watch clients grow and change since that demonstrated to them the human spirit's ability to thrive in the face of violence. However at the same time the most commonly reported difficulty for psychologists included hearing about the abuse, dealing with their own emotions such as anger towards the perpetrator or extreme sadness and dealing with changes on their beliefs (e.g. mistrusting men, loss of innocence etc).

At this point we need to also highlight the fact that participants did report some negative feelings on the scales given to them regarding CSA work but we cannot be sure whether they would have answered similarly if asked about depression work or the therapeutic work of any of the anxiety disorders or other disorders. Therefore it's not possible to know or make any definite conclusions in terms of whether the participants of this study feel any different about CSA work in comparison to other types of therapeutic work.

Furthermore, it was initially hypothesised that feelings of competency and comfort might be associated with the frequency professionals enquire about sexual abuse. In particular it was thought that professionals who would feel more competent or comfortable would enquire more frequently. However, no significant link between professionals' feelings of competence/comfort in enquiring about CSA and the

frequency with which they enquire was found in this study. Also no association was found regarding feelings of comfort/competence in treating sexual abuse and the frequency in which they enquire. Therefore the results of this study indicate that frequency of enquiry may be determined by other factors and not by how competent or comfortable professionals feel about such enquiry. This result is consistent with the fact that despite professionals in this study reporting feeling competent/comfortable still the majority of them said that they did not routinely enquire about CSA. Nevertheless, it seems interesting for future studies to examine this link using a larger sample.

<u>The impact of sexual abuse work on the therapist</u>

Another aim of the study was also to explore whether therapists who did some trauma work were at risk of vicarious trauma or of developing compassion fatigue (PTSD symptoms). Compassion fatigue was measured by ProQol (that consists of three subscales -compassion satisfaction -burnout and secondary trauma subscale) and vicarious trauma by TABS. The mean score for the ProQol subscale of secondary trauma as shown in result section was low (8.8, average score = 13) compared to ProQol's subscale of burnout (21.4), which is close to the scale's average score (average score=23). Also the mean score of participants on the scale that measures vicarious trauma (TABS) falls again within the average limit (please see pages 107-109 for further details). Therefore, the above scores indicate that the participants of this study showed more vulnerability in terms of burnout and vicarious trauma (cognitive disruptions) rather than secondary trauma (PTSD like symptoms) since the higher the scores on the above subscales the higher the risk.

The number of sexually abused clients in participants' caseload was associated with greater cognitive disruptions (vicarious trauma) and to PTSD like symptoms (secondary trauma), which is similar to results of studies conducted on professionals who worked specifically and exclusively with trauma (Shauben and Frazier, 1995; Pearlman and McIan, 1994, Stamm, 1997).

An interesting finding regarding vicarious trauma was that the number of sexually abused clients on professionals' caseload was associated with subscales that measure cognitive disruptions about "others" and not about the "self". In particular, significant correlations were found on scores of cognitive disruptions that refer to "other-esteem" and "other-control" that match results form previous studies as well (Shauben and Frazier, 1995; Pearlman and Mac Ian, 1995). Such findings indicate that professionals might be affected by sexual abuse work in a way that is manifested by them viewing others with disdain and disrespect or by wanting to control others. According to Pearlman (2003), respondents with elevated other-esteem scores might expect the worse from others and so they might start behaving in a blaming and shaming way. On the other hand an individual for whom the other-control scale scores are elevated feels uncomfortable when not in charge and so needs to control other people. According to Pearlman (2003), disruptions in the need for control are often linked to traumatic experiences in which one was unable to help while others suffered. It is therefore understandable in a way for a therapist who often encounters survivors of sexual abuse to start feeling powerless and helpless in relation to preventing such horrible crime happening in the world and protecting children from it. According to Hesse (2002), when therapists' sense of control has been altered due to vicarious traumatisation then he/she might not be able to tolerate client's "out of control"

feelings. As a result the therapist might try to give the client directions that are inappropriate or may establish unreasonable rigid boundaries (Hesse, 2002).

Why did therapists show disruptions in areas of "others" but not "self"? A possible explanation for this result could be the fact that because participants were not the victims of direct traumatic experiences the effect of trauma work had mainly to do with how their view of the world changed rather than the view of themselves. Listening to clients' horrific stories regarding their sexual abuse from significant others perhaps contributes to fundamental cognitive changes of the therapist in terms of how he or she constructs the world (i.e., unsafe, people can be bad, you can't trust people even significant others etc).

When similar associations were tested between percentage of PTSD clients who suffered a trauma other than sexual abuse and the total score of vicarious traumatisation scale as well as the compassion fatigue subscales no significant associations were found. That indicates that the process of treating sexual abuse survivors is different to other types of trauma work and further highlights the need for therapists to be properly trained and prepared when working with sexual abuse victims.

However, we need to be careful when interpreting such results since there are other variables that could have also contributed to obtaining them that have not been controlled in this study. For example participants' theoretical orientation or the type of difficulties that the remaining clients that professionals see present with (other than victims of CSA), or even the therapists' personal history of sexual abuse may have an

effect. Specifically, in this study 46% of the participants reported that the proportion of sexually abused clients in their caseload ranges from 20% to 40% and 24% of professionals reported a range of sexually abused clients from 50% to 70%, which highlights again the high prevalence of sexual abuse within adult mental health services (please see result section pages 84-85). However professionals were not asked to report other types of problems that the rest of their clients in their caseloads presented with and which could have also contributed to an elevated risk of vicarious trauma. The hypothesis that sexual abuse work might impact on the professional who doesn't exclusively work with survivors needs to be further tested in another study that would take into account all clients that professionals have in their caseloads.

Finally, no significant differences were found between professionals' reported levels of comfort/ competence and their scores on Vicarious Traumatisation and Secondary Trauma scales and the initial hypothesis was not supported. This could mean that feelings of comfort or competence might not act as protective factors to the development of vicarious trauma/secondary trauma as it was initially thought. However, due to the limitations of this study, which will be discussed below, future studies might be worth exploring this hypothesis further especially because our knowledge around contributing factors to the development of VT and ST is very limited.

Strengths and limitations of the study

Before discussing the implications of the above results for practice and training it is important to highlight the strengths and limitations of this study.

In particular this is the first study that integrated all these components (the issue of enquiry, professionals' feelings about CSA work and the impact of this work on professionals) and explored their links. A good balance of male and female client participants was achieved which is important contribution to literature since most sexual abuse studies have focused on the experience of female clients. Sexual abuse was not confounded with other types of abuse and there was a clear differentiation of vicarious trauma from compassion fatigue/secondary trauma, which is often confused in trauma literature.

This study however employed self -report questionnaires for both therapists and clients. Self- report is an indirect measure of actual clinical practice and therefore allows social desirability to be influential. Despite the questionnaires being anonymous responses may have been biased towards how participants wished to be perceived either by themselves or by the researcher. In particular, most clients who participated in the study reported that when they were asked about sexual abuse this was done in an appropriate way. It is not known whether such responses were influenced by the fact that clients did not want to give any response that would disappoint their therapist although the questionnaires were anonymous and clients were reassured by the researcher that their participation would not influence their progress of therapy in any way. Due to the necessity of obtaining a good sample size, however it was thought that a self -report questionnaire was the most efficient way of sampling a large number of participants within a limited time.

Secondly there is a potential sampling bias for both the professionals' sample and the clients' sample. In terms of the sample of professionals a postal questionnaire was

employed and therefore not all subjects who were sent questionnaires completed them. It is therefore unknown whether the professionals who didn't complete the questionnaire or didn't return it were any different to those who did and therefore this raises the question of how representative the sample of professionals is. For example we don't know whether the people who completed the questionnaires were more involved in sexual abuse work or more interested in working with sexually abused clients. If that is the case then the fact that it was found that professionals were aware of the current literature on the topic of sexual abuse and the difficulties inherent to this work might not represent psychologists in general but only those who are actually interested in sexual abuse work.

In terms of the sampling method for clients one limitation could be that this was actually a convenience sample since clients were recruited from the borough where the researcher worked rather than from all the boroughs that are served by the same trust. Although this might have resulted in a more heterogeneous sample a question is raised as to whether clients from other boroughs would have answered differently. Moreover, the fact that clients were recruited through their therapists introduces a bias, since their therapists chose the clients that were asked whether they wanted to participate in this study and so the criteria upon which they were chosen are unknown and possibly subjective to each therapist (e.g. personality, willingness to co-operate, those who have had a positive experience, those with whom a good rapport has been established). On the other hand asking therapists ensured the fact that clients were not in distress or in a critical moment of the therapeutic process that their participation in this study could have disturbed through triggering memories of traumatic material.

For ethical reasons, therefore, it was felt that this was a more appropriate method of recruitment.

It is also important to highlight in terms of the sample of clients that since there were only outpatients who participated in this study there is a potential bias in terms of level of functioning of participants. In particular, outpatients are usually considered as high functioning clients compared to inpatients or learning disabled clients and therefore we cannot be certain whether these other groups of patients would respond differently to the questions asked. On the other hand the results of this study agree with results from some previous studies that were conducted on clients who were inpatients (Craine et al., 1988, Jacobson and Herald, 1990) which gives indications that participants' answers could be representative of different client groups.

As with the therapists' sample it is unknown whether clients who refused to take part in this study are any different from those who agreed to take part. For example it could be that the clients who agreed to take part were the ones who felt more comfortable discussing personal experiences and more positive towards routine enquiry.

In addition, the questionnaires that were designed by the researcher and intended to explore both clients' and professionals' attitudes on sexual abuse enquiry, employed mostly forced choice questions which might have limited respondents' answers and therefore participants might have come up with different answers given more freedom to the way of responding to each of these questions. The inclusion of many open-

ended questions in the questionnaire however hopefully balanced the limitations of the forced choice ones.

Regarding the power of the sample, the aim of the study was to address the issue of attitudes towards enquiry in a relatively heterogeneous sample within a single Trust. Although there is afforded sample size of 200 professionals the response rate is such (36%) that on reflection future research might consider repeating the study with a larger sample (i.e. inclusion of other trusts, all registered clinicians within GP practices etc).

Implications for future research, practice and training

Implications for future research

The results of this study have answered some of the questions that were posed initially but also triggered more questions which open the door for future research on the topic of enquiry and impact of sexual abuse work on professionals. It therefore seems important for future studies to explore in greater detail the reasons why professionals avoid enquiry during an assessment and examine more explicitly whether feelings of competence or comfort might contribute to it or whether it is the fact that they are unsure about the way that such an enquiry should be made or even the way to respond to a possible disclosure. Based on clinical judgement it is true that enquiring about sexual abuse may often need postponed or deferred. However, the findings of this study suggest that many of the criteria professionals use to decide whether to ask or not are subjective and biased. Perhaps a qualitative methodology (i.e. semi structured interviews with professionals) would be useful in exploring that issue in more depth. It seems what would be more important though, either in a quantitative or a

qualitative methodology, is the need for a future study to explore whether professionals know how to enquire and how to respond to a possible disclosure of CSA during an initial assessment.

If a questionnaire were to be used again in future studies it would be helpful to include more specific questions about professionals' attitudes around enquiry like "How do you think an enquiry of sexual abuse should be made?", "do you feel competent responding to a client who discloses sexual abuse experiences during an initial assessment?" "If you were specifically trained on how to ask about sexual abuse and how to respond during an initial assessment would you ask clients about possible sexual abuse experiences more frequently?". Questions could be also added that refer to how comfortable/competent professionals feel responding to sexual abuse enquiry. Moreover, studies that would explore clients' experiences of assessment procedures and what clients found helpful or not would be important since that would increase professionals' knowledge and confidence on this matter and will decrease the possibility of professionals making assumptions that might be true only on some occasions but not always (i.e. clients feel uncomfortable being asked about CSA or its better to leave it to the client to bring up the topic of CSA). A useful question for clients that was not asked in this study is whether they would prefer to be asked about CSA experiences during an initial assessment or during therapy. In this study this question was posed to clinicians but not to clients and this is vital in order to understand whether clients consider the timing of posing such questions important.

This study shows that it is critical to involve clients in future studies that explore the issue of enquiry. The results of this study indicate that clients do not mind being asked

about sexual abuse experiences and most of them prefer to be asked directly by the professional, which contrasts with what the majority of professionals believed. Therefore future studies should further examine that, using more representative sample of clients. In addition, since clients who participated in the study reported that they preferred to be asked directly about sexual abuse experiences and preferred that over being given a questionnaire to complete by themselves was an important finding that can also be used in designing future studies in which clients' experiences can be explored through face to face interviews than through self- reported questionnaires.

Future studies might also explore how clients feel before and after a sexual abuse enquiry. Clients may feel worried about such an enquiry before they engage in an assessment but after this is done appropriately they may feel relieved and the assumptions that had before the disclosure, which prevented them from disclosing might have proved wrong. Thus future research could focus on the reasons why clients do not wish to disclose. This could inform interventions designed to challenge such attitudes and assumptions.

Furthermore, this study showed that therapists who work within adult mental health, who do not work exclusively with sexual abuse survivors still might become vulnerable to vicarious trauma and so future studies should give more emphasis on the impact of sexual abuse work on psychologists who work within adult mental health and not only to professionals who work in specialist services (i.e. trauma clinics etc). The importance of exploring the impact of sexual abuse work on professionals who work in more generic settings also lays in the fact that prevalence of sexual abuse

within these settings is high. Thus is almost inevitable that therapists will encounter survivors of sexual abuse in their day-to-day work.

Another important reason though is that perhaps there is a significant difference between professionals who work within trauma clinics or specialist services for trauma survivors and professionals who do more generic work. The former would probably be more prepared for such work and since they have chosen to work there they would probably be better equipped and aware of protective mechanisms when working with victims of abuse. Thus, there might be several qualitative differences that render psychologists within generic services more susceptible to vicarious trauma or secondary trauma than therapists who specifically choose to work in the area of sexual abuse or trauma generally do not share. Specifically future studies can include more detailed questions about sexual abuse work within adult mental health in terms of how prepared professionals feel, whether they receive appropriate supervision for that type of work, how do they deal with difficulties that CSA work poses (i.e. how professionals deal with the emotional and traumatic material, what coping strategies they use, their ability to create distance between themselves and the work) and these could be compared to the ones that are used by professionals who work exclusively with trauma or sexual abuse.

An additional reason that future studies need to explore the impact of CSA work when therapists do not exclusively work with CSA clients is the fact that it is unclear in the current literature whether a specific caseload mix renders therapists more vulnerable to vicarious trauma or secondary trauma. This is significant in terms of designing work policies (i.e. recommendations on what other clients should be on the caseload

of professionals who already work with survivors of CSA) that would contribute to the effectiveness of the workers, would prevent burnout and vicarious trauma and consequently would assist successful therapeutic outcomes.

Finally, in this study most professionals engaged in personal therapy and thought it was useful especially when working with sexually abused clients. However it was not clear whether participants engaged in personal therapy knowing that it would help them while working with trauma or they were involved in the process anyway because of personal issues or training obligations and found out later that it actually proved to be very helpful to them when working with CSA clients. This could be explored in greater depth in a future study that would use semi-structured interviews rather than questionnaires, which could include more detailed questions around the issue of personal therapy (i.e. how did you decide to engage in personal therapy? Do you believe that it would be helpful for therapists who work with sexually abused clients to engage in personal therapy? Is personal therapy useful generally or is it more useful when doing trauma work? Should all professionals who work with CSA clients go through personal therapy or only the ones that were sexually abused themselves? When working with sexually abused clients what do you think is more useful for therapists to achieve self-awareness? Is it supervision, personal therapy, both or other?).

Implications for practice and training

The results of this study showed that the majority of professionals believed that they should not routinely but only sometimes enquire about sexual abuse during an assessment. In light of recommendations in the literature that routine enquiry is

important for the formulation and treatment of the client (Briere, 1997, Douglas, 2000) and in light of recent scientific evidence that supports the link between sexual abuse history and the risk of suicide (Lanktree, 1991, Kaplan, 1995, Young, 2001) then not routinely enquiring about sexual abuse during an initial assessment seems an important gap in clinical practice. Therefore it seems that therapists need to be better informed through their professional training about the importance of sexual abuse enquiry and its relevance when conducting risk assessments.

In addition, the results of this study revealed that even when professionals decide to enquire about abuse they use most of the time inadequate, non -pragmatic and subjective methods to elicit such histories. Therefore, it seems that professional training courses could include modules on sexual abuse work that would focus on appropriate ways of enquiring and responding to such enquiries. This would be helpful since as shown from this study, what professionals are mostly concerned about is probably not whether they should enquire about sexual abuse but how to do that appropriately, which is a very legitimate concern considering the risk of retraumatising the client through inappropriate responses. Training should perhaps focus on how such enquiry needs to be done. Such modules could be required for program accreditation and assessed through essays, exams or observational methods such as videos and role -plays. Seminars and workshops within work places can further enhance professionals' knowledge on the topic of enquiry.

In terms of the impact that CSA work has on professionals it seems that supervision by specialists needs to be available in work places in order to recognise the symptoms and help professionals with prevention. If as this study revealed therapists are more

influenced in areas like "other-control" or "other- esteem", that means that professionals would feel the need to be in control all the time or would always expect the worse from others. This could affect the therapeutic process since professionals may expect the worse from their clients and would perhaps have difficulties empowering the client since they would need to be in control (Hesse, 2002). Disruptions on "other-esteem" and "other-control" areas can also impact negatively on therapists' relationship with other professionals and on their personal lives. There needs to be more research in this area to test how disruptions on "other-esteem" and "other-control" could impact on the therapeutic process or personal and professional life of a therapist.

Salston and Figley (2003) offer a comprehensive review of treatment and prevention strategies for vicarious traumatisation which include regular supervision, effective self care (i.e. pleasurable activities, physical activity, good dietary habits), a balance between physical, emotional and spiritual self, a good balance between work and home and social support. They also offer recommendations regarding the existing models for treatment of vicarious and secondary trauma such as sensory- based therapy, multiple stressor -debriefing model and Figley's (2002) treatments for Compassion Fatigue (Salston & Figley, 2003). Such information and reviews need to become available to therapists who do CSA work and could be incorporated into professional training courses.

This kind of information becomes more relevant to experienced professionals who supervise other therapists or line manage other mental health workers since they could address these risks in supervision and could ensure the existence of a balanced

caseload for less experienced therapists. However, perhaps the more experienced therapists are the ones who need to be more aware of these risks since clinical experience has shown that professionals in higher positions find it harder to receive regular supervision due to time constraints and their responsibilities. New therapists seem to be better protected since there is an expectation in professional bodies that they would receive regular supervision. A solution to this problem could be the establishment of ongoing group discussions in each workplace that the more experienced professionals could access any time and address issues of burnout, vicarious trauma, secondary trauma or any type of impact that they feel their work had on them.

In terms of the use of personal therapy for the therapist, although the results of this study revealed that most professionals have found it helpful, it is still unclear whether being engaged in personal therapy has a direct effect on the therapeutic work with CSA clients. In a period where the benefits of personal therapy are under question and professional courses are reviewing the possibility of personal therapy not being among their mandatory requirements, it seems essential to further clarify its benefits when doing trauma work. Definitely personal therapy is recommended when issues of vicarious trauma are present or when therapists have been victims of sexual violence themselves (Pearlman and Saacvitne, 1995; Sanderson, 1995). However, it is unclear whether it is essential for everybody who works with CSA clients since it can be argued that self awareness which is necessary in CSA work can be reached through supervision, group discussions, seminars or even individual creative activities (i.e. art, drama, sports etc).

Additionally, this study revealed that professionals held a number of negative feelings regarding sexual abuse work. Most of them reported that they consider the work difficult and they reported that if they had the choice they would avoid working with survivors of sexual abuse. The above raise some concerns about the therapists' well-being and vulnerability to vicarious trauma. If we consider the high percentage of sexually abused clients within adult mental health then the question is how professionals cope and deal with this type of work. More emphasis needs to be given through supervision and training to coping strategies that help professionals deal with the difficulties of doing trauma work or specifically sexual abuse work. Educating professionals on effective coping strategies is important in light of evidence that these correlate with lower symptom levels of vicarious trauma (Shauben and Frazier, 1995). Unfortunately it seems that so far therapists had to rely on finding their own coping mechanisms when dealing with work stressors or highly emotional demanding work such as sexual abuse work. However, not all therapists would have that knowledge nor would it be easy for some of them to focus on their needs since being in a caring profession usually the focus is on others and not on the self. Therefore, it seems important for work places to organise regular talks or circulate leaflets on self-care.

Finally, it is essential to say at this point that training, supervision and future research should probably focus also on the positive changes that CSA work might have on professionals. In this study, as in previous studies, professionals reported some positive feelings when working with CSA clients. Results also indicated that the more frequently professionals enquire about sexual abuse, the higher their compassion satisfaction. That indicates that when professionals enquire more frequently they might identify more CSA survivors, which subsequently increases the pleasure they

derive being able to do their work well and help others. Thus, there is a risk in overemphasising the danger of vicarious trauma, secondary trauma and the difficulties of CSA work in that it might put professionals off from doing this kind of work, a work that can actually be very rewarding, positively challenging, increase therapists' self-awareness and create positive alterations in spirituality and professionals' world view as some studies have already shown (Shauben and Frazier, 1995; Steed and Downing, 1998; Salston and Figley, 2003).

Summary and conclusions of the study

The aims of this study were to explore therapists' and clients' beliefs about routine enquiry, to explore therapists' feelings and practices around sexual abuse work and to examine the impact of such work on the therapist in terms of vicarious trauma and secondary trauma.

The results of this study revealed that there are still barriers among professionals that prevent routine enquiry of sexual abuse. Most therapists did not believe in routine enquiry of sexual abuse during an initial assessment and reported that they were not routinely asking their clients about a possible history of sexual abuse in spite of the fact that is recommended in the literature. The arguments that professionals use against routine enquiry seemed to reflect a concern about how such an enquiry should be made rather than whether it should be made. Therefore, the issue around routine enquiry about child sexual abuse might not be whether people should be asked but how people should be asked.

Clients' in this study revealed that they would not actually mind being asked about sexual abuse, and that they thought that such information was important for the therapist to have in order to determine their therapeutic plan. However, while therapists often stated that they would wait to enquire until the client raised or hinted at the subject of CSA, clients preferred that therapists asked directly.

In addition, professionals admitted their lack of training in this area and supported the need for training programmes to incorporate topics of both sexual abuse enquiry and sexual abuse work.

In terms of the impact of the work on professionals it was found that clinicians were more at risk of developing disrupted beliefs (vicarious trauma) rather than PTSD like symptoms (secondary trauma). Results of this study further supported previous studies that as the number of sexually abused clients increased in clinicians' caseload the risk of both vicarious trauma and secondary trauma increased as well. The same was not found for PTSD clients (who suffered trauma other than sexual abuse), which shows the specific nature of sexual abuse work and its risks.

Finally, the conclusions that follow the results of this study are tentative, subject to further research. Thus it seems that enquiry of sexual abuse needs to become an integral part of an initial psychological assessment. Asking routinely about sexual abuse seems to facilitate the process of a possible disclosure and contributes to a better formulation of clients' problems. Also therapists need to ask clients directly about such experiences and if they provide a relevant questionnaire it would be important to help the client complete this. The issue of sexual abuse enquiry and how

this should be done needs to be part of standard training. Policies need to be designed regarding the case mix and the percentage of CSA clients on therapists' caseload. Finally, professionals need to feel supported through ongoing supervision, workshops or special forums in their workplace that would address the specific issues that the work with survivors of CSA raises including the risks of vicarious trauma and secondary trauma.

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SECTION C: Case Study

PART A:

Introduction

This case study illustrates the therapeutic process of a 9-year old boy called Steve. All names and identifiers have been changed due to reasons of confidentiality. I consider this work important since it gave me the opportunity to work for two years within the psychodynamic model of therapy and apply in practice a theory that is different from the approach I use in my day-to-day work with adult clients (Cognitive Behavioural Therapy).

I believe this is an interesting piece of work not only for illustrating therapeutic techniques and highlighting difficulties and dilemmas in the execution of professional practice but because it became a vehicle for learning creative ways of working with trauma and understanding the "child within" each adult survivor of sexual abuse. I consider this piece of work relevant not only to professionals who work with children but to professionals who work with adults who often need to integrate techniques from various approaches of therapy and be creative and resourceful in order to help them process their difficulties. I have found the whole procedure challenging, interesting and exciting. Reflecting back, I can clearly see throughout the two years of therapy Steve's progress as a client and mine as therapist working on a particular model of therapy.

This case study will initially cover issues like the context of work, the referral, formulation, a summary of the theoretical approach used and reasons for choosing

that approach. The second part of the case study discusses the main techniques used, the frame of the therapeutic work and the use of boundaries. I will then discuss the content and progress of therapy as well as the termination and the importance of dealing with endings. During the final part of this case study, the difficulties encountered will be explored as well as a discussion of the use of supervision and how this work became the vehicle to learn about myself and about the effective use of psychodynamic approach.

Context of the work

I was allocated to work with Steve in a charity, which specializes in offering counselling to children in London. Therapy sessions took place at Steve's primary school. During the first year I was seeing Steve twice weekly and during the second year once weekly. The decision for children to be seen twice weekly during the first year and once a week during the second year of their therapeutic work was already part of the placement's policy as well as the fact that children would not be seen during school breaks (please see pages 212-213 for further exploration of the impact of breaks on the therapy and how these were used to facilitate the therapeutic work). The requirement for reduction of sessions to once a week during the second year was that the child involved in the therapeutic work would have shown improvement in terms of their presenting problems. Since Steve showed much progress at the end of the first year and the feedback I had from his teachers was very positive both in terms of the reduction of his self-distractive behaviour and his ability to socialise with other children, it was agreed that he will be seen once weekly during the second year. Over a period of two academic years I completed 64 sessions with Steve.

Children in general may be referred by parents, teachers, the charity's workers or they may even refer themselves. Children may be referred for many reasons including any of the following:

- Lack of concentration in class
- Aggressive or violent behaviour
- The child is being bullied
- Tearful and unusually unhappy
- Suspect of neglect or abuse at home
- Lack of self esteem or confidence
- Inability to socialise with peers

The therapy is considered as a wider part of the child's school environment and to help children unburden themselves of various concerns, in order to heighten their concentration skills in the classroom and ease school life generally. At all times the work must be done with the child's full consent and ensuring their confidentiality is appropriately maintained. Finally children are allowed to leave sessions or not attend them if they wish.

Referral-Client's profile

Steve was referred for psychological therapy by his teachers due to aggressive behaviour towards his peers and self-harming behaviour. There were also allegations of possible abuse and neglect at home and suspicions of the mother using illegal drugs. I was informed that social services were already involved in the case but I didn't have access to more information since according to the charity's policy, information about the client from a third party may be biased or distorted and

therefore what is important is what the child brings in the session. As a result of that only limited information was available regarding Steve's background.

The only information available was that he was living with his mother and that he was an only child. During our sessions Steve never disclosed to me directly that he was neglected however I witnessed a couple of instances outside our sessions that indicated neglect. These included times when he was left waiting after school to be picked up and nobody arrived at school and another instance when his mother came at school looking as if she was under the influence of illicit drugs or alcohol and was looking for him in a panic, saying she didn't know where he was. When the school phoned Steve's home, Steve was there and said he didn't come to school because he was waiting for his mother to come back home since she didn't sleep there the previous night. Finally there were a couple of instances when he turned up to our sessions wearing clothes that had holes and marks from cigarettes and when I asked him how he got these he had told me that his mother is very forgetful and sometimes she damages his clothes with her cigarettes. Later Steve provided additional information to me during our sessions about his family referring to occasional visits to his father and maternal grandmother. Steve also mentioned the presence of other male figures that according to him visited his house and referred to them as his "mother's friends". He also told me that his mother was often ill and that she needed money for her medication so he told me he would often try and think how he could help his mother to find the money. The information I received regarding Steve's life gave me only indications of him being neglected and I had no proof for that, however the focus of therapy was on child's feelings and on what he brought into our sessions.

Steve is a black Jamaican boy, aged 9. According to him they moved to London when he was still a baby (he did not specify the age) and he could not remember much about Jamaica. Steve is a tall, normal weight, usually sportily dressed young boy. He had never had counselling before and my initial impression was that he looked much older than his age and that he was trying really hard to look "tough", from the way he was walking and talking.

Summary of theoretical orientation

The approach adopted in this case was the psychodynamic one, which is the main model used in the particular organisation. Psychodynamic theorists believe that a person's behaviour is mainly determined by underlying psychological forces of which the person is not consciously aware. These internal forces are considered to be "dynamic", that is they interact with one another. That interaction shapes an individual's behaviour, thoughts and emotions (Comer, 1998). The psychodynamic model was first formulated by the Viennese neurologist Sigmund Freud (1856-1939). Following Freud, a number of various theoretical concepts have been emerged and many diverse sub-schools have been established (ego theory, self theory, object relations theory) (Mc Leod, 1998)

Psychodynamic theories range from the classical Freudian psychoanalysis to modern therapies. The first suggests the existence of inborn sexual and aggressive impulses that emanate from what Freud called the id and lead to unconscious fantasies. The id impulses might lead to conflict with those parts of the personality Freud labelled ego and superego, which is the main source of psychopathology (Bienenfield, 2006). Modern psychodynamic therapies on the other hand, focus on the early mother infant

relationship, drawing special attention to the long lasting impact of those experiences on the infant's later adult functioning (Slipp, 1988).

However, all psychodynamic theories seek to uncover past traumatic events and the inner conflicts that have resulted from them. All share the goals of helping clients to resolve and settle those conflicts. Psychodynamic therapy encourages the client to re-experience the unresolved conflicts and work them through with the therapist (Levinson, 1999). Kernberg (1997) suggests that, "awareness is the key to psychodynamic therapy and the process in order for the client to gain that awareness is neither imposed or rushed. It is a process where therapists guide the discussions so that the patients discover their underlying problems themselves". According to Freud personal change occurred when the person gained 'insight' into the roots of their problems and these insights were gained through the relationship or transference with the therapist (Wilkinson and Campell, 1997).

In this particular case the non-directive psychodynamic model was used within the context of play therapy. Play therapy has been used in Britain for over 50 years and students of Freudian psychoanalysis, like Anna Freud, Melanie Klein and Donald Winnicott have contributed to the development of the theory and practice of psychoanalytic work with children (McMahon, 1992). Although the work of each of the above people has influenced the therapeutic approach applied in Steve's case, Klein's therapeutic techniques were mainly followed. Melanie Klein, regarded children's play as the equivalent of free association in adults and a way of externalising any internal preoccupations that the child might have especially about relationships with internal objects (Hinshelwood, 1991).

The use of interpretation as the central intervention in Steve's case also represents mainly the work of Klein-influenced analysts "for whom interpretation is the lifeblood of their work" (Etchegoyen, 1991). While Freudian and ego-psychology therapists avoid intrusive interventions out of respect for the anxiety they could generate, Klein's model predicts that the patient's anxiety is lessened by such interventions (Bienenfeld, 2006).

Reasons for choosing psychodynamic approach

The psychodynamic approach was selected as a suitable intervention in the case of Steve for the following reasons: 1) It is the main approach used in that setting, 2) the indirect manner of the model would encourage the child to express himself and to explore his feelings in a safe environment. 3) Object relations theory seemed relevant to Steve's problems, since there were indications of a disturbed relationship with his significant others, particularly his mother, for whom there were indications of neglect. In addition the possibility of her using illegal drugs would have interfered with Steve's emotional development and so the exploration of his attachment patterns and his ways of dealing with loss would be beneficial to his emotional growth. Finally it was felt that the approach would be beneficial in exploring Steve's internal conflicts and repressed feelings that were externalised in ways, such as aggression towards peers and self harm behaviour. An additional reason was that Steve was the only child and as Winnicott (1964) suggests lacked the opportunity to express the aggressive side of his nature (as children with siblings do). This can be serious since for many children the legitimate expression of hate is very difficult (Winnicott, 1964). Psychodynamic play therapy would give him the space and the opportunity to do that.

Formulation

During our first sessions I tried to attend to and understand Steve's needs. I realized that Steve had to deal with losses in his family since his father was not living with them and there were indications that his mother was emotionally unavailable and neglectful which were factors that contributed to the development of insecure attachment patterns (Bienenfeld, 2006). Steve was unable to accept his experiences and emotions as his own, he was dividing the good aspects and bad aspects of himself and he seemed to have a great difficulty dealing with painful feelings and endings. According to Melanie Klein, Steve's difficulties can be explained by the lack of appropriate caring and containment from significant others that can result in disrupting the growth of the child's innate capacity to contain and process their own emotions (Mawson, 2006). Object relations theorists suggest that the infant needs to find a place to put unwanted parts of him/herself in distress and project them into an object of perception, which usually is the mother. An attentive mother can play that function by being open to the baby and willing to take in and reflect on what the baby projects into her and through the repetition of this process the child's capacity to be receptive to new emotional experiences and not disrupted by them is strengthened (Bion, 1962). Therefore, it was hypothesised that Steve's difficulty to adjust to the new experiences of his school environment and have healthy relationships with his classmates were because of the lack of this early containment by significant others.

Moreover, the absence of the father could have played significant role in Steve's development since, according to Anna Freud (1936) the father attracts his share of the child's anger and frustration and becomes a rival for the mother's attentions (Edgcumbe, 2000). A boy according to Herzog (1982) might have difficulty with his

aggression in the absence of a father figure as in Steve's case. The fact that Steve didn't have his father close to him could have meant he didn't have a protective shield to modify his aggressive and violent emotions and didn't have a model to work out his feelings for a woman (Herzog, 1982). The father's role in a child's life is important because the father's tendency towards activity puts him in the role of the stimulator for the child compared to the mother who is the comforter. The child's fascination with the father focuses the child outside of himself and outside the mother-infant path and by this way the father becomes the bridge to the external world (Akhtar and Parens, 2004). He is someone who may be experienced as a different person than the mother, who contributes to diminishing the impact of the nature of mother's attachment style and consequently offers greater flexibility in the entire-separation-individuation process for the child (Akhtar and Parens, 2004).

In addition it was hypothesised that the indications of the neglect and abuse that took place in his family had further contributed in him been heedless of danger to himself and in him behaving with unprovoked aggression to his peers (Rogers et. al, 1992, Holmes, 2001). From Steve's initial play in the room during our first session (which is described in detail later) it seemed that a lot of the characters he was using, including animals, became identified with the projected aggressive parts of himself and that could lead to him loosing any inner sense of being strong enough to stand up for himself (Bateman and Holmes, 1996)

Therefore those issues became the main goals of therapy: Help the child to integrate the divided aspects of himself, help him to develop emotionally and accept feelings and thoughts that he has disowned, enhance his self esteem and familiarize him with

the notion of loss as a normal part of our lives, in order for him to develop the capacity to mourn, which would be an indication of his emotional maturity (Holmes, 2001).

PART B:

Main techniques used

Following the psychodynamic model the following techniques were used in Steve's case: free association- (symbolic play), therapist interpretation, use and interpretation of transference-counter-transference processes, catharsis and working through.

Free association is the process where the client is asked to describe any thought, feeling or image that comes to mind, expecting that these will eventually reveal unconscious events and reveal underlying dynamics (McMahon, 1992). In Steve's case he was allowed to do whatever he wanted, to use any toys he liked, to talk about anything that was coming to his mind. During our sessions I tried to create the space for Steve to feel free and safe to bring into the room whatever he wanted. For some theorists the essence of psychoanalytic play technique is for a child to be seen individually in an unchanged background where the furniture is kept the same, the toys are left in the same position every time and this simple setting offers a reliable framework within which the client feels safe and the therapist can observe and evaluate the child's actions and responses (Mawson, 2006).

Although it seemed very difficult at the beginning for Steve to feel comfortable, as soon as he started to feel secure and contained, he felt more relaxed and the technique of free association proved very helpful. Play was used in Steve's case as the

equivalent of free association in adult psychoanalysis and as, Klein (1937) suggested, that could reveal the child's anxieties and fantasies. According to her, when a child strongly rejects an interpretation she felt that this indicated it was correct and when a child accepted an interpretation that would lessen his anxieties and guilt (Klein, 1937).

Interpretation refers mainly to the therapist's view on what the patient brings to the session and extends the patient's understanding on his acts and experiences. The therapist shares that interpretation with the patient when she thinks the patient is ready to hear her (Comer, 1995). According to Mawson (2006) when using interpretation with children " ...this relies less on logic than on a capacity to be receptively attentive to the child's inner world as aspects of it are communicated in sessions through the child's play". The purpose of interpretations during this work was to enable Steve to "see what he could not see before, to find meaning where there seemed to be none, to feel things he could not feel before and to make something conscious that was previously unconscious"(Bateman and Holmes, 1996).

The main interpretations in Steve's case referred mainly to Steve's resistance to therapy, on transference and counter-transference phenomena and on the symbolic meanings of his play.

Resistance is the clinical term that refers to the different methods that the patient uses in order to obstruct the process that tries to help him (Bateman and Holmes, 1996). Resistance is considered as the client's way to prevent from bringing into the awareness unconscious material that has been repressed since by this way clients

defend against the intense anxiety that they would experience if this material enters their awareness (Corey, 1996). Steve did this many times during our sessions, especially when he was confronted with difficult feelings (anger after a break, or fear of not seeing me again when a break was near) by not wanting to come in the room with me especially before school brakes like Christmas and Easter, by denying my interpretations saying "no, no, that is not true", by not letting me talk and interrupting me all the time during an interpretation and by turning his back to me in order not for me to be able to see what he was doing and make an interpretation. It is important to highlight at this point although many times clients might deny an interpretation or refuse to cooperate with the therapist as part of their resistance it is also the case that interpretations are denied because of being made at a time when the client is not ready to accept them (Saretsky, 1978). Resistances might get in the way of clients' progress but they need to be respected by therapists because clients use them as protection against anxiety. It is therefore considered crucial that interpretations are well timed and paced according to the clients' needs. Thus interpretations of resistances need to be made when the therapist knows that although the client has not yet seen the material to be interpreted they are able to tolerate it (Corey, 1996). It is also important though to highlight the need for a therapist to be reflective and open to the possibility that a client might reject an interpretation simply because the therapist hasn't got it right.

As far as interpretations that referred to transference-counter-transference, Strachey (1937), considered transference interpretation as the main tool for effecting change and Klein (1986) considered the child's feelings towards the therapist as extremely important since they had their origin in mother-child experiences. For Steve it seemed

very difficult to express directly his negative feeling towards me during our sessions and he was initially doing it symbolically through play. For example he sometimes tried to make my drawing on paper and then he aggressively painted all over my picture or sometimes he would ask me to pretend I was him and he would play me being selfish and leaving him all the time. The interpretation of such play seemed to have helped him to accept and integrate the bad and the good parts of his personality and avoid the conflict between loving and hating the same person for his good and bad parts. This was one of Steve's most extensively used defence mechanisms, called by many psychoanalysts as "splitting"(Bateman and Holmes, 1996)

Catharsis is the process of reliving repressed feelings in order for patients to settle internal conflicts and overcome their problems (Bateman and Holmes, 1996). In Steve's case we used play and art as tools for him to re-experience the several emotions he experiences in his life outside of the room we worked, emotions that he felt when he was at home with his mother, when he was at school and when he was alone. Those feelings and experiences he had were explored in a safe environment (our therapy room) where they could be dealt positively and restored.

Finally, *working through* refers to the process of patient and therapist examining the same issues over and over again, each time with new and sharper clarity. In Steve's case, the themes he brought to our sessions were repetitive for a long time and were examined on many different levels especially throughout the second year we were working together. The lack of security he was feeling, "the splitting", the aggressive feelings towards others, the difficulties he had dealing with loss and endings and the difficulties he had expressing and communicating his emotions, were worked through

throughout the two years and the shift in his behaviour was obvious towards the end, through his emotional development and his capacity to mourn (Winnicott, 1989).

Frame and boundaries

The therapeutic work took place in a carefully planned room within Steve's school. The materials included a number of miniature toys, drawings and painting materials, clothes, doll- houses, puppets and materials for cutting out. Each of these categories of material was kept in its own special drawer. This unchanging background is called the frame, which offers a reliable structure within which as mentioned before a therapist can observe and assess a child's actions and reactions (Mawson, 2006).

The duration of each session was one hour and Steve was allowed to do whatever he liked apart from hurt himself or me and apart from breaking anything. The session could also end if Steve left, but I had to wait in the room until the end of the set time. My responsibility was to take Steve from his class and bring him back after the end of the session. An additional ground rule was that five minutes before the end of the session we would tidy up the room together and leave it as it was when we first entered it. That "tidying up" time helps to ease the child's transition back to the real world (McMahon, 1992). These "rules were explained to Steve on our first session and were maintained throughout our work.

In this frame Steve initiated his play and I attended to him carefully, trying to understand him and make sense of what he was trying to communicate to me. Copley and Foryan (1987) describe such environment as providing a sense of "holding" and "containment". Like the "good enough" mother the therapist provides containment of

the child providing a mental space in which she attends to and reflects on the child's communication.

Hinshelwood (1999) comments on Bion's (1959) ideas about the importance of containment as a fundamental building block of the mind. As Hinshelwood (1999) reports containing can be divided in three categories where in the first the container (i.e the mother) reacts to the intrusions (child's distress) by becoming rigid and refusing to respond, the second type involves the container being overwhelmed by the contained and so it bursts and breaks down and finally the third type is the flexible one during which the contained enters the container and there is an ongoing process of mutual influence. The role of the therapist in this container-contained relationship is to become a flexible container and by keeping "balance of mind" to contain the child's distress and think about it (Hinshelwood, 1999). The therapeutic frame discussed above contributes in achieving a containing environment in which a therapist can attend and work on the needs of the child.

Confidentiality was another important issue that was addressed from the first session with Steve but it took some time until he felt secure and safe to start disclosing information about him. I assured Steve that I would not tell anyone what was going on in the room, and I also told him that when I talked to his teacher from time to time I would only report general things like "Steve is doing fine, etc". I also informed him that if I thought that his life was in danger then that would be a time when I would need to discuss this with more people in order to protect him.

A box was given to Steve in order to keep his pictures and things he was creating in the room and that box was kept in a locker so no one else would have access to it. He was allowed to take the box and the things that were kept for the child in it only before Christmas and Easter breaks or before the termination of the therapy.

All the above ground rules regulate space, time and the involvement of third parties. The frame plays the role of a contract between therapist and patient defining what it is they will be doing together and, as Langs (1992) advocates, "all of us unconsciously seek a basically similar psychotherapeutic frame". Finally, what transforms two people in a room into a psychotherapy session are such ground rules and as the one that says that one person is present to listen to the other in order to help the second with his emotional problems (Smith cited in Sullivan, 1999).

Main content issues and progress of the therapy

The first session with Steve was a very anxious one for both of us. I had not met Steve before and I knew very little about him. The first session was my opportunity to start to know the child and for him to enjoy it enough in order to want to come back (McMahon, 1992). I introduced the room to Steve and explained to him all the rules of the room. He didn't talk at all and he seemed very suspicious and hostile towards me. But as soon as I showed him the toys and the room, he smiled at me and went straight towards the castle with the soldiers. He wanted to share the game with me and we played the "good guys" fighting the "bad guys" that were outside the castle. I considered that as a very positive start and I could have made a good interpretation back then like "it seems that this castle looks like our room and it reminds me of us

working together in here, in order to make all the bad feelings go away and all the pain to go away".

On that first session, although I thought Steve's play was indicative of his willingness to relieve himself of many emotional conflicts and difficulties he had and of him wanting me to help him on that, I didn't say anything. Back then I was still not feeling comfortable with making interpretations since it was the first time I was using psychodynamic play therapy and I preferred to let the child express himself with no interruptions, worrying that by making an incorrect interpretation I would upset Steve and interfere with the therapeutic process. However that is unlikely according to Winnicott, (1971), since if the interpretation is wrong then the child will probably shrug it off or he will represent the material in a way that can be better understood by the therapist (West, 1992, pg128). At the end, we tidied up the room. I gave him his box, in order to keep a picture that he drew during this session and we left for his classroom. The use of the box creates a feeling of security and safety. His last words before we left the room were "Oh I am so glad I came here" and he looked sad that we had to go.

During our early sessions, Steve used the paintings, the table games and the clothes we had in the room in order to dress up. From all these games I noticed that a common theme kept coming up, the splitting of good and bad elements (i.e a character who at one point was according to Steve the good guy and who during the play he would suddenly transform to a bad guy). Another repetitive theme was the existence of a single good person that constantly fights and goes through very difficult tasks in order to kill the bad guys or in order to escape from the chasing of evil creatures.

Even when Steve played with the clothes the same theme kept coming up (i.e. he was dressed up as the "Zorro" trying to save me -the Zorro's girlfriend- from the bad people). I used catharsis as the main technique in combination with free association to allow Steve to reveal his anxieties through playing and re-experiencing emotions he had in his life in a safe environment (our room) (Bateman and Holmes, 1996). My thoughts about the themes of his play were, Steve wanted to communicate to me his anxieties and his fears about all the negative events in his life and at the same time his wishful thinking of having magical strengths and abilities in order to confront all those difficulties that seemed too painful for him. Children cannot give associations in the same way that adults do and so sufficient material cannot be collected by means of speech alone. Therefore it is important according to Melanie Klein to set children's fantasy free and induce them to fantasy (Klein, 1927).

The subsequent sessions with Steve followed similar patterns to the first session, except that more material was added to Steve's play and there was better exploration of his feelings and better communication between us. For the first eight sessions, he explored most of the toys in the therapy room, until he settled down to Action Man and the rest of the Barbie dolls in order to show me his stories for the majority of sessions we had together, until the end. He used Action Man as the main character in his play and another two male dolls as the bad guys. Action Man was always in trouble and the bad guys were after him. He had different adventures and it seemed that each day I was watching a different movie with Action Man as the main character. Steve was making up his stories and his play with Action Man was taking the place of free association (McMahon, 1992). He was using objects from the real world (e.g. the dolls, the setting of his story) in service of some aspects of his inner

world (e.g. feelings, conflicts) and, as Winnicott suggests, " the interplay of those makes play an exciting and even potentially frightening experience" (Winnicott, 1971).

My thoughts about the choice of that game were that at an unconscious level Action Man represented Steve and all the strengths he would wish to have in order to deal with the real world. Steve was trying to reverse his passive experience into an active one and he was using action man as a defence against feeling small, powerless and with no control over his life. Freud, (1949) talked about that reversal of the passive experience into an active one in order for the person to gain mastery over their feelings and thoughts that are related to their experiences. This was further confirmed since Steve would often talk to me about his need to be "tough" since there were many people in his neighbourhood with guns and knives and who would often threaten him. Steve at one point revealed to me that he sometimes felt scared of what was happening outside his house since he would often witness fights and physical violence. Therefore Action Man was, for Steve, an important means of reversing such powerless feelings and the helplessness that a victim or a witness of abuse feels and changing it to an active and liberating experience (Freud, 1949).

Through his play with Action Man, Steve could transfer his fantasies, anxieties and guilt to objects other than people and as Harding, (1973) says "because of the ability of the symbol to bring the conscious and unconscious elements of the psyche together, it allows energies to flow from within in a new creative effort". For example at one point Steve played with Action Man and used another Barbie doll that represented Action Man's mother who was sick all the time. Steve wanted to show in this play

that Action Man had a very close relationship with his mother and that he was trying to protect her and take care of her. At this point catharsis was taking place since Steve re-experienced an anxiety he had in his real life since there were indications that Steve's mother used illegal drugs, being sick quite often and as a result of that Steve needed to take care of her.

On the other hand, Action Man's dad appeared few times in Steve's games and when he did he looked so different from the rest of the dolls. He was like a robot or an alien, which was interpreted as representing Steve's alien feelings towards his dad, since he was not part of their family and probably Steve could not understand the reasons why his dad had left. Action Man's girlfriend also appeared in Steve's games, especially after my relationship with Steve was established. It was amazing how he could represent through that play all his feelings about me, which ranged from intense wishes for me to be part of his life outside the room or spend more time with him to intense anxieties of losing me suddenly. As a result, in Steve's play Action Man got married several times with his girlfriend, representing Steve's wish to spend more time with me and to become part of his family (Mc Mahon, 1992). Action Man was also hurt many times in Steve's play by the Barbie doll, representing Steve's painful feelings towards me when I was saying goodbye during breaks and when I was enforcing the rules of the room when Steve was testing my boundaries (McMahon, 1992).

Steve's main vehicle of communication was play. Whatever he wanted to tell me he told me through his play. For example before breaks like Easter holiday or half term in his play Action Man's girlfriend got lost many times and Action Man would

desperately try to find her. As soon as he found her, a bad guy came to take her away again. Such play revealed Steve's anxiety of losing me and not seeing me again after the break was over (for further exploration on the topic of endings see following section).

Moreover, I was communicating with Steve mainly through my interpretations. At the beginning of our work these were mostly made at the end of his play but later on and during our second year I used interpretations of Steve's unconscious meaning of his play at the start of each session, depending on the material he brought that day. By what Steve was doing after my interpretation I could understand whether he had accepted it or not, which meant that my interpretation was correct or incorrect (McMahon, 1992). For example, when Steve did not want to leave at the end of the session he would often open a draw where there were elastic bands inside and would try and take some with him even though he knew he was not allowed to take things from the room with him. I would interpret that as his need to keep parts of our sessions in his life outside the room and as his wish to use these elastic bands to keep us together so that we won't have to say goodbye every time the hour finishes and he would give them back to me immediately. However, there were other times when the interpretation was not right and so he would continue doing what he was doing until I did it right.

During the second year of working with Steve his play became more complicated and elaborate. He became less violent in the fight scenes with Action Man and he expressed a lot of positive emotions that replaced the despair and intense anxiety he had at the beginning of our work. Interestingly, the feedback I had from Steve's

teachers during that time matched the picture I had in our therapy room since they told me that he seemed much calmer and he stopped "acting out" or being aggressive towards other children.

During the second year Steve also added another way of communicating his feelings and thoughts to me. He started describing to me movies he had seen at the cinema or on TV the night before he saw me. The stories he was picking up to tell me matched the thoughts, anxieties, conflicts and emotions he needed to communicate to me. In particular, one day he was crying when I went to pick him up from the classroom and his teacher told me that he was not speaking to anyone. When he came into the room he told me he was in pain and was holding his cheek but there was no wound that I could see externally. So when I made an interpretation that perhaps he wanted to tell me that sometimes he was also hurting inside and wanted me to relieve his pain he stopped crying and he started talking to me about a movie he saw the night before. This sudden change in Steve's behaviour from him crying and not being able to tolerate his pain to immediately after my interpretation him stopping this and start discussing another topic implied that my initial interpretation was right and the child felt contained and safe to continue communicating his anxieties to me (Mawson, 2006). The movie was called "Buried Alive" Steve said he was really scared and he was still scared because he thought this was for real. After he had explained the movie to me he asked me to play football and asked me to be the goalkeeper. While I was saving the ball he kept saying, "you are a saver" which I interpreted as revealing that Steve accepted my previous interpretation and that helped to lessen his anxiety and fear about the movie (McMahon, 1992).

One of the strongest stories Steve described to me was after I started preparing him for our final session and our ending. He told me he saw a movie about a black mother who threw her child in the garbage and a white mother found that child and adopted it. But after some time the black mother returned and wanted the child back. Steve did not continue the story that day but he told me that he didn't want to play or do anything. He only sat on the couch and had a very sad face. I had seen that movie in the past so I knew the rest of the story, which was that the child went with the black mother and did not speak at all, did not eat or play, until the case went to a court and it was decided that both mothers would see the child.

On that day the session was full of intense emotions, which were a combination of transference and counter-transference. I told Steve that I believed what he was telling me was that he felt so sad that we had to finish working together, that he couldn't do anything in the room like the child on the movie and he wished so much to be able to see me again after we finished working together and for me become like a second mother to him. I also acknowledged how difficult it must be for him to know that we would not see each other again after working for two years together and how sad I was also feeling about that and because we could not change it. I then continued telling him that although we would finish working together we would have our memories of the room and of the times we spent together and that would be good, because every time he felt sad he could go back and search in his mind for me and him and our room and all the things we had done together. After I interpreted Steve's story like that, the atmosphere loosened again, he started engaging in activities and we both felt relief.

During our last 15 sessions Steve had reached a stage where he could talk to me openly about his feelings without using the Action Man or characters from movies, thereby owning them. He could discuss with me private matters like which girlfriend he would like to have and he had found ways to deal with painful feelings and felt more comfortable having them.

Termination of therapy –Dealing with ending

Dealing with endings was one of the main themes that were worked through in Steve's case. In psychoanalytic work, facing loss and expressing grief are considered to be curative and it is widely accepted that suppressed mourning leads to psychological difficulties (Bateman and Holmes, 1995). Therefore I have tried working with Steve to following Klein's (1940) idea that suggests that when loss can be mourned then the lost object is reinstated internally. This creates a balance of the inner world that compensates for the sadness of what has gone. From an attachment perspective, the aim of psychotherapy is to create a secure base, both in reality and as internal representation in a patient, a "good ending" can only be achieved if this secure base has been established (Holmes, 2001). In order to achieve this, I have worked on the idea of loss from the start of therapy with Steve. During our work there were many breaks (Christmas, half term, Easter, summer holidays) and therefore the therapy was lost and found many times.

When a break was near, Steve reacted with intense fear of not seeing me again, with anxiety and anger that was expressed through his play (example: Action Man lost his wife and tried desperately to find her, but she was dead; Action Man died; People were falling from roofs). Other ways Steve used to show me his painful feelings when

breaks were approaching was by refusing to come to the sessions, asking for elastic bands and when he wanted to take things outside the room with him. In all cases I tried to contain those feelings and express to Steve my interpretation of his symbolic play. *(Example: "now that I saw Action Man looking desperately for his wife I think you wanted to tell me how difficult and how sad it feels that a break is coming up and we will not see each other for some time. Perhaps you are telling me this is very difficult for you to handle and how much you wished for us to be tied up together with that elastic band in order not to have to say goodbye. Perhaps you also think that now we will be away I will forget all about you. But I will have you in my mind and perhaps you can try to do the same and create a place in your head where you can have me, you and the memory of all the things we do here together").*

In general, Steve's behaviour before and after the breaks was challenging in terms of him not wanting to leave the room, being angry with me and trying to test my boundaries. According to Bateman and Holmes (1996) all these elements of his behaviour represented an imagined exclusion from the parental relationship and were dealt with appropriate sensitivity. By containing Steve's feelings, empathising with him and acknowledging his sadness, we *worked through* the idea of loss in our sessions (Winnicott, 1989). Perhaps it is important to mention here that at an appropriate time Steve was reminded of the exact date of the ending and we created a calendar together in order for him to have a clear picture of that. Steve's progress was obvious towards the end.

During our last session together he was able to mourn and express verbally his sadness about the end of our work. It was a very difficult but rewarding moment for

me and I interpreted my counter-transference to him. I will always remember his last words as an indication of emotional maturity and as a result of two years work, he said: "So I guess this is our last, goodbye. I will never see you again, never in my life" and he gave me a very warm hug for the first and the last time. That time Steve did not try to delay the ending nor to avoid it, he was just sad and he could accept it. For me that was the greatest reward of our hard work.

PART C:

Difficulties encountered during the therapeutic sessions

Working with Steve I had to deal with many challenges such as him testing my boundaries or moments where he would protest by wanting to take things outside the room, by not wanting to leave the session, wanting to extend the session and by not wanting to tidy up with me. I found those moments really challenging and I tried to contain his feelings by trying to understand what he wanted to communicate to me by interpreting the unconscious meaning of his behaviour (Holmes, 2001). For example when Steve wanted to take things out of the room I was usually said to him: "*Perhaps you are telling me that it is very difficult for you to leave the session without taking something with you, because perhaps it is very sad when we say goodbye and by keeping something with you from this room it feels like you keep something from me and you feel less sad*".

Keeping the boundaries and making such interpretations showed Steve respect and helped him to feel contained, added to the stability of the environment and created more trust, security and lessened his anxieties (West, 1992). Finally, such interpretations helped Steve to get in touch with his negative feelings and encourage

more effective use of mechanisms such as the anti-regressive function, which is responsible for the maintenance of independent behaviour (Bateman and Holmes, 1995). This was important also as already mentioned before when there were breaks in treatment for holidays. These times usually were very challenging since Steve experienced them as abandonment. These moments were very important and needed careful handling also because as mentioned before one of the aims in therapy was to provide a safe environment that would foster attunement and that would be secure enough to cope with the child's protests since protest is the basis of autonomy. The therapist's capacity to accept protest, tolerate despair and hold the client at moments of hopelessness facilitate the development of an inner secure base (Holmes, 2001)

Finally, working in a school setting added to the difficulties since I often had to deal with suspicious teachers who did not understand my role or felt threatened by me spending time alone with Steve and becoming close to him in a way they could never do. It takes a lot of effort to learn to balance between a positive and constructive communication with them without breaking confidentiality. Spending some time with teachers explaining the nature of the counselling work with children and listening to their experiences or difficulties helped to build that communication. Moreover, together with my line manager we organised two one-hour meetings each year where we invited all teachers in the school and explained the role of the charity organisation. During these meetings the teachers could also ask any questions about the process of therapy and express their worries if any.

Use of supervision

The use of supervision was one of the main and crucial components of therapy, when working with Steve. Receiving supervision helped me improve the application of psychodynamic techniques, especially to use my counter-transference. It helped me to confront successfully all the challenging times that are mentioned earlier, since my supervisor helped me to be able to distinguish and identify Steve's resistances. In addition, it was a struggle for me sometimes not only to think but also to manage the negative behaviour and my own response to it. As Copley and Forryan (1997, p.103) also advocate, "to retain a containing approach could become a constant struggle, additional to the complexity of what is presented" and supervision proved to be most useful and essential during those moments.

Supervision contained my anxieties and worries especially at times when Steve was acting out his anger or when Steve refused to come with me to the room. Supervision helped me realise how sometimes the feelings I was bringing to supervision of being rejected and angry with Steve could possibly be Steve's feelings, using me as a transferential object representing aspects of his relationship with his mother, projected on me and needing to be addressed (Casement, 1999).

The "parallel process" was also helpful, since the feelings and thoughts that were brought by me to supervision and the way I was relating to my supervisor at different times reflected my relationship with Steve at those times. The feelings and thoughts that arose in supervision were paralleled with those in therapy (Jacobs, 1999). In particular on one occasion I was describing to my supervisor what had happened in the room she felt very emotional and she explained to me how that could reflect my

emotional state during that session and how we could then explain Steve's play as a response to that.

Supervision made me aware of the complexities and dilemmas that a therapist faces when confronted with issues of abuse and neglect. The process made me realise the importance of remaining clear and boundaried in the face of complex levels of meaning and awareness and intense affective responses on the part of both participants in the therapeutic process. Supervision has provided the context for the treatment. It had a relational focus that attended to both conscious and unconscious aspects of the therapeutic relationship. Finally the respectful interpersonal climate allowed attention to countertransference and parallel process.

Pearlman and Saakvitne (1995) highlight the necessity of appropriate supervision when doing trauma work that fulfils the above criteria. Thus one of the most significant contributions of working in this case was learning to use supervision appropriately in my current work with adult clients, especially when working with survivors of abuse and neglect. Moreover being in a position of supervising clinical/counselling trainees myself this was an excellent opportunity to learn to provide a relational focus and respectful forum that would facilitate the process of difficult emotions so the trainee can make clinical and personal use of his/her responses. This is important since the conflict inherent in the roles of supervisor and evaluator is experienced by many professionals and often prevents supervisees from expressing difficulties and challenges that are vital in the therapeutic work of trauma (Pearlman and Saakvitne, 1995).

What I have learned from the case about myself and about psychodynamic approach.

This case study is part of a portfolio that reflects on therapists' practices with survivors of sexual abuse. Therefore I chose to present the particular work with Steve even though this was not a case of sexual abuse but of general neglect and abuse, because this work has considerably contributed to my growing as a therapist and to the development of my self-awareness, which are important aspects of the therapeutic work with adult survivors of sexual abuse. One of the central aspects of my work with Steve was dealing with emotions that were coming both from him and from me. I was confronted with my own childhood and in particular, being an only child and Steve being an only child too had created for me a special feeling of connection with Steve that was expressed through transference/counter-transference processes. Also other intense feelings were brought to the surface like the need to protect him, intense sadness every time I had to leave him, the need to take his mother's place (parental countertansference), anger towards his parents for neglecting him, frustration for not being able to be with him when he needed affection and protection. I had to acknowledge all of them, contain them and then use them in a therapeutic way to help my client (Mawson, 2006).

The use of supervision was crucial during these times. It is well known and documented in literature that the work with adult survivors of sexual abuse, because of the nature of the trauma, triggers a lot of intense emotions to the therapist (similar to the ones I felt for Steve) that can only be useful when the therapist has familiarised herself with them in order to be able to explore how they can facilitate or inhibit the therapeutic relationship and the therapy process (Pearlman and Saakvitne, 1995).

Therefore having experienced a process of intense emotions during the therapy with Steve familiarised me and prepared me for the nature of subsequent intense work with survivors of sexual abuse.

Moreover, this work helped me to experience the effectiveness of an approach which is different from that with which I am most familiar (CBT), that of psychodynamic therapy.

In particular, in terms of the model, I've seen and felt in practice everything that Freud, Klein, Winnicott and other advocates of the psychodynamic approach have described and which made me confident to integrate elements of this work into my main approach when necessary. I've learnt to use the psychodynamic techniques such as free association, catharsis and interpretation of transference and counter-transference phenomena as well as how the acceptance of unconscious communication facilitates the therapeutic process. When working with adult survivors of sexual abuse it seems imperative to be able to incorporate such dynamic techniques in therapy which facilitate the expression of emotion and help clients who have suppressed negative feelings or had dissociative experiences at the time of abuse to be in touch with these feelings in a safe and containing way (Draucker, 2000). That is very important since the emotional expression that accompanies exposure to trauma-related material contributes to desensitisation (Briere, 1996).

In addition, Christiane Sanderson, (1995) supports the technique of discovering the "inner child" within adult survivors of sexual abuse as a useful tool in therapy. Although there is no scientific evidence of the existence of the inner child many

clinicians use it in order to help the survivor integrate the child with the adult self rather than letting the child direct and initiate inappropriate behaviour (Sanderson, 1995). The particular work with Steve has been of incredible help to me working with the inner child of every survivor, allowing it to emerge, nurturing it and caring about it. That process is often extremely demanding and the challenges become very similar to the ones of the work with a real child like Steve. Moreover, Sanderson (1995) refers to the use of "playing" as a cathartic technique that fosters accessing the child within the adult survivor and advocates that allowing the survivor to play with toys could reduce inhibitions and defences and so facilitate the release of emotions.

Using play with Steve as our main vehicle for the expression of his anxieties and fears contributed to me becoming familiar with its symbolic meaning, with interpreting it and thus confident incorporating it into my work with adult survivors and using it effectively. According to Sanderson (1995) adult survivors of sexual abuse are often fascinated by children's toys and collect childhood artefacts since they represent a part of their lost childhood. Therefore it is often useful for these to be incorporated into the therapeutic work to either facilitate grieving for the lost childhood or to even assist the process of survivors reclaiming their childhood. Similarly encouraging survivors to re-experience how it is to play according to Sanderson (1995) can be very cathartic because many survivors feel uncomfortable watching their children play since they never experienced unrestrained play and do not know how to play. Allowing survivors to do this in therapy contributes in reducing inhibitions and releasing emotions that can then be worked through (Sqroi, 1989). However, playing is a very sensitive technique and a therapist needs to be very careful when deciding to use it with adult clients, since a very good therapeutic relationship needs to have been

established and trust in order for this technique to facilitate therapy. It is possible that an adult client could easily misinterpret the introduction of playing in therapy as an insult to his/her intellectual abilities and capacity if this is not done appropriately or in the right timing.

Through my work with Steve I have also realised that children are extremely sensitive in picking up non-verbal communication and emotions no matter how hard you try to hide them. It feels like you cannot lie, you cannot pretend and you cannot be false. With children you have to be honest, open and extremely careful. Interestingly enough my clinical experience of adult survivors of sexual abuse is similar, since the therapist needs more than anything to be real and congruent, to create the sense of safety and security to sexually abused clients who are very sensitive to bodily cues, to non verbal communication and to the lack of honesty since their trust has been violated by significant others early on in their lives.

Finally, working with Steve who was still a child added to my knowledge on different developmental issues. That was extremely helpful to my current work since a key educational task within the therapy of adult clients who were sexually abused is developmental education. Both therapist and client need to understand the developmental level of the child at the time of the traumatic event and how the child's development was disrupted by the trauma (i.e. the capacity to manage strong affect) in order to help the adult survivor to build what is underdeveloped (Pearlman and Saakvitne, 1995).

In summary, I have experienced Psychodynamic therapy with children as a combination of art and science, where I had to bring all my personal qualities and I have had to work hard on my personal conflicts or weaknesses, because working with Steve, I was confronted with my own childhood and my own unconscious. So I thought I needed to be clear and to be emotionally mature enough in order to achieve a change or a shift in a child's behaviour. Working with children is not an easy path to follow in counselling psychology. It needs personal stability and mirroring the child's experiences does not always come easily. It is a challenging but at the same time a huge learning process and a rewarding experience. Such a reflective experience fully prepares you for other equally challenging areas of therapeutic work, such as the one with adult survivors of trauma.

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SECTION D: Literature Review

TITLE: Concerns for therapists when working with survivors of sexual abuse.

Introduction

During this review the term childhood sexual abuse (CSA), will refer to all experiences of childhood sexual contact with a trusted significant adult or older person. In addition the terms counsellor, clinician and therapist are used synonymously and interchangeably.

The issue of childhood sexual abuse (CSA) has now been fully emerged in scientific literature, extensively researched and explored. Jehu, (1994) explains the recent openness to the topic as a result of more permissive attitudes towards sex and more publicity around sexual matters. However, a vast number of studies have mostly focused on the impact of sexual abuse on the survivor (Sanderson, 1995, Draucher, 2000, Rind et. al., 1998, Davies & Petretic-Jackson, Maker & Buttenheim, 2000, Dallam et al., 2001) and on issues regarding therapeutic techniques (Price et al., 2001, Bradley and Follingstad, 2001). But what about the therapists? Are there any specific concerns or issues that therapists need to be aware of while working with survivors of CSA? What effect has working with CSA survivors had on them and what personal issues do the therapists bring to the therapeutic work, which could influence its process.

Prevalence rates of sexual abuse among the general population vary from 4% to 63% for women and 4% to 16% for men (Boudewyn and Huser Liem, 1995, Jehu, 1994, Rind et al., 1998, Dallam et al., 2001 McMillan et al., 1997, Bushnell et al., 1992, Wyatt & Peters, 1986, Stein et al., 1988, Fergusson and Mullin, 1999). In addition, studies done on clinical populations report higher rates, ranging from 24% to 70%

(Wurr and Patridge, 1996, Lombardo and Pohl, 1997, Stinson and Hendrick, 1992, Price et al., 2001). Considering the above prevalence rates, it is clear that sexual abuse does occur to an alarming extent in childhood and suggests the following: 1) that clinicians are almost certain to encounter victims of childhood abuse within their caseload and 2) that there is high probability of therapists themselves being survivors of CSA (Wilson, 1987, Elliott &Guy, 1993, Follette et. al., 1994).

Some clinicians (Briere, 1996, Courtois, 1999, Etherington, 2000 Couper, 2000, Bolen, 2001) have highlighted the fact that clients who have been sexually abused present specific difficulties in the therapeutic process that are different to other types of work and require from therapists high levels of self-awareness and ability to self reflect. As therapists we need to be aware of these difficulties and of the use of our personhood in the therapeutic process in order to be able to successfully help survivors overcome their difficulties. Moreover, the material that CSA clients bring is very intense and sensitive (Furniss, 1991, Sanderson, 1995, Pearlman and Saakvitne, 1995) and its effects on the therapist such as vicarious trauma and secondary trauma has already emerged in the trauma literature (Pearlman and Saakvitne, 1995, Jackson and Nutall, 1997, Sanderson, 1995, Draucher, 2000, Etherington, 2000, Courtois, 1999).

Therefore, therapists, counsellors and researchers need to have the conceptual frameworks and supportive environments for either examining their role in relationships with survivors of sexual abuse or for understanding the different issues that relate to them, when working in this field and that could potentially create

problems in the therapeutic process or impede a successful therapeutic outcome (Sanderson, 1995, Pearlman and Saakvitne, 1995, Jackson and Nutall, 1997).

The author's desire to write on this topic grows from the following sources: the relative inattention to the therapist in the current trauma treatment literature, the author's clinical observations about the needs of survivors and their therapists, and the dangers that the lack of self-knowledge in treating survivors of sexual abuse entails.

The body of literature regarding the personal issues which therapists bring to their work with CSA clients and the effect of such work on them is mainly based on anecdotal evidence, such as clinical experience and therapists' observations on the topic. Such information is presented in various forms as parts of book sections or articles and explored under titles such as "comments on the therapists", "issues for the therapists", "therapists' dilemmas and concerns", or "general experiences of therapy with CSA survivors", "staying alive" etc. Examining the literature on these concerns, the author identified the following topics that kept coming up in trauma literature as special issues that concern the therapist who works with CSA survivors: countertransference, vicarious traumatisation, the sexually abused therapist, the therapist's gender, boundaries and attitudes towards sexuality and sexual abuse. The aim of this review was to collect these topics that refer to what therapists bring to the process of sexual abuse work that could potentially impede therapy or create great concern and critically evaluate their presentation within trauma literature. The lack of empirical studies in this area is highlighted with the implications that such a gap could have for practice. It is important to highlight at this point that this review is not an exhaustive account of the topics that might relate to therapists who work with CSA

clients but rather a collective summary of the ones that could impede the therapeutic process, that keep coming up in the scientific literature and are included in most books or articles that refer to CSA work.

In addition, the present review will not cover legal issues or dilemmas that therapists have when working directly with children who are possibly currently abused. Due to space constraints, the context to the problem of sexual abuse, such as detailed historical perspectives, in depth analysis of prevalence rates, legal and child protection dilemmas, and detailed examination of any definitions or theory of sexual abuse, have been deliberately excluded. The structure of the review is presented in the following way:

The first part (Part A), presents literature on the topic of countertransference and a summary of the topic on the danger of vicarious traumatization since this was extensively explored in the main study of this portfolio. This first part also includes a detailed exploration of the concerns for therapists who have themselves been victims of sexual abuse. *The second part (Part B),* presents a summary of the literature on the therapist's need to be reflective on the following topics: gender issues, boundaries, attitudes toward sexuality and sexual abuse. The implications for practice and suggestions for future research are discussed in the *third part (Part C),* as emerging from the literature reviewed.

Part A: Countertransference, Vicarious traumatisation, the sexually abused therapist

Countertransference

There seem to be many writers who acknowledge the importance of countertransference in the work of CSA survivors and who generally agree that transference-countertransference phenomena play an important part of the therapeutic process, regardless of the therapist's theoretical orientation (Sanderson, 1995, Pearlman and Saakvitne, 1995, Nyman and Svensson, 1997, Read and Lindsay, 1997, Courtois, 1999). Such an agreement is further supported by recent research indicating the therapeutic relationship as the most important component of effective therapy (Howe, 1993, Dryden and Feltham, 1992, Sexton and Whiston, 1994, Lietaer, 1992). Such research has probably made therapists more aware of the therapeutic process and their relationship with their clients and therefore more open to accept and comment on countertransference issues.

The following information refers mainly to what certain authors have written on countertransference (Friedrich, 1990, Green and Schetsky, 1980, Draucher, 2000 Sanderson, 1995, Pearlman and Saakvitne, 1995, Courtois, 1999, Nyman and Svensson, 1997, Etheringhton, 2000), how they have conceptualized it in the context of working with CSA clients and why they consider this topic important based on their clinical experience and personal observations.

There are numerous definitions of both transference and countertransference in the literature. Transference is defined, as the client's unconscious shifting to the therapist

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related to their feelings of powerlessness/incompetence, detective feelings, adoption feelings and abusing feelings. Other authors have also highlighted similar feelings from professionals (Green and Scetsky, 1989, Friedrich, 1990). Dale and the above authors do not discuss therapists' feelings using the term "countertransference", however, the different emotional experiences that these authors report that therapists have when working with survivors resemble the identification patterns that are often reported in scientific literature (Etheringhton, 2000, Pearlman and Saakvitne, 1995). Specifically, the patterns that are most discussed within countertransference involve identification patterns which the various roles that a CSA client evokes to the therapist such as identification with the victim (when therapists feel powerless), with the rescuer (when therapists want to do more and more for the client) and with the abuser (when therapists feel cruel towards clients) (Etheringhton, 2000).

The most detailed exploration so far of these identification patterns during CSA work seems to be given by Pearlman and Saakvitne, (1995). The above authors address the various dynamics that can possibly develop between the therapist and the sexually abused client (i.e. parental countertransference, responses to the taboo against incest, professional identity issues) and the significance of their contribution lies on the detailed exploration of the possible ways that these dynamics impact on the therapeutic relationship with survivors of CSA. For example, they explain in detail how a parental countertransference and other responses could be beneficial and harmful to the client.

Moreover, Neumann and Gamble (1995) describe well countertransference responses that are common to work with survivors and they cluster these in four different

categories. According to them the first category refers to a group of therapists' responses that are evoked by client transference and they report that these are common in new therapists. One example of this category according to Neumann and Gamble (1995) is when clients feel passive victims of other's betrayal to have responses of new therapists that include rescue fantasies or intense preoccupation with the client. The second category of countertransference responses, result from the fact that clients' experiences could disrupt and shake therapists' beliefs about the human nature, purity of childhood, existence of evil in the world etc (Neumann and Gamble, 1995). A third category of countertransference responses according to the above authors involves the "voyeuristic" response, which refers to therapists' feelings of curiosity, arousal or even excitement while listening to an account of sexual abuse. Davies and Frawley, (1994) report that therapists should pay much attention and recognise such voyeuristic responses because they can evoke extreme guilt and shock to the therapist who might project them onto the client in the form of anger. Finally the fourth countertransference category that Neumann and Gamble (1995) mention refers to "the container countertransference" during which the therapist is called to help the client tolerate and manage strong affect.

Christine Courtois, (1999) contributed further to the notion of countertransference in the work with CSA survivors, by adding the socio- cultural component to it. According to her, countertransference does not only involve the therapist's reactions to the material that the client brings but also the therapist's reaction to the socio-cultural influences that their social and cultural contexts entail. This manifests to the different periods of time where CSA was seen and confronted differently at each time-period. Specifically the period of late 1960s is characterised by avoidance of the

issue of CSA, since then and up to 1995 there is recognition of the prevalence of CSA and growing literature on treatment issues, which reached the extremes of overemphasizing the issue, which is why the period that follows is characterized by intense critique on therapists and charges of implanting memories to clients. Such societal influences make therapists aware of the systemic influences on their work, and question their role as free agents within the therapy room. They also highlight how much more complex the treatment of CSA clients becomes. Courtois (1999) contribution seems to lie mainly on her focus on countertransference in a broader context, away from the narrow conceptualization of a particular school of thought.

Finally, Wilson and Lindy (1994) identified two types of defensive countertransference reactions specifically by trauma therapists which include avoidance reactions such as denial, minimisation, detachment from empathic states and overidentification reactions which include idealisation, excessive advocacy for the client. According to Wilson and Lindy (1994) both types of these reactions can seriously compromise a client's recovery.

Not every author perceives the importance of being aware of countertransference from the same view- point. Some as discussed above (Loewenstein, 1993, Wilson & Lindy, 1994, Pearlman and Saakvitne, 1995, Sanderson, 1995, Etherington, 2000, Etherington, 2001, Courtois, 1999) indicate that we need to be aware of it since CSA clients elicit countertransference patterns that can be very confusing for the therapist since the therapist might feel threatened, terrified, devalued, objectified and hated (Pearlman and Saakvitne, 1995). Others propose that the need for the therapist to be aware of countertransference issues does not seem to lie only to the complexities they

might cause but also because if appropriately dealt with, they could be regarded as sources of information and hypothesis-building and as an opportunity for therapeutic insight into the individual (Furniss, 1992, Chu, 1988). Finally, Neumann and Gamble, (1995) highlight the importance of working through countertransference patterns especially for new therapists because trauma therapy according to them requires therapists to tolerate lengthy periods of feeling helpless, shamed, attacked and abandoned. Moreover they do postulate that by working through countertransference patterns therapists learn to regulate their emotional responsiveness in the therapeutic relationship and that involves learning to be caring without being intrusive and learning to bring one's genuine and often vulnerable self into the therapeutic relationship (Neumann and Gamble, 1994).

Although there is a general consensus regarding the positive effect of exploring countertransference as mentioned above, Furniss, (1991) seems to be more skeptical about the use of it, arguing that countertransference could re-create the confusion between reality and fantasy, which is a problem inherent to the phenomenon of CSA, since clients often struggle with what is real and what has been created by their fantasy.

In general, the countertransference patterns that various authors suggest as they were discussed above, are mostly based on clinicians' perceptions on the therapeutic process or on clinician's subjective experience of them. Such perceptions are susceptible to biases such as theoretical orientation, knowledge, beliefs, professional experience and various personal variables. Moreover, the absence of research is evident in the area of countertransference. There seem to be no studies that investigate

the relationship between countertransference and clinical outcome in general whereas Sexton and Whiston (1994) who did a review of the literature report only one study that measures countertransference by Gartner et.al. (1990) and two that refer to the management of countertransference reactions by Robbins and Jolkovski (1987) and Van Wagoner et.al., (1991). Even fewer studies (Dale, 1999, Danieli, 1984) on countertransference have been conducted specifically on trauma work. One is the qualitative study by Dale (1999) that was described above and although this study has shed some light in terms of experiences and the feelings of therapists/clients and abused therapists who engage in trauma work, the questions asked referred to experiences of childhood abuse in general and there was no differentiation between sexual and physical abuse.

The other study was conducted by Danieli, (1984) and is a qualitative study, which examined the nature of emotional responses of 61 psychotherapists in working with Holocaust survivors. Forty- nine "countertransference themes" were abstracted from the interviews of this study (i.e. "bystander's guilt", "rage", "shame", "dread and horror", "viewing the survivor as hero" etc., interrater reliability for all 49 themes ranged from .94 to 1.00 and were all significant by t tests). Danieli (1984) describes in great detail the 49 countertransference themes and how these could impact on the process of therapy. This study has contributed to our knowledge on countertransference for therapists who do trauma work and some of the themes identified resemble the responses reported by clinicians who work with survivors of sexual abuse (Lindy, 1994, Courtois, 1999). However, Danieli's study refers specifically to Holocaust victims and so these countertransference responses do not

necessarily generalise to therapists who work with other types of trauma such as sexual abuse. Further research is clearly needed in the area of sexual abuse.

Vicarious Traumatisation

Another important topic that could become a concern regarding CSA work refers to the impact of such work on the professional. In particular, the shift of focus on the impact of trauma work on the worker started in the 1980s when field specific literature emerged on worker's related stress and focused mainly on the impact of working with survivors of war atrocities or on workers in emergency services (Stamm, 1997). Reviewing the relevant literature it seems that although there is an agreement that working with trauma or more specifically with sexually abused clients has inevitable effects on therapists, still researchers do not agree on how to call this phenomenon or how to define it.

Figley (1995) proposed the term secondary trauma, which later on was replaced by another term "compassion fatigue". With this term Figley, (1995) mainly referred to PTSD like symptoms that professionals experience as a result of listening to the traumatic experiences that their clients had gone through (i.e. flashbacks, hyper-arousal, nightmares, avoidance, difficulties in concentration). The term "countertransference" has also been used to describe professionals' reactions to clients' material but this term has traditionally been viewed as the therapist's reaction on unconscious or unresolved conflicts from the therapist's own life experiences (Freud, 1959). Other terms are also used like "burnout" but this is mainly related to increased work- load and institutional stress rather than the result of specifically doing trauma work (Stamm, 1997). However, the most influential work on the effect that

trauma work can have on the therapist was done by McCann and Pearlman, (1990) who named it"vicarious traumatisation". Vicarious traumatisation is defined by these authors as the natural response to a very specialized kind of highly demanding work. It is the result of the cumulative effect of doing trauma work and of its pervasive impact on the self of the therapist (Pearlman and Saakvitne, 1995). In particular, although both secondary trauma and VT are similar in resulting from exposure to interpersonally demanding jobs, vicarious traumatisation refers mainly to disruptions in cognitive schemas such that represent psychological needs of safety, trust, esteem, intimacy and control (Pearlman, 2003), whereas the symptoms of secondary trauma are identical to PTSD symptoms.

There is an agreement in the literature about the importance of knowing about the impact that trauma work has on the professional and specific concerns have been stressed by the various authors within the field (Dolan, 1991, Pearlman and Saakvitne, 1995, Herman, 1992, Etherington, 2000). As described in research part of this portfolio (pg 46-51) there is also growing research that highlights the effects of vicarious traumatisation and secondary trauma on trauma therapists and on therapists who work with survivors of sexual abuse (Pearlman and McIan, 1995, Neumann and Gamble, 1995, Steed and Downing, 1998 Shapiro et al., 1999, Cornille and Meyers, 1999, Collins and Long, 2003). Further studies (details of which have already been mentioned in research part of this portfolio pages 46-51) have also been conducted on the impact of CSA work on the professional and personal life of practitioners who were abused as children (Elliot and Guy, 1993, Jackson and Nutall, 1994, Follette et. al., 1994, Shauben and Frazier, 1995). Despite the extensive literature on the dangers of vicarious traumatisation and secondary trauma, the issue of the impact of trauma

work on the therapist is still controversial with studies having inherent limitations in terms of sampling, problems defining and differentiating vicarious trauma from secondary trauma and the types of measures they use to measure these constructs and often they present conflicting results. Also there are some studies highlighting the positive effects on the therapist when doing trauma work (Linley, 2003, McCann and Pearlman, 1990, Collins and Long, 2003). However, for a detailed exploration of the above studies that refer to both the negative and positive impact of trauma work on the therapist please refer to the relevant part of the main study of this portfolio (pages 46-54).

The sexually abused therapist

The likelihood of therapists to be survivors of CSA seems high according to prevalence rates in the general and clinical populations (Boudewyn and Huser Liem, 1995, Jehu, 1994, Rind et al., 1998, Dallam et al., 2001 McMillan et al., 1997, Bushnell et al., 1992, Wyatt & Peters, 1986, Stein et al., 1988, Fergusson and Mullin, 1999, Wurr and Patridge, 1996, Lombardo and Pohl, 1997, Stinson and Hendrick, 1992, Price et al., 2001). More studies report that the percentage of professionals who were victims of sexual abuse is even higher than the percentage in the general population (Wilson, 1987, Elliot & Guy, 1993, Follette et al., 1994, Pope and Feldman- Summers, 1992). However, the importance of including this topic among the most significant issues for therapists who do trauma work, does not lie only on the existence of high prevalence rates, but also on the fact that sometimes is only in the context of working with sexually abused clients that professionals begin to recognize, share and deal with their own past experiences (Glaser and Frosh, 1993, Sanderson, 1995). Such a sudden realization from the therapist often impacts and creates major

shifts on the therapist's work with CSA clients (Pearlman and Saakvitne, 1995). In addition, the professional neglect of this group could have significant personal and professional consequences as will be discussed later.

The author has reviewed the relevant literature in the area of sexual abuse, and it seems that the issue of sexually abused professionals has been discussed under three main topics that will be explored separately: a) the advantages and disadvantages of being both a survivor of CSA and a therapist, b) the dilemma of disclosing their experience to their clients and colleagues and c) in terms of being a taboo within professionals.

<u>A) Advantages/Disadvantages of being both a survivor of CSA and a therapist</u>

Regarding the advantages of being both a survivor and a therapist, there is a consensus in literature that exploration of their own victimization is a prerequisite for the survivor -therapist to be able to contribute positively in the therapeutic process (Dale, 1999, Dolan, 1991, Jackson and Nutall, 1997). This positive contribution refers to higher levels of empathy and understanding, to an enhancement of the therapeutic relationship, since the client's story becomes more believable for the survivor therapist compared to the non- abused and to an implicit communication of confidence that "the client could also get over it" (Sanderson, 1995, Dolan, 1991, Pearlman and Saakvitne, 1995, Dale, 1999).

On the other hand the above authors seem to offer extensive accounts on the possible dangers and disadvantages of being both a survivor and a therapist. These according to Pearlman and Saakvitne, (1995) refer to specific countertransference issues or to

the projection of unresolved material on the client, imposing therapists' internalised myths about their own abuse on the client, using the therapy to resolve personal issues (Dolan, 1991, Sanderson, 1995), complex identification patterns (Furniss, 1991, Glaser and Frosh, 1993) and violations of boundaries (Jackson and Nutall, 1997). Finally Doyle (1994) questions the ability of survivor-therapists to remain objective and highlights the difficulty of the survivor-therapist to believe that they can remain unscathed by their abuse since they see so many cases that have been deeply affected from a similar experience.

Moreover, few studies (Follette et. al., 1994, Shauben and Frazier, 1995, Pearlman and Mc Ian, 1995) have emerged regarding the impact of doing trauma work on the professional who has a personal trauma history, the results of which seem inconclusive. In particular, Follette and her colleagues (1994) conducted a survey study on mental health professionals consisted of psychologists and family therapists (N=225) and law enforcement officers (N= 46). What they found was that the impact on law enforcement officers with a history of personal trauma was higher than of the mental health professionals as measured by the Trauma Symptom Checklist (TSC-40), $t(269)=6.89$ ($p< .001$), general distress, $t(269)= 3.76$ ($p< .001$) and PTSD symptoms $t(269)= 7.65$ ($p<.001$). Shauben and Frazier, (1995) sent out questionnaires and relevant measures to an organisation of women psychologists and sexual violence counsellors. Data from 148 respondents (118 psychologists and 30 sexual violence counsellors) were analysed. Using multiple regression analyses the three outcome measures (TSI belief Scale, PTSD symptom checklist, 5-point scale for vicarious trauma) that Shauben and Frazier used in order to measure distress were each regressed on a number of variables including prior victimization. Their findings

showed that the interaction between a victimisation history of psychologists and sexual violence counsellors and each of the measures of distress was not significant.

Such results contrast findings from a study conducted by Pearlman and Mc Ian, (1995) on 136 female and 52 male self-identified trauma therapists. In terms of symptoms of vicarious traumatisation (scores from TSI Belief Scale) they found that the difference between the total score of the TSI belief scale for therapists without victimisation history (174, SD=34) and of those with a history of victimisation (190, SD= 38) was significant $F(1, 182)= 9.41$, $p< .01$. This indicates that self-identified trauma therapists with a personal trauma history experienced greater disruptions in psychological need areas than therapists without a personal history (Pearlman and Mc Ian, 1995).

However, comparisons are difficult to be made since there is no clear differentiation of the type of trauma history (i.e. sexual abuse, rape, physical abuse etc) that professionals in the above studies might have experienced and so we do not know whether the conflicting results are because particular traumatic experiences impact more and might put the trauma worker at disadvantage compared to others. Moreover other limitations like gender (the first two studies conducted on female participants), differences between professions, response biases, and the use of different measures of distress (the first used the Trauma symptom checklist and the other two the TSI belief scale) in each of these studies make comparisons more difficult.

Furthermore, there are even fewer studies (Pope & Feldman-Summers, 1992, Follette et. al., 1994, Jackson and Nutall, 1997) to explore the link between personal trauma

history of the worker and their levels of competency. Two of these studies (Pope & Feldman-Summers, 1992, Follette et. al., 1994) found no connection between a history of victimisation and competence of the worker to deal with survivors of trauma. Specifically, Pope & Feldman-Summers, (1992) conducted a national survey of female (N= 153) and male (N= 137) clinical/counselling psychologists and found that a substantial proportion of the participants (33.1%) reported some form of abuse. However a multiple regression analysis exploring the possibility that the overall level of competence might be related to gender, abuse history or year of highest degree yielded positive findings only for gender with women perceiving themselves as more competent than men in treating survivors of sexual abuse (Pope & Feldman-Summers, 1992). Therefore, the above researchers didn't find a link between personal history of trauma and perceived competence in providing services to trauma survivors. Another study which was described above by Follette et. al., (1994) did not find any difference between therapists with and without an abuse history in terms of clinical responses but did find significant difference in terms of the use of coping strategies. In particular their results indicated that therapists with a CSA history did not report higher levels of negative clinical responses (i.e. inattentiveness, dissociating during therapy sessions, lack of empathy) but did report using significantly more positive coping behaviours to deal with sexually abused cases than their non-abused colleagues, and that was for both mental health professionals, $t(182) = 3.25$ ($p < .001$) and law enforcement professionals, $t(30) = 2.14$ ($p < .05$). However caution is needed when interpreting such results due to limitations of these studies (i.e. gender biases, the competence levels were based on the first study on professionals' self report of their in-session behaviour and on the second study on negative clinical responses).

On the other hand, the most striking disadvantages of sexually abused therapists reported in the literature seem to come from Jackson and Nutall (1997). Their study is the first nationwide survey study to examine a large randomly drawn sample (N= 655, 39% social workers, 32% paediatricians, 44% psychologists and 43% psychiatrists) to determine prevalence rates of child abuse (both physical and sexual) within professionals and examine personal attributes and case factors that affect clinician's responses to allegations of sexual abuse. Their follow up survey study (N= 392, 56% female and 43% male) aimed specifically at examining the effects of abuse history upon their professionals' personal and professional lives, involving also comparison groups of non -abused professionals. In the follow-up study the questionnaire they used included questions about personal and professional boundary violations and their findings suggest that a childhood abuse history can affect clinical evaluation of data and clinical decision –making (i.e. boundary violation). When Jackson and Nutall (1997) examined the effect of childhood abuse on sexual relationships with client by gender and discipline they found a significant effect only for male psychologists ($p = .02$, Fisher's Exact Test). In general, respondents with a history of child abuse were found to be 3 times more likely to have engaged in sexual activities with their clients than their peers with no history of sexual abuse (8% vs. 2.3%, $p < .05$). However, this association was according to Jackson and Nutall (1997) much stronger for male professionals than female. Specifically they found that 5% of male professionals who reported no abuse said they had sex with a client and this value tripled to 18% for male professionals who reported being abused themselves.

The above results agree with Pearlman and Saakvitne (1995) who report that sexually abused therapists may be more prone compared to non-abused, to violate therapeutic

boundaries and consider such violations as therapeutic, because they are driven by their own needs, defences and distortions of interpersonal relationships (this will be further discussed later, under the section for boundaries). Jackson's and Nutall's (1997) findings and Pearlman's and Saakvitne's (1995) observations strongly suggest that a history of childhood abuse may be a hidden factor contributing to sexual exploitation of clients by professionals. Such a suggestion becomes an important topic for future research and has major implications for the education and training of all professionals.

However, Jackson's and Nutall's (1997) study, albeit the methodological improvements of their two projects compared to earlier studies in the field (i.e.: large sample, operational definitions of both sexual and physical abuse, standardised instruments) these have also some limitations that we need to take into account. These include the use of definitions about both sexual and physical abuse, which is not differentiated in the analysis of the data and so causes confusion in the interpretation of relevant statistics. Also the sample was drawn from four different disciplines (social workers, pediatricians, psychiatrists, psychologists) responsible for the evaluation and care of sexually abused children and therefore it is not representative of therapists or specialists who work with adult survivors of CSA, and although the sample was large, the number of abused respondents was relatively small, which limited the statistical power when they examined mediating variables. Finally, their projects include biases inherent in retrospective data and the reluctance to disclose abuse (Jackson and Nutall, 1997). Therefore future empirical research is important to extend such results.

B) The dilemma of the therapist for disclosing their own abuse history

Some authors (Sanderson, 1995, Everett and Gallop, 2001, Dale, 1999) discuss the dilemma that sexually abused therapists face in terms of whether to disclose their abuse to their clients. Again there are various arguments in the literature regarding this issue. Sanderson (1995) advocates that self-disclosure on this issue depends on the individual case and it depends on the therapist's judgment. However, such a disclosure will impact on the process of the therapy and therefore she proposes that therapists disclose this information even before therapy starts and leave it to the clients to decide whether they want to be referred to a therapist with similar experiences as them or not (Sanderson, 1995). However, such a proposal seems difficult to apply since sexual abuse within therapists is still a taboo area and also because it depends on the therapist whether they would want to give such information about themselves (Doyle, 1994, Everett and Gallop, 2001).

Everett and Gallop (2001) and Pearlman and Saakvitne (1995), seem to be more reluctant regarding such a disclosure from the therapist. They argue that the focus of the therapy should be on the client and such a disclosure will shift the focus. Pearlman and Saakvitne (1995) in particular, mention that sometimes therapists present good reasons for disclosing their personal victimisation to a client (i.e.: due to the client's experience of isolation, or the client's need for reassurance), but they also argue that it is possible for a sexually abused therapist to be mistaken in these reasons and it would therefore be better to explore with the client first the meaning of such disclosure. Pearlman and Saakvitne (1995) illustrate that in cases of group work where a client might ask the therapist to make such self-disclosure and another member to refuse to listen to the therapist's answer (Pearlman and Saakvitne, 1995).

Finally Dale's (1999) qualitative study on client's and therapists' experiences on receiving and providing help on the issue of CSA, shows that such a disclosure from the therapist might be helpful for some clients and unhelpful for others. In particular, during the interviews that Dale conducted, some clients reported that they benefited from such disclosure and felt better understood, validated and had a strong sense of optimism that healing will take place, whereas others felt under pressure to compare themselves with the counsellor. Dale's (1999) findings also suggest that clients seem to receive such information more emotionally, whereas therapists provide that information after a logical processing and based mainly on their theoretical orientation (i.e.: psychodynamic therapists do not agree with it, humanistic therapists agree with it only on some occasions and psychiatrists viewing it as contaminating the therapists' actions).

However, according to Dale (1999) what matters more is the degree to which that self-disclosure comes from a "healed" or an "unhealed" position. Thus, Dale's findings suggest that the sexually abused therapists should carefully consider the decision of self- disclosing since the therapists logical arguments about doing it might not match the client's emotional responses to it. Although Dale's study has many advantages, since he discusses in great detail methodological issues, which is an important component of validity to qualitative studies, and he used adequate validation strategies for the data analysis, as mentioned previously his study referred to general abuse experiences and not only to sexual abuse, certain perspectives were not represented, such as male clients and clients who had positive experience of therapy and the sample was self- selected which introduces a bias.

C) The sexually abused therapist: a taboo topic

One final area that has been discussed in literature about sexually abused therapists is the issue of silencing and keeping their abuse a secret. Pearlman and Saakvitne (1995) argue that a history of sexual abuse in therapists is a taboo area. The lack of literature on this issue perpetuates the stigmatisation of those therapists and parallels the slow progress of the profession towards the recognition of the prevalence of CSA in the lives of our clients. This notion is in agreement with what other writers advocate. In particular, Everett and Gallop (2001) and Doyle, (1994), highlight how sexually abused therapists are seen within the organisational setting. They argue that sexually abused therapists are usually invalidated and undermined by their colleagues. They might worry about being judged or considered as weak. This in particular seems to characterise the western cultures where people are divided into "copers" and "non copers" and where people who seek help are considered as lacking the ability to cope with stress. Such attitudes seem to add extra strain to sexually abused therapists, resulting in them avoiding addressing personal issues that might arise. Furniss (1991) supports that addressing the issue becomes even more difficult for professionals who are in senior positions and proposes that an indirect communication through meetings, workshops and case discussions could be partially a solution.

In summary, many clinicians (Sanderson, 1995, Glaser and Frosh, 1993, Dolan, 1991, Doyle, 1994, Dale, 1999, Everett and Gallop, 2001), have addressed the unique challenges that sexually abused therapists face when doing trauma work, which range from complex countertransference patterns, dilemmas regarding self disclosure, unethical practice and client's exploitation. However, there are not enough studies exploring the effectiveness of abused versus non-abused therapists who are involved

in trauma work, nor is there, systematic research regarding the advantages and disadvantages of being both a survivor and a therapist. In this sensitive area there are no simple answers. Perhaps it is not so important whether a therapist has been abused or not, but rather the degree to which an abused therapist has worked through his/her own issues before embarking on trauma work. Systematic research with sexually abused therapists has been widely neglected and therefore the observations regarding advantages and disadvantages of sexually abused therapists, in treating survivors of CSA, are still not clear. The empirical findings from Jackson and Nutall, (1997) and Dale, (1999) raise important questions for ethical and professional practice but, until further research is conducted, these should be considered carefully since they might contribute to further stigmatisation of the survivor-therapist. Specific recommendations for more systematic research are made later in this review.

Part B: Issues of gender, boundaries, attitudes towards sexuality and sexual abuse.

In the first part of this review important therapeutic concerns in the work with CSA survivors that referred to countertransference, vicarious traumatisation as well as the dilemmas regarding sexually abused therapists, were addressed. However the topic of this study would seem incomplete without examining concerns around some more specific personal characteristics of therapists and how these may impact on the work with CSA clients. Therefore the issue of gender, boundaries and attitudes towards sexual abuse and sexuality will be explored.

Gender

This part refers to the debate in the literature of whether the gender of the counsellor who works with survivors of sexual abuse, impacts on the therapeutic relationship or not. According to the National Clearinghouse on Child Abuse and Neglect (www.calib.com/nccanch/pubs/usermanuals/sexabuse/field.cfm) the gender of the professional is likely to influence reactions to cases of child sexual abuse and the main issue around this influence refers to identification patterns. Gender identification can lead to either greater empathy or greater rejection of the person of the same sex. Both males and female professionals have empathy for victims but there is the possibility when there is gender identification therapists to become more empathic and sensitive.

Therefore as it is explained later, some arguments on this issue (Hall and Lloyed, 1989, Sanderson, 1995) refer to the advantages and disadvantages that male and

female therapists have when working with survivors of sexual abuse in general, other authors (Pearlman and Saakvitne, 1995, Dolan, 1991) examine separately the work of female/male therapists with male and female victims and discuss the advantages and drawbacks in each case. Others consider the importance of the perpetrator's gender within the above relational patterns. Finally there are some authors (Furniss, 1991, Friedrich, 1990) arguing the gender of the therapist is not important and others who advocate both a male and a female therapist are equally needed for a successful therapeutic outcome.

In particular, writers like Schetsky and Green, (1988) and Hall and Lloyd, (1989) support that both genders have advantages and disadvantages. Dolan (1991) agrees with such a notion and she examines the advantages and disadvantages in dyadic combinations (i.e.: male therapist/female client, male therapist/male client). Specifically, Dolan (1991) advocates that a female therapist might establish alliance easier when working with female clients but at the same time they might become the symbolic target of the client's anger towards the mother who never protected them. Whereas for a male therapist who works with a female client some extra effort might be needed to establish trust but at the same time male therapists can provide a positive role model to the survivor (Dolan, 1991). Pearlman and Saakvitne (1995) adopt Dolan's combinations of gender (i.e. male therapist-female client, female therapist – female clients etc) in order to address the advantages and drawbacks of each combination. They however discuss it within the context of countertansference and they argue that the gender of the therapist is important in CSA because it intensifies the various countertransference patterns they address.

On the other hand there are some writers (Blake-White and Kline, 1985, Belohlavek, 1984, Sanderson, 1995) who argue that although male and female therapists have both advantages and disadvantages working with clients with a history of CSA, they advocate that the most effective therapeutic relationship is between a female therapist and a female client. In particular Sanderson, (1995) highlights the advantages of female therapists especially during the start of the therapy whereas she says a female therapist might encounter difficulties in later stages of the therapeutic process, when for example the female client might start rejecting her female side.

A major drawback in Sanderson's arguments seems to be the fact that she appears to make many assumptions when she explores the therapist's gender. She assumes the victim will always be a female and the perpetrator will be a male. The fact she doesn't make clear her reasons for presenting the topic in that way, makes her presentation look incomplete and biased. With both Dolan, (1991) and Pearlman and Saakvitne, (1995) as discussed above, take into account the gender of the perpetrator (e.g. they describe the dynamic between female therapist-male client when the perpetrator is male and when the perpetrator is female etc) and how this could further complicate the dynamics that are created between client and therapist according to their gender. They also highlight the issue of the female perpetrator, which seems to have been neglected in literature. Such a neglect could be explained by a number of reasons among which one could be that sex role stereotypes have led us to accept men's abuse of children and deny abuse by women (i.e. holding beliefs like it is less likely that females abuse, the female sexual abuse is more covert) or there might be a cultural reluctance to acknowledge that abuse. (Pearlman and Saakvitne, 1995).

Others (Dolan, 1991) suggest that giving the opportunity to the client to have both male and female therapist, could help the client to explore issues regarding both genders. Dolan, (1991) and Sanderson (1995) refer particularly to the advantage of a female therapist starting the therapeutic work and introducing a male therapist later on when the client would feel ready to do so. The same could apply with a male therapist starting the therapeutic work and a female therapist following. However there are other authors Bruckner and Johnson, (1987) who advocate the benefits of mixed-gender co-leaders.

Finally professionals' reactions to sexual abuse might differ by gender because men and women experience society from a different perspective. For example women are generally in the subservient position and so as professionals might appreciate better the relationship of sexual abuse to a general male dominant society (National Clearinghouse on Child Abuse and Neglect, (www.calib.com/ nccanch /pubs / usermanuals/sexabuse/field.cfm). Friedrich (1990) has also commented on the therapist's gender within the field of sexual abuse and he also explores the topic as being part of a socialisation process, where males are more directive and controlling and females more nurturing with both sides having the capacity to impact positively and negatively. However, he stresses that training perhaps is more important for the therapist than gender. He also highlights the importance of knowing the abuse happens within a context and the victim can have the same ambivalence about non-protective parents as the one she/he has about abusive parents. As such the therapist's gender, male or female, could always trigger client's issues that would necessitate appropriate exploration.

Furniss, (1991) seems to agree with Friedrich (1990) on the fact that gender might not be so important as soon as therapists are aware of the advantages and disadvantages. He also adds that it is the therapist's projections that lead to such ideological discussions about gender and it would have been more helpful to accept that we all have strengths and weaknesses not only due to gender, but due to our life experiences, attitudes and background. Moreover, Westerlund, (1992) is also in agreement with the above authors, arguing that the gender of the therapist does not seem so important compared to the style of therapy (i.e. whether collaborative or directive etc). Finally, Evans (1990) advocates that the key issue in the work is the gender attitudes and the therapist's ability to examine their own gender issues.

Some empirical studies have been conducted on various professionals, demonstrating the influence of the professional's gender on the decisions they make (Little and Hamby, 1996, Allison, 1998). In particular, the study by Little and Hamby, (1996) was a survey of 501 clinicians that examined the impact of clinician's gender and history of sexual abuse on treatment of survivors of CSA through a questionnaire. What they found was there were significant differences in clinical practice based on therapist's gender and in particular they found that CSA issues are more salient to female than male clinicians, that women screen more routinely for CSA in their clients, $F(1, 434) = 3.98$, $p<.05$, assess more harmful effects to their clients than male colleagues, $F(1, 414) = 7.38$, $p<.01$ and report more countertransference responses (i.e. females reported higher frequencies than males on "feeling deep hopelessness" $F(1, 398) = 2.27$, $p<.05$, "feel disgust and discomfort" $F(1, 407) = 3.85$, $p<.05$ and "cry with clients" $F(1, 401) = 11.26$, $p<.001$) (Little and Hamby, 1996).

Allison (1998) reviewed findings from studies that explored how the therapists' gender impacts on therapy. According to her, the results of the studies she describes are inconclusive with some studies suggesting that women therapists are more likely to address the issue of sexual abuse (Adams & Betz, 1993, Attias &Goodwin, 1985 cited in Allison, 1998) whereas others not finding any difference (Sagal, 1988 cited in Allison, 1998). In her study Allison, (1998), (N= 250, 180 psychologists and 70 psychiatrists) used a vignette describing a client presenting for initial treatment and asked professionals to rank order a list of treatment issues as well as diagnostic categories that were provided with the vignette. The results of this study showed that it is probably the client's gender that would impact on the therapeutic process (F= 32.614, df=1, p< .001) than the therapist's gender (F=3.806, df=1, p< .052) and specifically she found that there is a lack of knowledge regarding male victims and the impact that the abuse can have on them which is also supported by Lab et. al. (2000).

Nevertheless some of the evidence presented suggests the gender of the therapist could be relevant in the different dynamics that develop with survivors of sexual abuse as well as generally on treatment decisions of the clinician and therefore the need for more empirical research is imperative. Moreover, there seem to be so many variables that could confound with the counsellor's gender (i.e.: personality, upbringing, skills, knowledge, experience) that need to be taken into account when conducting relevant research or interpreting results from future studies.

On the other hand, some studies have been conducted examining how professionals' gender impacts on attributing responsibility for the sexual abuse (Jackson and

Sandberg, 1985, Reidy and Hochshadt, 1993, Johnson et. al., 1990). The study by Jackson and Sandberg (1985) showed that male professionals rated victims of CSA as having more responsibility for the abuse than female professionals whereas the study by Reidy & Hochshadt, (1993) showed that male professionals attributed less responsibility to non-offending mothers than female professionals. However, the sample of the first study included professionals from other disciplines irrelevant to mental health (i.e. judges and lawyers) and in the second study, which was conducted on general mental health professionals (N=101), the effect of responded gender may be confounded with professional affiliation (71% of psychologists were male while 68% of social workers and counsellors were females). The overall sample size did not permit the evaluation of possible interactions between gender and professional affiliation. The study by Johnson et. al., (1990) (N= 201, 99 teachers and 162 social workers), used a case vignette of a female child sexually abused by her father and found that although most respondents placed no blame to the victim still a high percentage (47.5%) of the participants did feel that the child's behaviour may have influenced the actions of the perpetrator, most of which were male participants. Also female respondents were more likely than male respondents to believe that the abuse experience would negatively impact on the child.

Furthermore there are more researchers (Attias & Goodwin, 1985, Jackson and Ferguson, 1983, Broussard & Wagner, 1988) who indicate that male participants are more likely to attribute blame to the victim in abusive situations, more likely to see it as fantasy and to see it as less damaging to the victim. Such results raise questions in terms of how the therapist's gender could impact on the identification and therapeutic process with victims of child sexual abuse. However, most of the above studies and

the ones that were described above were conducted on teachers, social workers, judges and general professionals and so more research is needed using therapists as a sample since it might be that therapists or mental health professionals in particular have an increased awareness and knowledge regarding child sexual abuse compared to non mental health professionals and might not hold such biases.

Boundaries

Complex boundary issues are part of therapists' concerns in every therapeutic setting, but when working with sexually abused clients that seems to become even more critical. People who have been sexually abused have had their boundaries ignored and violated. Therefore part of the therapeutic process would be for the therapist to re-introduce the notion of boundaries to the client in a way that contradicts the client's experiences of fusion and violation and therefore enable them to feel safe and respected again. Various authors have discussed boundaries in the field of CSA from three different perspectives. A) Some (Sanderson, 1995, Pearlman and Saakvitne, 1995, Broden and Agresti, 1998) stress the importance of keeping clear boundaries for the client and exploring ways of doing that, B) others (Etherington, 2001, Couper, 2000) stress the importance of the therapists keeping strict boundaries for themselves (i.e.: adopting strategies to prevent the impact of the material on their personal lives and vice versa) and C) others (Dolan, 1991, Dale, 1999, Jackson and Nutall, 1997, Broden and Agresti, 1998, Avery and Disch, 1998) explore the possibility and ways that therapists might violate therapeutic boundaries.

A) Specifically, Sanderson, (1995), argues that because the issue of sexual abuse is particularly sensitive, it is the therapist's obligation to create a sense of safety to the

client, through the establishment of clear boundaries. The same author recommends the therapist can achieve that through negotiations with the client regarding the length of the sessions, telephone calls, payment, contact between sessions and generally by creating a contract with the client regarding these topics. She also discusses the issue of physical contact and stresses that this should be kept to a minimum when working with cases of sexual abuse.

In contrast, Pearlman and Saakvitne (1995) discuss the issue of boundaries within the context of countertransference and explore under this prism the various meanings of the use of boundaries by therapists (i.e.: the adoption of firm boundaries in response to identification with a powerful authority figure). Regarding the issue of physical contact they argue that it mostly depends on the therapist's theoretical orientation. On the other hand they highlight that regardless of the model of the therapist if any physical contact takes place it should be initiated by the client and never be of a sexual nature. Exploring this issue further, they conclude that perhaps it is not so important to know whether physical contact is appropriate or not but for the therapist to be personally and ethically comfortable with any decision he/she makes. However, both Sanderson, (1995) and Pearlman and Saakvitne (1995) seem to be more influenced by the westernised values and do not address any cultural differences in both therapists and clients when addressing the topic of physical contact. Further study on the cultural differences among therapists' use of physical contact with victims of CSA is suggested.

Furthermore, Broden and Agresti, (1998) in their article discuss complex dynamics between therapists and clients in relation to the need of keeping clear boundaries and

its importance when working with survivors of sexual abuse. They do stress the importance of training courses addressing issues like erotic countertransference and acknowledging the reality of sexual attraction between clients and therapists in order to help therapists explore these appropriately and work ethically.

B) On the other hand, Etherington (2001) emphasises the need of boundaries as a protection strategy for the therapist, due to the possible impact the material can have on them and stress issues such as the need for therapists to keep their professional lives out of their every day activities, not to over-work, not being available all the time, etc. Couper's (2000) exploratory study (although referring to work with children) supports the above arguments and emphasises the difficulty for professionals to keep their personal lives completely separate from their professional lives. Couper (2000) interviewed nine members of a team, who worked with abused children and found that all people interviewed had difficulties keeping the impact of their work outside their personal lives. According to him some workers said they couldn't stop thinking about the cases even after going home, others said had problems sleeping and others said experiencing feelings of upset and angry. Despite the limitations of Couper's study (small sample of 9 professionals, unclear about methodology and validation methods) his findings suggest that extending such research in professionals who work with adult survivors of CSA would be a valuable contribution in the field.

As a result of the emerging literature on the impact of trauma work on the therapist and the dangers of vicarious traumatisation (refer to "discussion- implications for research and practice" in research part of this portfolio), a number of researchers and

clinicians (Steed and Downing, 1998, Collins and Long, 2003, Salston and Figley, 2003) propose preventive strategies for the trauma therapist emphasising the need for keeping clear boundaries by protecting their personal life and separating it from their professional life (www.questia.com/PM.qst?action).

C) One very sensitive area in the treatment of adult survivors of CSA refers to the violation of therapeutic boundaries. Dolan (1991) addresses the issue by examining various ways that such violations can occur and by exploring their effects on the therapeutic process. Some of the boundary violations she presents relate to not keeping appointments, times etc and to turning the therapeutic relationship into a social interaction. Another violation she presents refers to the therapist's self-disclosures. Self-disclosures of victimisation history from the therapists can easily become the central issue of the sessions since sexually abused clients are used to adopt the role of "caretaker".

Dolan's (1991) argument is in agreement with Dale's (1999) qualitative study on experiences of both clients and therapists of therapy. Dale (1999) suggests that clients often receive therapist's self-disclosures as violation of their personal space, since such a self-disclosure shifts the focus of the therapy from their needs to their therapist's needs (details of Dale's study have already explored in a previous section). As a result clients become attentive to the therapist's needs and seem to perceive that as a replication of the dynamic between them and their abusers. This dynamic is created since a lot of sexually abused clients have a history of behaving in adaptive and care taking ways to their abusers the way they become now care taking to their therapists (Dale, 1999).

There are a number of studies conducted on large samples (395 to 1423) of psychologists and psychiatrists regarding sexual contact with clients (Akamatsu, 1988, Pope et al., 1987, Pope, KeithSpiegel & Tebachnick, 1986) that have shown that 0.5% to 3.1% of female and 3.5% to 12.1% of male psychiatrists and psychologists had sexual contact with a current client. There are also some studies that have shown that professionals who have had sexual contact with their clients reported that under specific circumstances this was acceptable (Gabbard, 1994, Stream, 1993, Twemlow & Gabbard, 1989). The above studies support that violation of boundaries from therapists might take place more often than we might think.

Some studies have been conducted regarding boundary violations particularly with sexually abused clients (Salter, 1995, Kluft, 1990, Armsworth, 1990, Avery and Disch, 1998). In particular, Ana Salter (1995) reports studies by Gil (1988) conducted on 99 survivors and Deyoung (1983) on 10 incest victims, who reveal a high percentage of clients (27% on the first study and 30% of survivors of the second study) who have been sexually abused by their therapists. These findings relate to other studies by Avery and Disch, (1998) which have shown that clients with a history of sexual abuse are at high risk for boundary violation from professionals. A study by Kluft (1990) found that in a sample of 12 incest survivors all of whom had been sexually abused by their therapist, 28% of the total number of therapists they had seen had been sexually abusive. Armsworth (1989) reports that in a sample of 30 adult survivors 23% had been sexually involved or pressured to be involved with the professionals they sought for help.

There are more clinicians and some studies that discuss issues on clients who have been survivors of childhood sexual abuse and the risk of their subsequent involvement with a therapist (Herman, 1981, Feldman-Sommers and Jones, 1984, Deyoung and Lowry, 1992). In particular, Deyoung and Lowry (1992) discuss this vulnerability of CSA survivors through the concept of "traumatic bonding". According to them sexual abuse contributes to the evolution of emotional dependency between two persons of unequal power (i.e. parent-child, therapist-client), which is characterised by intense attachment feelings, cognitive distortions and behaviours that tend to strengthen that bond (Deyoung and Lowry, 1992). Penfold (1992) further discusses the issues of child sexually abused clients who have been subsequently abused by their therapists and advocates that the inequality of therapist-client relationship resembles the parent-child relationship and this perception of the therapist as a parental figure together with the role reversal, the refocusing on therapists' needs and the secrecy which surrounds it are very similar to the parent-child incest.

Feldman-Summers and Jones (1984) conducted a study that highlights the negative impact of sexual involvement with a therapist. In particular they compared three groups of thirty- one women in total (first group: 14 women who had sexual contact with their therapists, second group: 7 women who had sexual contact with other physicians and third group: 10 women who had received counselling and did not engage in any sexual contact with their therapists). Their results indicate that women who had sexual contact with their therapists differed from those who had not in terms of having greater mistrust and anger toward men and the therapist ($t(21) = 3.76$, $p < .001$) and greater symptomatology one month after treatment was terminated ($t(19) = 2.35$, $p < .03$.

There are suggestions that sexual boundary violations could arise within professionals who have been victims of sexual abuse. Jackson's and Nutall's (1997) study regarding the characteristics of clinicians that could influence their credibility, showed that a history of childhood abuse could influence the way clinicians handle therapeutic boundaries. In particular, as reported earlier in this review, their study has shown that male professionals who reported a history of sexual abuse were more likely to cross professional boundaries in ways that could be damaging to clients. Male sexually abused professionals were more likely to report having engaged in sexual activity with their clients than their sexually abused female colleagues or their non- sexually abused peers (Jackson and Nutall, 1997). Considering the results from Jackson and Nutall's (1997) study that a personal victimization history of the therapist is a risk factor for later sexual contact with clients then it could mean that a history of CSA in professionals may be a hidden factor in some of these studies mentioned above that refer to later sexual exploitation of clients. Future studies on violation of boundaries from therapists need to take that into account.

However, a major impediment to research in this area could be the unwillingness of clients and professionals to report. Identification of such ethical violations depends highly on the abused client or on subsequent therapists, and because of their unwillingness to report most cases remain undetected (Moore, 1985, Pope& Bouhoutsos, 1986). According to Pope & Bouhoutsos (1986) when a history of incest is added to client-abused by therapist picture research is impeded even further since issues of double stigmatisation affect this client group.

Even in the case where other professionals are informed of such violations they are also confronted with an ethical dilemma of exposing the behaviour or preserving client's confidentiality. Such research could become even more difficult including sexually abused therapists, due to ethical constraints inherent to the development of appropriate designs, the sensitivity of the issue and the tendency of sexually abused therapists to keep such information a secret. Nevertheless, boundary violations can have catastrophic effects on clients, including revictimisation and re-enactments of powerlessness and exploitation (Armsworth, 1990). The implications on counselling practice and the need for training will be discussed later in this review.

Attitudes towards sexuality and sexual abuse

There is consensus in literature regarding the importance of therapists to explore their attitudes towards sexuality and sexual abuse when working with clients with a history of CSA (Deyoung, 1982, Schetsky and Green, 1988, Glaser and Frosch, 1993, Little and Hamby, 1996, Sanderson, 1995, Draucher, 2000). Sexuality involves complex and confusing emotions that many people, including therapists, struggle to come to terms with (Sanderson, 1995). Therefore, they run the risk of communicating their own discomfort to the client and not allowing them to talk about it or they may even attempt to ascribe the report of sexual abuse to client's fantasy (Schetsky and Green 1988). In addition, Glaser and Frosch (1993) agree with the above notion highlighting the existing risk of therapists to project their own fears and anxieties to their clients. Moreover, such exploration seems significant because of the different socialisation processes of males and females and how these have impacted on different attitudes about sexuality (Draucher, 2000).

One article by the National Clearinghouse on Child Abuse and Neglect (www.calib.com/nccanch/ pubs/usermanuals/ sexabuse/ field.cfm) suggests professional involvement in sexual abuse cases may impact on professionals' own sexuality in terms of the professional having intrusive images of the sexual acts of their case which might lead in diminishing their sexual desire. In the same article it is highlighted that sexual abuse cases might affect professional's own sexual role performance, for example men might start becoming concerned whether they coerce or manipulate their partners.

Pearlman and Saakvitne (1995) explore the importance of the therapists' awareness regarding their own attitudes about sex and sexuality when working with survivors of CSA from a psychodynamic perspective and offer a detailed examination of erotic and sexual responses in the therapeutic relationship with CSA survivors. According to them "the content of trauma material often arouses fascination both because of cultural taboo against CSA and the sadomasochistic fusion of sexuality and aggression" (p. 209). They also highlight that because the therapeutic relationship is an intimate relationship strong feelings of love and attraction are likely to emerge. The problem seems to arise according to them when therapists are not prepared for the intensity of these feelings and feel embarrassed or anxious about their responses. Pearlman and Saakvitne (1995) have extended their exploration of the issue of therapist's sexuality by addressing the issues of gay and lesbian therapists who work with CSA clients. According to Pearlman and Saakvitne (1995) it is inevitable that the cultural taboos against same –sex erotic attachments will enter the therapeutic relationship since according to them the cultural taboo and requirement of silence about homosexuality create a parallel between sexuality and incest dynamics.

Specifically for gay and lesbian therapists they say " ...gay, lesbian and bisexual therapists may struggle with another lever of anxiety with erotic or erotised material from the same sex clients and might be worried that their client is responding to clues from them..." (Pearlman and Saakvitne, 1995, pg 210). Therefore further exploration on the impact of therapists' sexuality on CSA work is clearly needed as well as how therapists coming from different theoretical perspectives deal with this matter (i.e.: how do CBT therapists address this?).

Apart from the need for an increased awareness of the therapists' attitudes towards their own sexuality, some writers stress the need for professionals to be clear about their attitudes towards child sexual abuse such as the prevalence of sexual abuse and about where the responsibility lies (Sanderson, 1995). Draucher (2000) emphasized the socio-cultural influence on the therapist. She argues that helping professionals who come from a tradition of denial of both the reality and prevalence of CSA, which reflects deeper values regarding gender roles, power issues and children's rights would be important. Therefore therapists need to explore their internalisation of such beliefs and how these could influence the therapy.

Some studies have been reported in literature regarding attributions of various professionals and beliefs about CSA (Bolen, 2001, Hanson and Slater, 1990, Wagner et. al., 1993, Johnson et. al., 1990, Hetherton & Beardsall, 1988, Hall and Lloyd, 1989, Hartman et. al., 1994). In particular, some studies revealed that, although the victim-blame factor has been minimised after 1980, professionals' attribution of responsibility of the abuse still varies based upon the age of the victim (Wagner et. al., 1993) and on the offender's motivation for the abuse (Hanson and Slater, 1990).

Moreover, Johnson et al., (1990) conducted a study (N= 261) on 99 teachers and 162 social workers and found that the type of victim's behaviour seems to be another factor, that influences attribution of blame. In particular subjects were given one of four brief histories of a fourteen-year-old girl who had been sexually abused by her father. Cases varied according to whether the child had/had not resisted her father's advances and whether she had/had not other sexual experiences. Subjects then completed a questionnaire and indicated the extent to which they attributed censure to the child. Significant differences were found between occupational groups with teachers attributing more censure to the child than social workers ($F= 7.58$, $p< .05$), also significantly greater censure was attributed to the child when she did not resist ($F= 6.55$, $p< .05$) and when she was described as having other sexual experiences ($F= 5.36$, $p< .05$).

Moreover, other studies report beliefs of professionals such as that abuse by female offenders is less serious (Hetherton & Beardsall, 1988) and that sexual abuse occurs only in certain subgroups (Hall and Lloyd, 1989). Hartman et. al., (1994) conducted a study on 329 lawyers (178 defence lawyers and 151 prosecuting lawyers) and asked them to indicate through a questionnaire if they felt that a number of behaviours listed (21 behaviours were listed in order of severity) were acceptable, inappropriate or sexual abuse. Their findings indicated that behaviours that were not obviously sexual in nature were not considered abuse by the majority of respondents but what was worrisome was that there was still a small percentage (10%) who reported that penile penetration to a 15 or 16 year old by an adult was not considered sexual abuse.

Although the results of the above studies do not represent therapists' beliefs since the samples did not include only psychologists/therapists but also professionals from various disciplines (i.e.: lawyers, doctors) and do not show whether or how such attitudes could influence the therapeutic process, they do raise concern regarding professionals attitudes and reveal the need for more training and basic information.

Finally more recent research (Read and Frazer, 1998, Lab et. al., 2000) has shown professionals' attitudes towards the client's gender or presenting problems are some of the biases in the identification of CSA. Specifically male clients seem less likely to be asked by professionals whether they have been sexually abused compared to female clients (Lab et. al., 2000, Read and Frazier, 1998). There are also studies that indicate professionals are less likely to ask about CSA experiences with people diagnosed with schizophrenia (Cole, 1988, Read and Frazier, 1998). The above studies indicate that professionals might hold beliefs in relation to characteristics of victims of sexual abuse (such as female clients are more likely to have been abused) that highly influence the identification and subsequent treatment of CSA.

In summary, both clinical experience and some growing empirical evidence show that professionals' beliefs and attitudes towards sexuality and sexual abuse vary upon different factors. The suggestion, however that professionals do not yet always place the blame fully on the offender is worrisome. Moreover, such findings need to be extended to therapists who work directly with CSA cases since it is somehow understandable to expect that some professionals, especially those that are more removed from working with victims (i.e. pediatricians and non specialists in this field), might espouse some outdated beliefs (Bolen, 2001). In addition, there seem to

be some studies to reveal how certain beliefs about the client's gender or their diagnosis (schizophrenia) might influence the identification of sexual abuse but there does not seem to be any empirical study done on how attitudes towards sexuality or sexual abuse, could influence the actual therapeutic process with victims of CSA, if at all. One could argue that regardless of the therapist's personal beliefs the process of therapy remains intact since, as therapists, we are trained to focus on our clients' needs and not impose our own attitudes and experiences on them. But even if we decide that personal attitudes do not constitute a barrier in therapy we still have a responsibility to examine ourselves in order to expose individual attributes, judgmental attitudes or hidden believes (Everett and Gallop, 2001).

Part C: Implications and recommendations for training and practice –Future research orientations.

Having collated and discussed information from the literature regarding how personal characteristics of therapists might negatively influence the process of working with survivors of sexual abuse, it is hoped to clarify these issues in the field of trauma work that, as professionals, we need to be aware of. Such issues though still remain unclear and under addressed, both within training and research. The implications that will be discussed refer to the areas of training and supervision, personal therapy and future research.

In particular, surveys (Andrews, 1997; Palm and Gipson, 1998; Poole et al., 1995) have shown that most therapists seem to have received little if any education about human traumatisation, interpersonal victimisation and child abuse in their academic life. Most training programs do not offer training in the treatment of abuse and this is

highly problematic not only due to the increased likelihood for therapists to encounter such cases but also due to the inherent ethical and professional dilemmas that such work involves (Courtois, 1999).

It seems vital to recognise the risk that both experienced and inexperienced counsellors run due to the lack of inclusion of such issues in professional training. It is an irony for researchers and clinicians to stress the need of highly skilled and knowledgeable therapists to work in this field and yet for therapists still to have not received any formal training on this issue. Instead they have to rely on supervision, continuing educational programs, professional reading, adequate consultation, and on their personal resources (Courtois, 1999, Chu, 1998, Briere, 1996).

Christine Courtois (1999) provides clinicians with essential information for treating clients where memories of sexual abuse are an issue. Such texts and other professional material (Cohen and Mannarino, 1998; Pearlman and Saakvitne, 1995; Cambell & Carlson, 1995) are available and can be incorporated into professional training. Deyoung's (1982) paper on reasons that incest victims could be held responsible for their victimisation could also prove really helpful for all therapists who work with victims since it challenges hidden societal beliefs that hold the victim responsible and focuses on the importance of therapists taking into account the familial context of incest as a way of diminishing the culpability of the child. In this article, Mary Deyoung explores topics such as the "victim's passivity", "victim's behaviour in therapy", "victim's promiscuity", "seductive behaviour", "separation anxiety", "lack of protective model" and explains how these can contribute in professionals attributing responsibility to the child.

Moreover, training can include classroom or workshop instruction, supervised clinical experience and personal development groups specifically designed for trauma work (Draucher, 2000). Coursework in trauma theory and therapy could include a focus on therapist issues such as countertransference and vicarious traumatisation (Pearlman and Saakvitne, 1995). Training could emphasise self- awareness, self-monitoring and the best utilisation of supervision and consultation (Jackson and Nutall, 1997).

Especially for the new trauma therapist, adequate support is needed such as enough supervision and additional forums to check out their experiences with others and improve their knowledge on issues surrounding the work (Mannarino and Cohen, 2001). Etherington's (2000) guidelines regarding the issue of supervising therapists who do trauma work could be incorporated into courses for supervisors in this field. Moreover, resources for outside supervision (if there are not enough experienced therapists within the organisation) and for the therapists attending conferences and workshops seem necessary. As a result funding at the state and national level needs to be increased to support education and training in these issues.

Furthermore new therapists need to be provided with a safe place where they can acknowledge a possible personal history of sexual abuse and where they can freely talk about the interaction of that history with their work (Pearlman and Saakvitne, 1995). At the moment professional courses in counselling psychology have incorporated personal therapy as a requirement of the course, which gives therapists the opportunity to explore such issues, and possible personal histories of trauma. However students who enter such courses often are not fully aware of the

complexities inherent in trauma work and during the initial stage of training they usually are not allocated complex cases in the organisations where they work. As a result, personal conflicts might not be triggered and therefore never explored. By the time they start to encounter sexual abuse cases in their caseloads they have completed the minimum hours of personal therapy required for the course and most of them are discouraged from re-entering therapy, even if they feel it would be useful, due to financial constraints. Thus, some suggestions could be to either spread the hours of personal therapy throughout all the years of professional training (which most courses in Counselling Psychology have recently started applying) or offer funding for personal therapy to students who want to specialise in trauma work.

On the other hand there are some authors (Glaser and Frosch, 1993) who suggest that self-awareness can be achieved through supervision and peer-discussion. However, one could argue that there are many examples of therapists, especially at the beginning of their career who do not feel safe to use supervision in this way, either out of fear of being judged or because such an opportunity was never given to them. The debate over therapists receiving personal therapy is ongoing in the literature and more in depth exploration of this issue is beyond the scope of this review. Nevertheless the existing literature in trauma work (Everett and Gallop, 2001, Dale, 1999, Friedrich, 1990, Sanderson, 1995, Etheringhton, 2000, Glaser and Frosh, 1993, Pearlman and Saakvitne, 1995) seems to conclude that personal exploration, however this is done, becomes necessary in order for therapists to guard against the danger of unprocessed and unaware emotional responses which could impede therapy or even, in more extreme cases, harm both parties.

Moreover, personal therapy becomes vital in cases where therapists are survivors of CSA themselves. The literature stresses the ethical obligation of these therapists to go through a personal journey of processing their own trauma, before embarking on treating CSA survivors (Sanderson, 1995, Dolan, 1991, Doyle, 1994). Finally, personal therapy could be useful in treating symptoms of vicarious traumatisation for even more experienced therapists, since vicarious traumatisation refers to the cumulative effect of doing trauma work (Pearlman and Saakvitne (1995).

In terms of research, more studies seem necessary to address the following issues: transference-countertransference patterns, vicarious traumatisation, sexually abused therapists and issues such as gender, boundaries and attitudes towards sexuality and sexual abuse.

In particular, conducting empirical studies on the issue of countertransference may be difficult because the dynamics between therapist and client are not considered quantifiable. However, qualitative studies utilising video-tapes, transcripts from sessions or even rooms with two way mirrors could be some suggestions. But even in that case there are ethical considerations regarding the client's consent and the impact of the observer or audio-tape on the dynamic. Moreover the researcher would have to be very experienced since many arguments could arise such as how he/she would observe countertransference phenomena and would his/her school of thought introduce a strong bias to that.

In addition, a longitudinal survey on the effects of vicarious traumatisation would seem useful. Also, the use of operational definitions would seem necessary especially

because the conseptualisation of vicarious traumatisation seems problematic. Moreover, the use of correlation to test hypothesis regarding therapists' personality characteristics as mediating factors between trauma work and vicarious traumatisation, could improve our knowledge regarding proneness to the latter. More comparison studies on the effects of therapeutic work on the therapist when dealing with sexually abused individuals and dealing with clients of other presenting problems, could give more information on the relationship of vicarious traumatisation and trauma work compared with other areas of therapy.

In addition, more studies are needed involving therapists who have themselves been victims of sexual abuse in order to further explore the benefits and limitations they bring to work with sexually abused individuals. The study conducted by Jackson and Nutall (1997), suggested a history of sexual abuse could be a hidden variable in the case of sexual violation of boundaries by therapists which forms a very important hypothesis for future research. In addition to this hypothesis, however, questions like what makes men or sexually abused therapists more likely to violate therapeutic boundaries and develop sexual relationships with their clients could also be explored.

Furthermore, it has been suggested in literature that there are different dynamics developed with sexually abused clients depending on the gender of the therapist and depending on the gender of the perpetrator (Dolan, 1991, Sanderson, 1995, Schetsky and Green, 1988, Pearlman and Saakvitne, 1995, Furniss, 1991, Hall and Lloyd, 1989, Draucher, 2000). However information is hampered by the lack of empirical evidence. Comparison groups could be used to test the advantages and disadvantages of female or male therapists. Moreover qualitative research on CSA clients' experiences

regarding the therapist's gender and whether this was an issue in the process of therapy is another suggestion.

Finally, research is needed in order to establish whether therapists' attitudes towards sexuality and sexual abuse influence the therapeutic process and, if so, how? A combination of quantitative and qualitative methodology, using transcripts from sessions with sexually abused clients and questionnaires answered from therapists could be used to test whether therapists' attitudes impact or not on the process of therapy and whether therapists or clients are aware of such an impact. Moreover, studies regarding the way that gay and lesbian therapists' attitudes towards sexuality could influence the therapy of sexually abused clients and what are the specific issues that might arise for the first also seems necessary.

Summary

The present review has explored various topics that relate to what therapists bring into the therapeutic work with sexually abused clients and what might create concern to the process of therapy if not addressed properly. These refer mainly to the communication of the client's pain to the therapist and the therapist's personal characteristics that could influence the therapeutic process. Feelings and re-enactments of being abused, being bad and useless, being terrified and numb, seem to volley between the client, the worker and the outside world. As therapists within this field we are not simple observers but active participants in these interactions that could have a deep impact on us. The dangers of vicarious traumatisation have been addressed (both in this literature review and the research part of this portfolio) and specific issues that refer to sexually abused therapists have also been highlighted.

Finally, the existing literature regarding the therapist's gender, boundaries and their attitudes towards sexuality and sexual abuse, has been examined.

The information provided is mainly based on anecdotal evidence, clinical observations and on clinicians' subjective experience of working with clients who have been sexually abused. A paucity of empirical evidence regarding this topic was identified and the few studies that exist have certain limitations (i.e. unclear definitions, small sample sizes yielding inadequate statistical power, unrepresentative samples of mental health professionals, and various limitations inherent in retrospective designs) that do not allow enough comparisons or generalisations to be made. Despite the lack of empirical studies and methodological rigor, some consensus exists in the literature regarding the importance of raising therapists' awareness on these issues that have significant implications to practice. Therefore a number of suggestions have been made, emphasising an improvement in training, support mechanisms and future research.

Therapy has the potential to facilitate positive changes for adults who were abused as children and can be very rewarding for both parties involved but it can also cause significant harm and can often result in unethical practice and exploitation of clients (Jackson and Nutall, 1997, Dale, 1999). As such it seems crucial for therapists to sacrifice some of their valuable therapeutic time in order to reflect, further explore and research such issues.

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List of appendices

Appendix A: Information sheet for professionals

Attitudes and practices on routinely enquiring about child sexual abuse with adult clients/patients during assessment and the impact of such work on therapists.

Information Sheet

Investigators:
Matina Sotrilli, Chartered Counselling Psychologist, Westways Resource Centre, 49 St James' Road, West Croydon, CRO 2UR. Tel: 020-8700-8830/8523(ext)
e-mail:msotrilli@hotmail.com
Dr Mike Slade, Health Services Research, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF
Dr Jacqui Farrants, Psychology Department, City University London, Northampton Square, London, EC1V OHB, tel: 02070400172
Dr Nicholas Troop, Psychology Department, London Metropolitan University, Calcutta House, Old Castle Street, tel:02073201087.

We are inviting you to participate in a study **exploring current practices and attitudes on routinely enquiring for child sexual abuse and the impact of such work on the therapist.**

Have you ever wondered whether during an initial assessment you should routinely ask adult clients about experiences of child sexual abuse? Each of you will of course have your own opinion on that matter and adopt certain practices according to your training, theoretical orientation and the precise policy of the department in which you are currently working. Some of you might even find such a question irrelevant to your work. No matter to which of the above groups you belong your participation in this research is extremely valuable, even if you have never worked with survivors of sexual abuse. Your opinion and experience as a therapist will inform and help other professionals in the field to have clearer answers on the issue of enquiring, how such enquiry should be done and what improvements need to be made in order for therapists to feel prepared for such work.

The study is entirely **voluntary** and you are under no obligation to take part. If you do choose to take part and then change your mind, you are free simply to stop completing the questionnaires at any time without giving a reason. The completion of all the questionnaires takes approximately 25 minutes.

This study is entirely **confidential** and you are asked not to write your name anywhere on the questionnaires. No one will know which individuals gave which answers and the findings will be presented in a form in which no individual's answers can be identified.

The questionnaires will be distributed to all psychologists/therapists (excluding those in child and adolescent services) within SLaM and IoP who may or may not encounter adult survivors of child sexual abuse within their caseloads. **If you have never worked with survivors of sexual abuse** you can still participate in this study and your opinion is equally important to us.

While you are completing the questionnaires you will encounter many times the term "sexual abuse". This term will not be defined for you. Please answer the questions having in mind your own definition of child sexual abuse. If you have any questions or concerns about this study, please contact Matina on the above e-mail address or telephone number.

We will be happy to send you information on the results of this study, if you are interested, in which case, please provide your name and address on the piece of paper in the small envelope provided and seal it. Please use the large envelope to put both the questionnaires and the small envelope with your details sealed inside (if you would like a summary of the results). The small envelopes will be collected and opened only after the study has been completed.

Thank you very much for your co-operation

Matina Sotrilli

Appendix B: Information sheet for clients

Attitudes on routinely enquiring about child sexual abuse during a psychological assessment.
Information Sheet

Investigators:
Matina Sotrilli, Chartered Psychologist, Westways Resource Centre, 49 St James' Road, West Croydon, CRO 2UR.
Tel: 020-8700-8830/8523(ext) Mon-Wed-Fri.
Dr Mike Slade, Health Services Research, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF
Dr Jacqui Farrants, Psychology Department, City University London, Northampton Square, London, EC1 OHB.
Dr Nicholas Troop, Health Psychology Department, London Metropolitan University, Calcutta House, Old Castle Street, E1 7NT.

Most of you have been through an assessment with a psychologist during which you have been asked to discuss your current difficulties and the therapeutic programme that would be most suitable for your needs. In order to improve clinical services it is very important that we understand the best ways to approach and ask about certain issues that may affect the way that care is delivered. We are therefore inviting you to participate in a research study **exploring current practices and attitudes on routinely enquiring about child sexual abuse experiences in clinical settings. We are interested in everyone's opinion, regardless of whether they have actually experienced abuse or not.**

Please read this information sheet before deciding whether or not you wish to take part. After having read the information sheet, and if you decide to take part, please complete the questionnaire and put it back in the box next to the reception. The completion of the questionnaire takes approximately **5 minutes.**

The purpose of this study is to investigate how you find and experience some of the questions that psychologists might have asked you during an initial assessment. In particular, we would like to know how you feel about questions that relate to experiences of child sexual abuse. **If you have never been asked about this issue your participation in this research study is still extremely valuable.** Your opinion and experience as a client would help professionals in the field to have clearer answers on the issue of enquiring and how such enquiry should be made in order to improve the service we provide by taking into account your needs.

If you decide to participate you will provide valuable information that may be used to improve working practices and patient care. However, the study is entirely **voluntary** and you are under no obligation to take part. Not participating in this study will not affect your treatment in any way. If you do choose to take part and then change your mind, you are free simply to stop completing the questionnaire without giving a reason.

This study is entirely **confidential** and you are asked not to write your name anywhere on the questionnaires. Nobody will be able to know which individuals participated and the findings will be presented in a form in which no individual's answers can be identified.

This questionnaire will be distributed randomly to people who are waiting to be seen by a psychologist in different services within South London and Maudsley NHS Trust and Institute of Psychiatry. It is not the intention of this study to cause any distress. However, given the nature of the topic, if while you are completing the questionnaire you experience any discomfort or distress you are advised to discuss this with your therapist who has already been informed about this research study. If you have any further questions or concerns about this study, please contact Matina on the above telephone number.

We will be happy to send you a summary of the results of this study, if you are interested, in which case, please provide your name and address on the piece of paper within the small envelop provided and seal it. Please use the large envelop to put both the questionnaire and the small envelope containing your details (if you requested a summary of the findings) and place it in the box at reception. The small envelopes will be collected and opened by the researcher alone and only after the study has been completed. Since the small sealed envelopes will be collected altogether there would be no possibility for matches between the questionnaires and your personal details to be made.

Thank you very much for your co-operation

Matina Sotrilli

Appendix C: Therapists' Questionnaire (P-SQAPRESA)

Questionnaire: Attitudes and practices on routinely enquiring about child sexual abuse with adult clients/patients during assessment.

Please try to answer all questions as accurately as possible and according to what you think, not what you ought to think or do and feel free to write any comments anywhere on the form.

Demographic Characteristics

1
Please state your gender. Circle the one that corresponds to your gender

1=Male 2=Female

2
Please state your age here _____

3
Please state your profession: Tick one or more of the following

Occupational Therapist ☐1 Counselling Psychologist ☐2 Therapist ☐3

Clinical Psychologist ☐4 Trainee Psychologist ☐5 Psychotherapist ☐6

Other, specify_____

4
In which area of mental health do you work? Please tick one or more

	Inpatients a	Outpatients b
Adult mental health	☐1	☐1
Forensic	☐2	☐2
Addictions	☐3	☐3
Older Adults	☐4	☐4
Learning Difficulties	☐5	☐5
Eating Disorders	☐6	☐6
Other/specify_____	☐7	☐7

5
How long have you worked in the field you stated above (question 4)? Please state here_____(months/years)

6
How long have you worked in the mental Health field since you finished your professional training? Please state here_____ (months/years)

7
What is your theoretical orientation (i.e psychodynamic, CBT etc)? Please state here_____

8
Do you work:
Please tick the one that applies to you

Full-time ☐1 Part-Time ☐2

9
How many adult clients/patients do you see per week in your current job? Even if it is not a standard number every week please give an estimation here_____

10
Approximately, what proportion of the adult clients/patients you work with has disclosed to have been sexually abused as children?
Please circle the one that applies to you

None	10%	20%	30%	40%	50%	60%	70%	80%	90%	All
1	2	3	4	5	6	7	8	9	10	11

11
Approximately, what proportion of the adult clients/patients you work with, have been through major trauma other than child sexual abuse which has resulted in suffering from symptoms of PTSD?
Please circle the one that applies to you

None	10%	20%	30%	40%	50%	60%	70%	80%	90%	All
1	2	3	4	5	6	7	8	9	10	11

Attitudes and practices on assessing child sexual abuse

12

How do you define child sexual abuse?

*Please give your definition here*_____

_____

13

Do you think the assessment of adult patients/clients should include questions about child sexual abuse?

Please circle the one that applies to you

Yes	No	Sometimes	Not Sure
1	2	3	4

If yes go to the next question, If no go to question 15, if sometimes go to question 16 and if not sure go straight to question 17

14

If you answered Yes to question 13, why in your opinion do you think the assessment of adult patients/clients <u>should include</u> questions about child sexual abuse?

15

If you answered No to question 13, why in your opinion do you think the assessment of adult clients/patients <u>should not include</u> questions about child sexual abuse?

16
If you answered sometimes to question 13, could you give some examples of 1) when you would definitely ask and 2) when you would definitely not ask a patient/client about sexual abuse experiences?

1)

2)

17
During your work with adult patients/clients do you ask them about possible history of sexual abuse?
Please circle the one that applies to you

Always 1 Sometimes 2 Never 3

18
If you do enquire about sexual abuse do you think it is better to do this during assessment or later in therapy?
Please circle

During assessment (1)

Later in therapy (2)

19
If you do enquire about child sexual abuse how do you go about it?
Please circle

With a structured interview (1)

Only if clients bring it up (2)

Use a questionnaire or relevant scale (3)

Ask when it comes to mind (4)

Other/Specify (5)_____

20
Have you had any specific training <u>in assessing</u> adults for child sexual abuse?
Please circle

Yes 1 No 2

If Yes please give brief details here_____

21
Have you had any specific training <u>in treating</u> adult survivors of child sexual abuse?

Yes 1 No 2

If Yes please give brief details here_____

22
How comfortable do you feel <u>asking</u> patients/clients about sexual abuse experiences?

Please circle:
Not at all comfortable 1 2 3 4 Extremely comfortable

23
How comfortable do you feel <u>treating</u> survivors of sexual abuse?

Please circle:
Not at all comfortable 1 2 3 4 Extremely comfortable

24
How competent do you feel <u>asking</u> clients/patients about sexual abuse experiences?

Please circle:
Not at all competent 1 2 3 4 Extremely competent

25
How competent do you feel <u>treating</u> adult survivors of sexual abuse?

Please circle:
Not at all competent 1 2 3 4 Extremely competent

26

How much do you know about the effects that trauma work has on the therapist (i.e. vicarious traumatisation and secondary trauma)? Please circle.

Not at all 1 2 3 4 I know a lot

27

Although the initial assessment of clients/patients might differ from case to case, which of the following methods <u>in your opinion</u> should be used when therapists want to enquire about sexual abuse during an initial assessment? Although you might agree with more than one please tick the one you feel is best.

☐1 The therapist should directly ask the client/patient whether they had any experiences of sexual abuse as a child.

☐2 The therapist should give a questionnaire on this topic for the client/patient to complete on his/her own during the assessment.

☐3 The therapist should use a questionnaire on this topic and help the client to complete it.

☐4 Other/ Specify_____

28

In your opinion from the following what is <u>the most important</u> when enquiring about sexual abuse?

Please tick one or more of the following.

___The exact words the professional chooses in order to ask (1)

___The way the professional asks (i.e. tone of the voice, nonverbal communication) (2)

___The way the professional responds to such enquiry (3)

___All the above (4)

29
How do you feel overall about working with adult survivors of sexual abuse?
Please circle

a.I don't mind such work at all	1	2	3	4	I do mind such work a lot
b.I find such work very easy	1	2	3	4	I find such work very difficult
c.I feel such work is very stimulating	1	2	3	4	I feel such work is not at all stimulating
d.I enjoy such work very much	1	2	3	4	I don't enjoy such work at all
e.I don't find such work draining	1	2	3	4	I find such work very draining
f.If I had a choice I would often choose to work with survivors of sexual abuse	1	2	3	4	If I had a choice I would never choose to work with survivors of sexual abuse
g. I find such work very satisfying	1	2	3	4	I don't find such work satisfying at all

Attitudes on training

30
Which year did you complete your professional training? _____

31
How do you feel about your professional training in terms of equipping you with skills to work in the area of sexual abuse?
Please circle one of the statements that applies to you

--1--The topic was adequately addressed

--2--The topic was inadequately addressed

--3--The topic was not addressed at all

--4--Other/Specify_____

32

According to you what would you regard as sufficient in order for therapists to gain skills in assessing and treating adult survivors of sexual abuse?
Please tick one or more of the following

-----The topic of assessing and treating child sexual abuse to be included in therapists' professional training. (1)

-----It should be up to each professional to pursue such training through professional development, seminars, workshops, own reading etc (2)

----- Supervision (3)

-----All the above (4)

----Other/Specify (5)_____

33

In your opinion should professional training programmes offer specific training on the assessment and treatment of adult survivors of child sexual abuse?
Please circle your answer

They should offer training on the assessment of child sexual abuse

Yes	No	Not Sure
1	2	3

They should offer training on the treatment of child sexual abuse

Yes	No	Not Sure
1	2	3

34

Do you believe that personal therapy of the therapist could help him/her work more effectively with clients who have been sexually abused? *Please circle your answer.*

Yes	No	Sometimes
1	2	3

If you answered Yes or Sometimes please state how personal therapy could be helpful, here_____

35

Have you had any personal therapy? *Please circle your answer*

Yes	*No*
1	*2*

36

How often do you receive supervision in your current job?

Please circle one of the following

-1- Weekly

-2- Twice a month-3- Once a month

-4- Once every three months

-5- I don't get any supervision

-6- Other/Specify_____

37

Please write in the space below any other comments or thoughts you had during the completion of this questionnaire.

Thank you very much for taking time to complete this questionnaire

Now please continue with the rest of the questionnaires

Appendix D: Clients' Questionnaire (C-SQACRESA)

This questionnaire is voluntary and anonymous. It will not be seen by your therapist and will not affect your treatment in any way. However your opinion is very important to us in order to improve our service in any way and offer you care that will suit your needs.

1) Please circle your gender:

Male (1) Female (2)

2) Please state your age_____

3) Please state your ethnicity:_____

4) During an initial assessment with a psychologist how far do you think you either would or would not mind being asked each of the following questions?
Please **indicate by putting the number that represents your feelings next to the following:**

1=don't mind being asked, 2= I don't want to be asked, 3=I want to be asked, 4=No opinion

-------Being asked about my family

-------Being asked about my educational history

-------Being asked about my relationship with my parents

-------Being asked about use of illicit drugs

-------Being asked about intimate relationships

-------Being asked about possible suicidal attempts

-------Being asked about experiences of child sexual abuse

-------Being asked about experiences of physical abuse

5) In your opinion what is more important when psychologists ask about experiences of sexual abuse? **Please tick one or more of the following**

____The exact words the professional chooses in order to ask (1)

____The way the professional asks (i.e. tone of the voice, nonverbal communication) (2)

____The way the professional responds to such enquiry (3)

____Other/Specify here (4)_____

6) If a Psychologist wanted to ask you **during an initial meeting/assessment** about experiences of sexual abuse, which of the following ways do you feel would be best? **Please tick one of the following**.

----The psychologist should initiate such a topic and ask about experiences of sexual abuse rather than wait for the client to disclose it. (1)

----The psychologist should wait for the client to talk about it. (2)

----The psychologist should ask about possible experiences of sexual abuse but leave the details and address them later in therapy. (3)

----I am not sure (4)

7) When you come to therapy for the first time do you think it would be important for your therapeutic plan for the psychologist to know whether you had any experiences of sexual abuse as a child? **Please circle**.

Yes 1 | No 2 | I am not sure 3

8) Regardless of whether you have actually experienced sexual abuse as a child, if a psychologist were to ask you **during an initial meeting/assessment** about possible sexual abuse as a child, how would you prefer them to do it? **Please tick the one that in your opinion represents the best way**

----I would prefer the psychologist to ask me directly whether I had such experiences or not (1)

----I would prefer the psychologist to give me a questionnaire on this topic to complete on my own (2)

----I would prefer the psychologist to give me a questionnaire on this topic, which I will go through and complete together with the psychologist (3)

-----Another way? Please write here (4) _____

9) Have you ever been asked about experiences of sexual abuse by a psychologist? **Please circle**

Yes 1 No 2

If Yes, please continue and complete a) and b). If No, go straight to question no 10.
a) If Yes was it during **(Please tick)**

----your initial meeting/assessment (1) or

----later in therapy (2)

b) and do you feel it was done in an appropriate way? **Please circle**

Yes 1 No 2 Not sure 3

If no why? Please state here_____

_____

10) If a psychologist has never asked you about experiences of sexual abuse would you like to have been asked? **Please circle**

Yes 1 No 2 I wouldn't mind 3

11) Have you ever disclosed experiences of child sexual abuse to a therapist? **Please tick** one or more of the boxes.

Yes ☐1 No ☐2 I never had such experiences as a child ☐3

12) Please give here your own definition of child sexual abuse:

Thank you very much for your co-operation.
Now please put the completed questionnaire in the large envelop provided, seal it and put it in the box. If you want information on the results of the study please write your name and address on the paper which is in the small envelop, seal it and put it in the large envelope together with your questionnaire.

Appendix E: Vicarious Traumatisation Scale (TABS)

BELIEF SCALE

AutoScore™ Form

Laurie Anne Pearlman, Ph.D.

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Directions

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please circle the number next to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item. Use the following response scale.

1 = Disagree Strongly
2 = Disagree
3 = Disagree Somewhat
4 = Agree Somewhat
5 = Agree
6 = Agree Strongly

If you want to change your answer, cross it out with an X, and circle the number for your new answer.

PLEASE PRESS HARD WHEN MARKING YOUR RESPONSES.

Name: _____ Date: _____ Age: _____

ID #: _____ Education (highest grade level completed): _____ Gender: ☐ Male ☐ Female

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

1 = Disagree Strongly	2 = Disagree	3 = Disagree Somewhat	4 = Agree Somewhat	5 = Agree	6 = Agree Strongly

1. I believe I am safe.	1	2	3	4	5	6
2. You can't trust anyone.	1	2	3	4	5	6
3. I don't feel like I deserve much.	1	2	3	4	5	6
4. Even when I am with friends and family, I don't feel like I belong.	1	2	3	4	5	6
5. I can't be myself around people.	1	2	3	4	5	6
6. I never think anyone is safe from danger.	1	2	3	4	5	6
7. I can trust my own judgment.	1	2	3	4	5	6
8. People are wonderful.	1	2	3	4	5	6
9. When my feelings are hurt, I can make myself feel better.	1	2	3	4	5	6
10. I am uncomfortable when someone else is the leader.	1	2	3	4	5	6
11. I feel like people are hurting me all the time.	1	2	3	4	5	6
12. If I need them, people will come through for me.	1	2	3	4	5	6
13. I have bad feelings about myself.	1	2	3	4	5	6
14. Some of my happiest times are with other people.	1	2	3	4	5	6
15. I feel like I can't control myself.	1	2	3	4	5	6
16. I could do serious damage to someone.	1	2	3	4	5	6
17. When I am alone, I don't feel safe.	1	2	3	4	5	6
18. Most people ruin what they care about.	1	2	3	4	5	6
19. I don't trust my instincts.	1	2	3	4	5	6
20. I feel close to lots of people.	1	2	3	4	5	6
21. I feel good about myself most days.	1	2	3	4	5	6
22. My friends don't listen to my opinion.	1	2	3	4	5	6
23. I feel hollow inside when I am alone.	1	2	3	4	5	6
24. I can't stop worrying about others' safety.	1	2	3	4	5	6
25. I wish I didn't have feelings.	1	2	3	4	5	6
26. Trusting people is not smart.	1	2	3	4	5	6
27. I would never hurt myself.	1	2	3	4	5	6
28. I often think the worst of others.	1	2	3	4	5	6
29. I can control whether I harm others.	1	2	3	4	5	6
30. I'm not worth much.	1	2	3	4	5	6
31. I don't believe what people tell me.	1	2	3	4	5	6
32. The world is dangerous.	1	2	3	4	5	6
33. I am often in conflicts with other people.	1	2	3	4	5	6
34. I have a hard time making decisions.	1	2	3	4	5	6
35. I feel cut off from people.	1	2	3	4	5	6
36. I feel jealous of people who are always in control.	1	2	3	4	5	6
37. The important people in my life are in danger.	1	2	3	4	5	6
38. I can keep myself safe.	1	2	3	4	5	6
39. People are no good.	1	2	3	4	5	6
40. I keep busy to avoid my feelings.	1	2	3	4	5	6
41. People shouldn't trust their friends.	1	2	3	4	5	6
42. I deserve to have good things happen to me.	1	2	3	4	5	6

Continue on back

1 = Disagree Strongly	2 = Disagree	3 = Disagree Somewhat	4 = Agree Somewhat	5 = Agree	6 = Agree Strongly

43. I worry about what other people will do to me.	1	2	3	4	5	6
44. I like people.	1	2	3	4	5	6
45. I must be in control of myself.	1	2	3	4	5	6
46. I feel helpless around adults.	1	2	3	4	5	6
47. Even if I think about hurting myself, I won't do it.	1	2	3	4	5	6
48. I don't feel much love from anyone.	1	2	3	4	5	6
49. I have good judgment.	1	2	3	4	5	6
50. Strong people don't need to ask for help.	1	2	3	4	5	6
51. I am a good person.	1	2	3	4	5	6
52. People don't keep their promises.	1	2	3	4	5	6
53. I hate to be alone.	1	2	3	4	5	6
54. I feel threatened by others.	1	2	3	4	5	6
55. When I am with people, I feel alone.	1	2	3	4	5	6
56. I have problems with self-control.	1	2	3	4	5	6
57. The world is full of people with mental problems.	1	2	3	4	5	6
58. I can make good decisions.	1	2	3	4	5	6
59. I often feel people are trying to control me.	1	2	3	4	5	6
60. I am afraid of what I might do to myself.	1	2	3	4	5	6
61. People who trust others are stupid.	1	2	3	4	5	6
62. I am my own best friend.	1	2	3	4	5	6
63. When people I love aren't with me, I believe they are in danger.	1	2	3	4	5	6
64. Bad things happen to me because I am a bad person.	1	2	3	4	5	6
65. I feel safe when I am alone.	1	2	3	4	5	6
66. To feel okay, I need to be in charge.	1	2	3	4	5	6
67. I often doubt myself.	1	2	3	4	5	6
68. Most people are good at heart.	1	2	3	4	5	6
69. I feel bad about myself when I need help.	1	2	3	4	5	6
70. My friends are there when I need them.	1	2	3	4	5	6
71. I believe that someone is going to hurt me.	1	2	3	4	5	6
72. I do things that put other people in danger.	1	2	3	4	5	6
73. There is an evil force inside of me.	1	2	3	4	5	6
74. No one really knows me.	1	2	3	4	5	6
75. When I am alone, it's as if there's no one there, not even me.	1	2	3	4	5	6
76. I don't respect the people I know best.	1	2	3	4	5	6
77. I can usually figure out what's going on with people.	1	2	3	4	5	6
78. I can't do good work unless I am the leader.	1	2	3	4	5	6
79. I can't relax.	1	2	3	4	5	6
80. I have physically hurt people.	1	2	3	4	5	6
81. I am afraid I will harm myself.	1	2	3	4	5	6
82. I feel left out everywhere.	1	2	3	4	5	6
83. If people really knew me, they wouldn't like me.	1	2	3	4	5	6
84. I look forward to time I spend alone.	1	2	3	4	5	6

Appendix F: Secondary Trauma Scale (ProQol)

ProQOL - R III

PROFESSIONAL QUALITY OF LIFE

Compassion Satisfaction and Fatigue Subscales – Revision III

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Write in the number that honestly shows how often the statement has been true for you *in the last 30 days*.

0=Never	1=Rarely	2=A Few Times	3=Somewhat Often	4=Often	5=Very Often

_____1. I am happy.

_____2. I am preoccupied with more than one person I help.

_____3. I get satisfaction from being able to help people.

_____4. I feel connected to others.

_____5. I jump or am startled by unexpected sounds.

_____6. I have more energy after working with those I help.

_____7. I find it difficult to separate my private life from my life as a helper.

_____8. I am losing sleep over a person I help's traumatic experiences.

_____9. I think that I might have been "infected" by the traumatic stress of those I help.

_____10. I feel trapped by my work as a helper.

_____11. Because of my helping, I have feel "on edge" about various things.

_____12. I like my work as a helper.

_____13. I feel depressed as a result of my work as a helper.

_____14. I feel as though I am experiencing the trauma of someone I have helped.

_____15. I have beliefs that sustain me.

_____16. I am pleased with how I am able to keep up with helping techniques and protocols.

_____17. I am the person I always wanted to be.

_____18. My work makes me feel satisfied.

_____19. Because of my work as a helper, I feel exhausted.

_____20. I have happy thoughts and feelings about those I help and how I could help them.

_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.

_____22. I believe I can make a difference through my work.

_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

_____24. I plan to be a helper for a long time.

_____25. As a result of my helping, I have sudden, unwanted frightening thoughts.

_____26. I feel "bogged down" by the system.

_____27. I have thoughts that I am a "success" as a helper.

_____28. I can't remember important parts of my work with trauma victims.

_____29. I am an unduly sensitive person.

_____30. I am happy that I chose to do this work.

Appendix G: Participants' answers to open-ended questions

Answers from the qualitative items of Therapists' Questionnaire (P-SQAPRESA)

Q12: Definition of sexual abuse

1: Being asked or against ones will to engage in perpetuating sex at a young age (until 11 y. old)
2: someone who is older interferes sexually with a child (0-15)
3: when someone in power involves in sexual activities a person that is inappropriate due to their age, developmental stage or social circumstances.
4: violation of an individuals' rights, personal space and crossing boundaries in a sexual way.
5: any kind of sexual harassment, verbal, tactile etc including threats to a child not to disclose them anywhere
6: any kind of interference with a child which aims at the sexual gratification of the perpetrator
7: exposure to any form of sexual contact with an adult or older child
8: Any sexual relationship between a child and another adult
9: sexualised behaviour towards a child
10: unwanted sexual contact of any kind
11: inappropriate sexual contact between a child and an adult.
12: sexualised behaviour experienced at an inappropriate developmentally age
13: any inappropriate actions implying sex
14: any incident of sexual nature perpetuated on a child by a person in authority
15: sexual advances towards children under 16
16: any unwanted sexual contact with adult
17: any unwanted sexual experiences during child/teen years
18: experience of inappropriate physical contact to children by adults
19: inappropriate sexualised behaviour of an adult to a child
20: when a child is exposed to a form of sexual activity
21: any sexual contact between child and adult
22: anything that introduces a child to the sexual behaviour of adults
23: any inappropriate sexual behaviour from an adult to a child (5-16 ages)
24: sexual actions that happens to someone below 17 y.old without consent
25: sexual contact between an adult and a child where consent cannot be given
26: inappropriate behaviour of sexual nature between a child and older person
27: sexual activity carried out by an adult to a child
28: sexual contact between a child and an adult
29: transgression of appropriate child/adult boundaries
30: any sexual contact experienced by a child without their consent
31: when clients believe they have been given sexual attention which caused distress
32: inappropriate intimacy with a child for the purpose of adult pleasure
33: sexual acts perpetuated on a child
34: sexual activity initiated by an adult or older person on a child
35: sexual contact of an adult and a child/young person without consent
36: sexually inappropriate behaviour with a child
37: wanted or unwanted sexual acts to a person under 16 where consent cannot be given
38: forcing or persuading a child to perform sexual acts

39: an experience of a youngster or a child where a person in power inflicts sexual acts on them
40: sexual exploitation of a child by adult
41: forced to take part or observe sexual activity
42: any sexual act conducted upon a youngster who is not capable of consent
43: sexual behaviour towards a child or youngster with or without consent
44: no definition
45: being involved in sexual act at a developmental age that is inappropriate
46: sexual contact under the age of 16 with an adult
47: exposure to sexual material under the age of 16
48: being treated as a sexual object by an adult
49: children or adolescents involved in sexual activity with an adult
50: no definition
51: sexual contact with a child under 16 years old
52: inappropriate cross of sexual boundaries with a minor under 16 years old
53: any sexual act performed by an adult onto a child
54: Inappropriate sexual contact with an underage person by an older person
55: any sexualised behaviour between a child and an adult
56:any sexual contact between an adult and a child under 16 years old
57: sexual contact with a child and an adult
58: interference of a sexual nature against someone's will when the person has not consented to it
59: a person under 16 engaged in sexual acts
60: any attempt to involve a child under 18 into sexual acts
61: any inappropriate sexual behaviour towards a child
62: no definition
63: any sexual contact between a child and an adult
64: any effort of an adult to involve a child under 16 into sexual acts
65: sexual contact between a child under 16 and an older prson
66: any sexual act performed on a child
67: sexual contact between an adult and a youngster without consent
68: inappropriate sexual contact with a minor where consent cannot be taken
69: sexual behaviour between a child and an adult
70: any involvement of a child or teenager into sexual acts for gratification of an adult or a person in power

<u>Q14: if yes in Q.13. Reasons why professionals routinely ask about CSA</u>

1: clients may be frighten to disclose so you validate their experience by asking and give them permition to talk about it.
3: due to evidence that sexual abuse can have number effects on mental well being
4: to dispel secrets in family
5: to provide better treatment and specific to survivors of CSA
6: because CSA defines how the child or later the adult views the world or self
14: it sends the message that is not something to be kept a secret and so gives opportunity for disclosure
16: important for formulation

19: it is so common so why not ask. I should not be a taboo
20: because it is catalyst in a client's psychological state and it is also so common
22: it is a common practice when clients enter psychiatric services
24: in order to obtain complete history
26: is a predisposing factor to mental health problems
29: clients feel ashamed and therapists must show they can hear it
38: clients need to feel they have permition to disclose such experiences and therapists have to give this opportunity
40: very important factor in psychopathology
47: to make sure that this issue can be discussed and to give the message that therapist can hear such information and is used to this topic
52: clients tend to keep it a secret so it helps if therapists asks them
56: if it is not mentioned in the assessment a therapist misses a big part of an individual's history especially because CSA has a profound effect on the person
60: to help formulation, spell the taboo and help a client's disclosure
61: you communicate the message that they can discuss that with the therapist and so it makes the disclosure easier
65: important for formulation
66: gives the opportunity to client to open up

<u>Q15: if no in Q13. Reasons why professionals do not ask about CSA</u>

8: patients can introduce this in therapy when they want
9: people have their own issues to discuss initially and asking about it may lead client to think that this is the most important issue
10: it might feel abusive to the client. It should be the client's choice to disclose otherwise it could be traumatic to them
15: clients should not feel obliged to disclose such a thing and also they should feel comfortable with the therapist first
18: not all children are traumatised by CSA
32: assessment is not about exploring such issues it is more about suitability to therapy
39: assessment is not the right time to ask such a thing because clients might not have the necessary support after disclosure
43: the client might feel pressurised and terminate therapy if asked such a thing
44: it implies causation and also implies that CSA is damaging
50: there needs to be evidence in order to ask
53: if therapist asks might be overly intrusive for clients
62: it might be too intrusive for the client
63: can put clients at risk

<u>Q16: if professionals ask "sometimes" about CSA when do they decide to ask and when not to ask</u>

1: ask when client brings it up
do not ask if client is guarded and so not ready to disclose more
2: ask when it is an issue clients want to discuss or is in the referral letter

do not ask when is not relevant with client's problem
4: ask when is raised by client
do not ask if client is unwell/psychotic or if very defensive
7: ask only if assessing sex offenders or someone who committed a relevant crime
do not ask not to interfere or trigger defence on other background information.
9: ask only if clients say something relevant
do not ask otherwise
10: ask only if it is written in the referral letter
11: ask when there is a hint from the client
do not ask during early stages or when client is uncomfortable with any self-disclosure
12: ask when presenting problems are complex
do not ask when the treatment goal is on the here and now
13: ask if they offer the info themselves
do not ask when client is in distress during assessment
16: ask when client mentions something relevant
do not ask when there is nothing to suggest that CSA occurred
21: ask only if it is suggested by client
22: ask only if I suspect
do not ask if client is in a bad state or not comfortable
25: ask when client presents with symptoms
do not ask when presenting problem is irrelevant
27: ask if clients mention this
do not ask otherwise
28: ask if client mentions it
do not ask if it is too early because it can damage relationship
30: ask if the referral indicates it or client mentions something
do not ask if there is no suspicion due to clients presenting problem
31: ask when client indicates some trauma in childhood
do not ask if there is no indication of trauma
33: ask if it is in the referral letter
do not ask if clients find the assessment procedure difficult
34: ask if client's history indicates a possible CSA
do not ask if there is no indication
35: ask if there is a hint from the client
do not ask if client states that do not want to talk about childhood
36: ask if relevant to presenting problem, like sexual dysfunction
do not ask if it is irrelevant to the presenting problem like panic attacks
42: ask if client mentions it or gives a hint
do not ask if client is not comfortable in disclosing events
45: ask when there is some reason to think CSA happened
do not ask when client is acutely unwell or if there is no further support available
46: ask when the referral explicitly mentions a history of CSA
do not ask if the clinical problem is not relevant
48: ask only if a relationship has been established
do not ask if the question interferes with engagement
49: ask if it is mentioned by referrer
do not ask if engagement is already difficult during assessment
51: ask if client is able to cope with such a question without elevation of risk
do not ask if that would create more distress to client

54: ask when it is mentioned in case notes
do not ask if it is initial meeting since client might feel pushed to it.
55: ask if there are indication either on the referral or background history
do not ask if in my clinical judgement it will not be helpful to the client or if I feel it will damage the therapeutic relationship
57: ask if there is a hint from the client
do not ask if client psychotic or is likely to relapse
58: ask if it relevant to the presenting problem
do not ask if the presenting problem refers to the here and now
59: ask as part of a routine assessment
do not ask if there isn't strong therapeutic relationship
64: ask if there is some indication from client
do not ask if client is in distress
69: ask when there are indications from presenting problem
do not ask if client is psychotic
70: ask if it is mentioned in referral or background history
do not ask if client finds the assessment process difficult

<u>Q34: Does personal therapy help in CSA work? (Reasons when participants answered "yes" or "sometimes")</u>

2: only if this work has triggered difficult emotions to the therapist that affect their work.
3: to prevent overidentification with the victim and process feelings around abuse
4: by understanding your own sense of personal rights/space
8: CSA clients might trigger feelings and thoughts to therapists that need exploration
10: it allows a deeper insight into processes
11: if therapist is abused and also generally it is helpful to be in client's position and feel how it feels to be a client asked to discuss personal matters
12: dealing with vicarious trauma or countertransference
13: depends on therapists own history
14: prevents vicarious trauma and helps therapists who have been abused as well.
15:therapists should discuss the personal impact of such work because it can be distressing and colours our view of the world
16: therapy can help in many ways both for work and personal life of therapist
17: if the therapist has difficulties in this area of work
18: this is a very difficult area to work and therapists need to explore own issues, their limitations and it is dangerous to abuse the client again emotionally
19: recognise own blind spots and limitations
21: if therapist has gone through similar experiences
22: greater understanding of erotic feelings or sexual feelings that such a disclosure triggers to therapists
26: to work through emotional response of therapist.
27: understanding own attitudes towards sexuality
29: explore therapists' experience of abuse
30: to be in the position of a client always helps, also if therapist's personal trauma
32: therapy always useful to explore our own issues that clients trigger
33: therapy helps therapists work better with all clients

34: therapy helps generally but specifically when therapist has been abused as well
35: therapy helps all therapists and makes them more sensitive to client's needs
36: therapist becomes more aware of own issues surrounding this
38: therapists become more aware of their own issues and limitations around this issue and also prevents a possible negative impact of such work on them
40: helps to explore personal issues that might be relevant and also understand the client better
41: can help the therapists to deal with difficult emotions that this work can trigger
42: helps therapist to process own issues especially if abused and also process difficult emotions that such work brings
44: helps explore attitudes around sexual abuse
45: to work through feelings that such work evokes and understand own reactions
46: helpful if therapist has been abused and needs to work on their issues
47: it helps if therapists are abused themselves and also to address areas around sexual abuse that therapists might not feel comfortable with
49: the content of such work might be difficult for the therapist to cope with
51: increase reflective capacity and insight into countertransference
52: it helps if therapist had experienced CSA and also helps to process thoughts and feelings that such work can trigger in a therapist
53: knowing oneself is always helpful
54: understanding countertransference is very important
55: if therapist is a survivor and also to understand countertransference
56: therapists can process difficult emotions that otherwise could get in the way of the therapeutic process
57: helps to identify therapist's vulnerabilities and feelings around this type of work
58: therapy helps when therapist has been abused as well and also it shows to the therapist how it is for a client when someone asks them such personal questions
59: therapy helps to understand therapist's sexualised feelings when working with CSA clients
60: it helps therapists who have been abused themselves and also it helps to process emotions and thoughts that can be triggered during such work
61: the material that CSA clients bring might be traumatic to the therapist and so they need to be processed in personal therapy
62: it helps to explore blind spots and therapist's own childhood experiences
64: it helps process difficult thoughts and feelings
65: therapy is always helpful
66: CSA work can trigger chords to therapists that need processing
67: identification of limitations and countertransference
68: when therapists have been sexually abused

<u>Q37: general comments</u>

4: interesting, reinforces my passion for this work
8: working in NHS makes it mandatory to know about CSA work because the percentage of CSA clients is high
9: we need to know that clients might not want to address the issue and therapists must be flexible
11: useful questions to think about

15: although is important to know that there is a possibility of CSA we should be careful not to lead clients into disclosing such a thing
17: there are implications for training, CPD etc
18: assessment can have different meaning for each therapist.
34: we need to have in mind that sexual abuse does not necessarily have bad consequences and does not always lead to PTSD
39: these issues might be relevant more to specialist services that offer CSA treatment
44: need to be aware that not always clients want to process this issue and it is not always damaging
45: the questionnaire made me more aware of the importance of asking clients about CSA and the need to attend workshops on this
46: why focus on sexual abuse and not all abuse and why is important to ask during assessment since that could drive clients away
47: skills on assessing and treating sexual abuse are important and should be integral part of training and work
51: more support from NHS is needed for therapists when working in this area

Appendix H: Ethical approval

Institute of Psychiatry

at The Maudsley

Ethical Committee
(Research)
Research Ethics Co-ordinator
Margaret M Chambers Msc

P006, Room W109
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel 020 7848 0797
Fax 020 7848 0147
Email m.chambers@iop.kcl.ac.uk

KING'S College LONDON

University of London

ETHICAL COMMITTEE (RESEARCH)

21 April 2004

Dr M Slade
P029
Health Services Research
Institute of Psychiatry

Dear Dr Slade

Re: Towards curing the unthinkable (023/04)

At its meeting on 16 April 2004, the Ethical Committee (Research) considered and confirmed Chair's action to approve Study No 023/04 from an ethical point of view.

Yours sincerely

Margaret M Chambers
Research Ethics Co-ordinator

023/04

ETHICAL COMMITTEE (RESEARCH)

Verification of Departmental Screening of Student Applications

I verify that the enclosed application, submitted for ethical approval by Matinoc Sotrilli (DCouns Psych), as part of the DClinPsych / ~~MPhil~~ / ~~PhD~~ / ~~MSc~~ / ~~Diploma~~ * requirements in the Counselling Psychology Department, has been screened within the department and meets the standard required by the department.

Signed _____
(Course Leader)
EXTERNAL SUPERVISOR

Name DR NICHOLAS TEOP
(Please Print)

Date 5TH FEBRUARY 2004

* Please delete as appropriate

023/04

ETHICAL COMMITTEE (RESEARCH)

Verification of Departmental Screening of Student Applications

I verify that the enclosed application, submitted for ethical approval by Natuna Sotrilli, as part of the DClinPsych / ~~MPhil~~ / ~~PhD~~ / ~~MSc~~ / ~~Diploma~~ * DCouns Psych.

requirements in the Counselling Psychology Department, has been screened within the department and meets the standard required by the department.

Signed _____ (Course Leader) SUPERVISOR

Name DR JACQUI FARRANTS
(Please Print)

Date 5/2/04

* Please delete as appropriate

Appendix I: Approval of the study from local authorities

CROYDON COUNCIL
Social Services

South London and Maudsley NHS
NHS Trust

Croydon Directorate
Carolyn House
Suite A, 6th floor
22-26 Dingwall Road
Croydon
CR0 9XF

Tel: 020 8700 8758/9
Fax: 020 8700 8753

11 December 2003

Matina Sotrilli
Counselling Psychologist
Westways Resource Centre
49 St James' Street
West Croydon
CR0 2UR

Dear Matina

Proposed Research Project "Towards curing the unthinkable"

This is to confirm my agreement for you to undertake the above research project within Croydon Adult Mental Health Services.

Yours sincerely

Steve Hill
Acting Borough Director, Croydon

Appendix J: Raw data

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