Exploring therapists' understandings of childhood sexual abuse and the impact of this on their practice with adult 'survivors': A discursively informed thematic analysis.

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CONTENTS

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ABSTRACT

Childhood sexual abuse is often seen to have long-lasting effects. Consequences of the experience identified in the clinical literature include depression, interpersonal difficulties, anxiety and self-harming among others. How professionals understand the concept of childhood sexual abuse will potentially affect how they work with adults who have had this experience. This study aims to explore the issue of how therapists construct childhood sexual abuse and how their understandings impact on their practice in working with adults who have experienced it. The research was undertaken from a social constructionist perspective wherein the phenomenon of child sexual abuse is conceptualised as being understood by way of a set of interconnecting narratives. These include ways of talking about power, gender and what it is to be a victim. Semi-structured interviews were carried out with eight therapists who worked in specialist services for adults who have experienced childhood sexual abuse. The data were analysed using a discursively informed thematic analysis to explore therapists' engagement with child sexual abuse. The participants' talk only partially supported the harm narrative associated with the phenomenon of childhood sexual abuse, but refuted the often expressed view that the harm is irreparable. A level of ambivalence was expressed around the notions of power and the perceived effects of child sexual abuse. In addition how clients were positioned was seen to open up some avenues of conversation in the therapeutic encounter and to close others down. Clinical implications highlighted in the study were making explicit the power dynamic in the therapeutic relationship, the importance of avoiding assumptions, the need to work with ambivalence and complexity and being open to the client's reality. Finally the impact of organisational context on the work of therapy was considered.

CHAPTER ONE – INTRODUCTION

This study aims to explore childhood sexual abuse (CSA) and understandings of adults who have experienced it, from the therapist's perspective. Much research has been carried out with adult 'survivors' of CSA (e.g. McGregor et al, 2006; Liem et al, 1997; Callahan et al, 2003; Woodward and Joseph, 2003). Research has also been carried out on therapists' experience of working with this client group. As examples, consideration has been given to vicarious trauma (e.g. Way et al, 2007; Way & VanDeusen, 2006), therapeutic boundary issues (e.g. Harper & Steadman, 2003), psychologists' beliefs about the veracity of CSA memories (Gore-Felton et al, 2000) and therapists' treatment decisions (e.g. Higgins Kessler & Nelson Goff, 2006). None of this research, however, was based specifically on the clinicians' understandings of CSA. And none of this research was undertaken from a social constructionist position as was done here. There have, however, been studies undertaken which do appear to consider social contexts, e.g. research in the areas of challenging victim and survivor paradigms (Hunter, 2010) and challenging gender stereotypes (Simpson & Fothergill, 2004). These studies, though, were not specifically about therapists' understandings of CSA as a concept.

The current study considers how therapists understand child sexual abuse which, from a social constructionist position, must emerge from the discursive social context within which they practise. The therapists interviewed all worked in specialist services for those who had experienced sexual violation and all had a case-load that included adults who had been sexually abused as children. Within this setting 'survivors' of CSA are generally seen to have experienced what was done to them similarly: CSA is seen as always harmful with that harm being long-lasting and also the most important thing for which a person might need therapy. Thus if a client wanted to talk about something that did not fit with this position, they might

be seen as avoiding the reality of what had happened to them and what they really needed to work on. Clearly if therapists understand CSA as uniform in this way, then certain avenues of conversation might be closed down as not fitting the organisational context. Thus a client would be 'allowed' to talk about the awfulness of the abuse and the harm she suffered but less likely to be 'allowed' to say that actually it really had not been that bad and she would prefer to talk about a work issue.

Therapists understandings of agency and responsibility also have an effect on what can be spoken about in therapy. Generally the participants in this study saw the abuser as completely to blame and the person who experienced the CSA as never to blame. This tends to position the person who was abused as totally powerless in that situation. Allowing the client to construct herself as having had some agency would also allow her to have had some power in the situation, which may well be a more preferable position for her than no power at all. Taking the position that the client has no responsibility for the abuse may well stop her from exploring what possibilities she did have and how she chose to behave. It also leaves her as a passive, powerless individual (Maracek,1999) hence the focus in many therapies on empowering the client.

How the participants positioned their clients in terms of gender also had an impact on what could and could not be spoken about in therapy. Generally women were positioned as passive and powerless which was something that confirmed their status as women. Men were also positioned as powerless which challenged the hegemonic view of masculinity and allowed those therapists who worked with men to position CSA for them as much worse than for women. The understandings around gender can be seen to link back with issues of responsibility and agency and what avenues of conversation that can open up or close down.

The focus on empowering men can be even stronger than for women as, in society, men are supposed to be powerful and often women are not.

Clients may have ambivalence about what was done to them and whether it was actually CSA. Therapists may often have certainty that what their clients experienced was indeed CSA but have ambivalence around actually saying that. This links to the notion of the therapist's knowledge and power and her often perceived position as 'expert': the client does not know but the therapist does, and so could 'make' the client know, which could be seen as a use or even an abuse of power. Therapist ambivalence, however, was mostly seen around issues of harm: whether the harm from CSA is inevitable and long-lasting and around clients' power: that they actually did have resources and strengths and thus positioning them as powerless was not always appropriate. Participants also spoke about common themes they saw in their clients but also positioned their clients as having unique responses to the CSA they experienced, which suggests that CSA should not be presented as uniform. Doing so may mean that the therapist's agenda is followed rather than the client's due to the way in which those who have been sexually abused 'should' be treated.

Much of what was seen during the interviews in this study and has been introduced above comes mainly from a psychological perspective on CSA and therapy. Such a perspective tends to treat therapy as an individual process without focusing on the socio-political context. McLellan (1999) suggests that traditional psychotherapies let women down because they tend not to take into account the socio-cultural context of oppression and injustice. Thus any attempts to empower women are often doomed to failure because it is difficult to be powerful in a culture that is oppressive. Gavey (1999) suggests that the positivism of a lot of psychological approaches does not allow for nuanced and possibly contradictory meanings. It

raises the question of whether or not it matters that what someone experienced was definitely CSA. If they are ambivalent about it, then perhaps therapists have to work with that and not focus on giving a definitive answer.

In much feminist literature (e.g. Gavey, 1999; Maracek, 1999; McLellan, 1999; Lamb,1999a) the notion of the importance of language is emphasised. For example, by conceptualising all incidents of sexual assault as victimising, there is the danger of creating victims where they might not have been created before. A lot of therapy imitates the medical model and pursues healing (Maracek, 1999). The assumption is that clients are ill and often the consequences of CSA are seen as mental illness (e.g. Sanderson, 1995). However, if one avoids the positivist approaches and use of language associated with diagnoses and certainty then one can allow clients to tell a story of their experiences and how they understand them. The work of therapy then might be to help clients to tell a different story and understand their experiences in a different way. This tends to be the way in which post-modern therapies work. They take into account the client's whole experience, including social context, and do not make assumptions about what and how she might feel about it.

This study used a social constructionist approach to engaging with the phenomenon of CSA and how therapists understand and work with it. It was also informed by feminist therapeutic literature and some of the post-modern approaches to therapy. It does not seek to offer ways of 'doing therapy' with those who have been sexually abused but does seek to raise questions about how therapists understand CSA and how those understandings inform their practice. On the basis of a discursively informed thematic analysis of the data, some recommendations for practice are offered for consideration. These are, of necessity, only suggestions for to be prescriptive would be against the theoretical position of this study.

CHAPTER TWO – LITERATURE REVIEW

2.1 INTRODUCTION

This literature review will be divided into two key areas as follows:

- Understandings of CSA
    - Defining CSA
    - Effects of CSA
    - The media portrayal
    - Feminist constructions
    - Gender
    - Paradigms within CSA
- Working therapeutically with adults who have experienced CSA
    - Approaches to therapy
    - Issues for therapists

This division is made so that contexts from which CSA might be construed can be made clear (Phillips & Hardy, 2002).

2.2UNDERSTANDINGS OF CHILDHOOD SEXUAL ABUSE (CSA)

2.2.1 Defining CSA

Defining Child Sexual Abuse (CSA) has been problematic for researchers and practitioners (Draucker, 1992; Sanderson, 1995), as what constitutes 'sexual' has been debated, as has what constitutes 'abuse'. Indeed, Haugaard (2000) highlights that there is no agreement on how to operationalise each word in the phrase 'child sexual abuse'.

Stainton Rogers & Stainton Rogers (1992) challenge the idea that childhood is something that can be objectively known and defined. They suggest instead that concepts such as childhood

are construed through the narratives that exist in society. For example, the childhood of a child living in sub-Saharan Africa is sure to be different from that of a child living in the UK. Equally at different times within the same country childhood will have looked very different. Whilst this may be the case, the United Nations have tried to globalise the concept of childhood and formulate this definition which is documented on the UNICEF website:

> Childhood is the time for children to be in school and at play, to grow strong and confident with the love and encouragement of their family and an extended community of caring adults. It is a precious time in which children should live free from fear, safe from violence and protected from abuse and exploitation. As such childhood means much more than just the space between birth and the attainment of adulthood. It refers to the state and condition of a child's life, to the quality of those years. (2005)

The UN Convention on the Rights of the Child, which built on this view of childhood and enshrined children's rights in law, has been adopted within law by most countries in the world and therefore is likely to have a major influence on people's thinking about childhood.

Hauguaard (2000) argues that some behaviours might be considered sexual by almost everyone, e.g. intercourse or genital fondling. However other behaviours may not be construed as sexual by some people but would be by others, e.g. bathing children or being nude in front of them. Equally there is some controversy about the term abuse (Haugaard, 2000). Sometimes it has been used to imply the existence of harm, but that may then imply that an incestuous relationship in which a child is not harmed is not abuse, which is exactly how many people would view it. With these points in mind the chapter will now go on to consider some of the ways in which abuse has been defined both by Government and in the literature.

The Department of Health(DH) (2006) in its guidance on safeguarding children gives the following definition: "Child sexual abuse is forcing or enticing a child or young person to take part in sexual activities not necessarily involving a high level of violence whether or not the child is aware of what is happening, they do not truly comprehend, and to which they are unable to give informed consent and that violate the sexual taboos of family roles"(p.38). The guidance goes on to say that "sexual" relates to genitalia, breasts (female) and inappropriate contact with other parts of the body such as rubbing or kissing. 'Abuse' does not need to be contact but may include being made to watch pornography or to behave in inappropriate sexual ways. This makes clear that children/young people are being made or enticed to do something it is assumed they do not fully understand.

Sanderson (1995) gives this definition: "Child sexual abuse is…the involvement of dependent children and adolescents in sexual activities with an adult, or any person bigger, in which the child is used as a sexual object for the gratification of the older person's needs or desires, and to which the child is unable to give consent due to the unequal power in the relationship." (p.15). Here Sanderson (1995) explicitly talks about the power differential between the abuser and the abused, which is not mentioned in the DH guidance. Macdonald et al (1995) also emphasise power misuse as being a key part of the sexual abuse dynamic and suggest that the power difference is often due to an age difference. Both Sanderson (1995) and Macdonald et al (1995), as with the DH (2006), frame the abuse as not necessarily only involving touching but also including being made to watch sexual activity and being made to listen to sexual activity or sexual suggestions. It seems that the government guidance, by avoiding the power aspect of abuse, is deliberately apolitical. Other authors (e.g. Sanderson, 1995; Herman, 2001; Macdonald et al, 1995) writing about CSA are more political, as can be seen by their focus on inequalities and power positions. Herman (2001)

equates the trauma of child abuse with the trauma of political terror and war. Haugaard (2000) recognises the different needs which exist between research and therapy. He suggests that perhaps a narrow definition of the concept of CSA could be used for research purposes, whilst therapists might want to use a broader definition. Mannon & Leitschuh (2002) suggest that whilst there is no agreement, therapists might choose to treat the symptoms and worry less about the definition.

It can be seen from the above that CSA is generally construed as negative, with power inequalities and parallels with political terror and war. Furthermore, adult-child sex is almost always considered to be abusive. However beyond more 'paedophilic' views of sex, others also exist. For example, Card (2002) asks the question "What is wrong with adult-child sex?" and clearly makes the point that there is a difference between sex with a child that is abusive, that humiliates, physically damages and deceives and that which is not 'abusive' and in which the child may wish to engage. Card (2002) also differentiates between adult sexual activities and childlike ones, suggesting that for an adult and a child to engage in childlike sexual activities might be seen as acceptable. The fact that Card (2002) does not automatically assume that adult-child sex is wrong is different from much of the literature on CSA and offers a different position that one could take.

2.2.2 Effects of CSA

According to CSA-related psychological and counselling literature, the effects of CSA on an adult 'survivor' may be several and long lasting. Sanderson (1995) breaks these long-term effects into six key areas: emotional effects (e.g. depression and low self-esteem), cognitive/perceptual effects (e.g. cognitive distortions and dissociation), interpersonal effects (e.g. isolation and fear of intimacy), physical effects (e.g. psychosomatic pains and sleep

disturbances), behavioural effects (e.g. self-harm and substance abuse) and sexual effects (e.g. impaired motivation and promiscuity). Herman (2001) suggests that the adult 'survivor' is left with fundamental problems in basic trust, autonomy and initiative. Macdonald et al (1995) describe the long-term effects of abuse as including poor self-esteem, depression, guilt, anxiety, phobias, self-destructive behaviours, difficulties in sexual relationships, alcohol and drug abuse, difficulties with trust and intimacy, a sense of powerlessness and a vulnerability to revictimisation.

Other research also argues that CSA has major negative effects on those who experience it. Alexander et al (1989) suggest that depression, fearfulness, social isolation, difficulties trusting both men and women and an increased risk of victimisation are likely in those who experienced CSA. Price et al (2004) include anxiety, depression, sexual dysfunction, somatic concerns, interpersonal difficulties, parenting difficulties and substance abuse among the potential long-term consequences of CSA. Callahan et al (2003) not only recognise the symptoms outlined above as being issues for those who have experienced CSA but also highlight that interpersonal difficulties are particularly problematic for them. This research seems to reinforce the view that CSA is negative and has negative effects on those who experience it.

Draucker (1992), however, puts forward some mediating factors related to the effects of CSA, suggesting that facts such as the age of the victim, the level of force used, the relationship of the perpetrator to the victim can all affect the level of trauma and hence the long-term impact of the abuse. Whilst there is still the assumption that CSA causes trauma, which could be open to debate, Draucker's (1992) suggestions seem to be a move towards there not being just one understanding of the effects of CSA. Other literature supports this

view. For example Mannon & Leitschuh (2002) offer the idea that the effects of CSA are also influenced by how well the child was functioning in emotional and social terms before it happened. Feinauer et al (2003) also identify that there are personal characteristics or resources that can allow children to cope with their abuse with less distress than others, without these resources, may experience.

Quantitative methods, which are generally designed to test hypotheses, have been used to look at the effects of CSA. These methods tend to use natural science practices and are positivist in approach. The implicit belief is that there is a reality 'out there' that can be measured and explained (Bryman, 2008). Quantitative research studies in the area of CSA have used measurement to try to explain phenomena such as the psychological functioning of those who have had this experience or why therapy leads to improvement and the decrease of symptoms (e.g. Brand & Alexander, 2003; Callahan et al, 2003; Price et al, 2004; Luterek et al, 2005; Haase et al, 2008; McAlpine & Shanks, 2010). If, for example, the psychological functioning of people who have experienced CSA can be explained, that knowledge might be seen as informing therapeutic treatment (Luterek et al, 2005). However, these explanations would be relevant only if we could assume that all survivors responded in the same way to being abused or to therapy. Statistically significant findings tend to be generalised, for example women who have experienced CSA show more defensive avoidance symptomatology (Luterek et al, 2006), and this is usual with findings from quantitative research (Muijs, 2004). This type of generalisation, however, could lead therapists to expect all their female clients who have experienced CSA to present in a similar way. Any particular client, though, might not do so. So to deliver appropriate treatment the therapist would need to manage their expectations effectively. It could also be that CSA clients presenting without expected symptoms might have their experience doubted. Thus quantitative methods tend to

reinforce the uniform view of CSA and do not allow for the complexity of the human condition and the ways in which each individual who was sexually abused as a child might have responded to that experience (Hunter, 2008).

In much of the clinical literature, then, CSA is medicalised by looking at the associated symptoms and problems which tend to pathologise the individual who has experienced it. Feinauer at al (2003) seem to be moving away from this position. Going one step further, Joseph and Linley (2006) suggest that the pathologising of individuals is not conducive to their well-being. They suggest that being hugely distressed after having experienced CSA is a 'normal' rather than a 'pathological' response. So whilst the effects of CSA can still be seen as negative, their proposal is that the way in which the effects and the person are dealt with should not be medicalised. The focus here tends to be on people's strengths and resources rather than their deficits, which seems to be the focus of the medical model approach. Of course, there are people who experience CSA who do not go to therapy (Hunter, 2010) and who do not enter the mental health system. One can imagine, but not know, that the effects of the CSA on them were minimal, which offers another perspective than the often held assumption of harm. In the media, however, the effects are almost always seen as negative and the media will be considered next.

2.2.3 Media portrayal of CSA

In newspapers the individual who has experienced CSA is often portrayed as damaged almost beyond repair and there tends to be an assumption of trauma. One article (*The Guardian*, 2009, p.31) reported, "When this [sexual abuse] is compounded by another parent who allows the perpetrator to get away with the abuse, the damage to the child's self-esteem is incalculable. The trauma to which they were subjected leads them to suffer from depression,

difficulties in forming intimate relationships… and many other wounds, from which it is a lifetime's work to recover." This suggests that recovering from sexual abuse takes an extremely long time. Headlines in the tabloid newspapers seem to focus on the horror of sexual abuse for example: "House of horrors mother jailed for torturing six children with years of incest and sex abuse" from the *Daily Mail* and "Paedophiles get life for 'dreadful' sexual abuse" from the *Daily Express.* These media messages, as part of the cultural and discursive context within which therapists practise, may contribute to their constructions of CSA and those who have experienced it.

The media might also be seen as playing a major part in the moral panic that surrounds the concept of sexual abuse and the associated role of the 'paedophile'. A moral panic may be identified as the [over]-reaction to a role or concept within society. It was originally coined with regard to the fights between mods and rockers in the 1960s (McRobbie & Thornton, 1995). In the summer of 2000 the *News of the World* began a campaign to "name and shame" convicted paedophiles following the alleged sexual assault and the murder of eight year old Sarah Payne (Critcher, 2002). In this way a moral panic about paedophiles began. Critcher (2002) highlights that other newspapers picked up on and supported the campaign and that in *The Sun* "the dichotomy of innocent victim and evil killer was reproduced on every page, verbally and visually" (p.525). The media coverage influenced the government to consider legislation change regarding paedophiles and also was arguably the cause of vigilante action in the Paulsgrove area of Portsmouth. People in the area, including children, marched to the home of Victor Burnett, a known paedophile named by the *News of the World* (Critcher, 2002). Public outrage was expressed at the paedophile 'folk devil' who, interestingly, was generally seen as a stranger. This is interesting because according to the NSPCC (Radford et al, 2011), more than 80% of sexual abuse against children is carried out by someone they

know. The tabloid newspapers did not mention this and although some of the broadsheet newspapers did, it was in passing rather than as a key point (Critcher, 2002).

More recently, the exposure of the DJ and entertainer Jimmy Savile as a paedophile has aroused public feelings of outrage again. Tiffany Jenkins writing in *The Scotsman* (10th January 2013) suggests that the potential existed for further moral panic and that a more measured approach is required. Many of the newspapers though, reported with language that was very emotive. They used the following expressions: "preying on the vulnerable and weak"; "subjecting hundreds of innocent victims to a vile catalogue of abuse"; "his depraved secret life"; and "during his perverted reign" (*Daily Mirror* online, 2013) among others. This use of language creates a monster, and Savile was described by fellow DJ Tony Blackburn as having committed "monstrous acts" (*BBC News online*, 2012). Monsters are creatures to fear and the moral panic around paedophilia helps to create that fear of them and their actions.

Most people are exposed to the media in one way or another and thus see or hear such language about paedophilia and CSA, which can influence each person's construction of the concepts. Most people, including therapists, are likely to be more thoroughly influenced by the hegemonic discourses, in this case surrounding CSA, as it is to these that they are most frequently exposed.

2.2.4 Feminist constructions of CSA

Until the early 1970s CSA was understood as "the rare result of seductive children, distant wives or deviant fathers" (Whittier, 2009, p.21). Feminists began speaking out against CSA as a political issue and one of many affecting women. The anti-rape movement had been offering the notion that rape was not about men's sexual perversion but about patriarchal

male power over women. This analysis was extended to the rape of children and as such focused mainly on girls. Some feminists at the time (e.g. Rush, 1974) argued that incest could be constructed by men as preparing a girl to be able to fulfil later expectations of her by her boyfriend/husband. In this analysis, children were positioned, like women, as powerless and unable to resist male strength. The feminist movement at this time saw the personal as political (Whittier, 2009) and saw CSA as a social problem that needed to be changed politically and socially. Just as women had few legal and social rights at this time, neither did children and the focus of activism was on changing the social system to deliver those rights, e.g. strengthening the position of women such that they did not have to be economically dependent on their husbands.

Whittier (2009) writes about the 'therapeutic turn' in feminism which heralded a move away from political activism to individual efforts to improve one's own situation. There was also more of a demand on the state to intervene: to protect children, to improve the criminal justice system and medical treatment. This allowed for the institutions of the day to regulate much of the thinking and activity around CSA. From a Foucauldian perspective this might be considered a major shift in feminist thinking in that the power and regulatory mechanisms of the state, which is inevitably patriarchal, were called upon for aid. There were dissenters who saw that the need for political activism was as great as ever (Whittier, 2009) but the mainstream feminist voice in relation to CSA seemed to have become apolitical. The focus was more on the self-help for dealing with CSA issues rather than "promoting a feminist or other larger political analysis" (Whittier, 2009, p.8).

More recently, literature on CSA has presented as 'fact' that this experience does long-term psychological damage. In addition to this, the damage is seen as pathological and women,

children and men who are affected by CSA may be considered as always being a product of their past abusive experience (O'Dell, 2003). Many of today's feminist writers take a social constructionist approach to CSA and their constructions of it generally challenge the received wisdom about the phenomenon. In her chapter in *New feminist stories of child sexual abuse: sexual scripts and dangerous dialogues*, O'Dell (2003) challenges the 'harm narrative' not because she thinks that CSA is never harmful, but because it cannot necessarily be assumed to be harmful for everyone who experiences it. Levett (2003) suggests that there are large numbers of women who have experienced CSA who are no more anxious, depressed or otherwise psychologically disturbed than women who have not. However, construing CSA as producing pathological effects justifies medical and psychological interventions and the medicalisation of the whole field and maintains the patriarchal position: men treat women who are weak and victimised. Furthermore, it is important for CSA to be seen as harmful for the legal system to function: in order for compensation to be paid, long-term suffering is required (O'Dell, 2003). Thus one might see that someone who has been sexually abused as a child is encouraged to demonstrate that they have been harmed. If the someone is a woman, then that fits with the hegemonic view of women as being weak and passive and maintains the existing power relations and social hierarchies (Reavey & Warner, 2003).

Feminist constructions also challenge the status quo in gender and power relationships of which CSA is undoubtedly a part. Levett (2003) recognises that both boys and girls are sexually abused but that the implications of this are different for both. For both genders there is an exploitation of the adult-child inequality of power but for girls there is the gender inequality to contend with too. There are many more rules of behaviour and constraints on girls than on boys and Levett (2003) offers the notion that whilst CSA may not be a daily occurrence for girls in actuality, it often is in effect because girls have to live their lives in

ways "which take into account the possibility of sexual abuse" (p.68). Reavey (2003) offers the view that use of language can produce different views of women who have been sexually abused as children: either they are 'damaged' and 'not normal' because their development has been interrupted, or they are 'survivors' with a right to 'personal power' and 'healing'. Abused women are also presented as needing to adjust their thinking about men as they are seen as always fearing the possibility of male sexual violence. However this fear may actually be there for many 'normal', 'right thinking' women too, as Brownmiller (1973) in Herman (2001) purports: "It [rape] is nothing more or less than a conscious process of intimidation by which *all* men keep *all* women in a state of fear." (p.30) Whatever the language used to describe a woman who has been abused, it tends to come with many meanings and the woman spoken about may not ascribe to any of them, but the labels still exist.

2.2.5 Gender

With their focus on women and children and often female children, feminists such as Kitzinger construe sexual violation as a male crime with female victims. However, abuse of boys certainly happens and can be seen to affect significantly the development of their masculinity (Kia-Keating et al, 2005). Interestingly sexual violation of girls is not seen to affect the development of their femininity possibly because female sexuality has been and tends still to be defined by men (Muehlenhard & Kimes, 1999; O'Dell, 1997). This section will consider the ways in which men and women are socially constructed together with the subject positions offered by these constructions as these relate to CSA.

2.2.5.1 Construction of women

Frequently in the literature about CSA women are construed as victims or survivors (e.g. Bass & Davies, 1988; Sanderson, 1995;). When considering the prevalence of CSA, it is true that girls tend to be abused more often than boys (Radford et al, 2011) and feminist commentators would suggest that this is because of the patriarchal nature of our society (e.g. Egan & Hawkes, 2008; Levett, 2003). In section 2.2.2 it was demonstrated that the effects of CSA are often seen as negative and harmful. Thus women may be seen as harmed by their experiences of CSA and are presented as having been unable to resist the assault(s) they experienced as girls. Wilson & Strebel (2004) suggest that women/girls are expected to be compliant and submissive to male initiatives and demands and so may not only have been unable to resist assault physically but also psychologically. McLellan (1999) argues that women have learned that male violence is a normal part of masculinity and therefore cannot be changed and so again they might be seen as accepting this and not resisting.

Women, then, are seen as harmed by their experience of CSA and this might be seen to leave them with a range of consequences such as depression and low self-esteem, cognitive distortions, dissociation, isolation, fear of intimacy, psychosomatic pains, sleep disturbances among others (Sanderson, 1995). They may also be seen to behave inappropriately e.g. self-harm, substance abuse and promiscuity or celibacy (Sanderson, 1995). This construction seems to be aligned to the idea of women being victims. The idea of women being seen as survivors has come mainly from the literature known as recovery literature, (e.g. Bass & Davies, 1988). Here, women are seen as having strength and resilience and the ability to work through the abuse that they suffered. The concept of CSA being harmful is also present in this approach but women are seen as overcoming that harm and being victorious over it rather than defeated by it.

The subject positions women are thus offered, tend to be those of victims or survivors. They are often defined by the abuse that they experienced, abuse that is seen as inevitably harmful. Hunter (2008), however, found women who did not wish to be defined by their childhood experiences and refused to take the position of either victim or survivor. It was, however, more difficult for other people to allow them the freedom to do this once they knew about the CSA these women had experienced. Women are expected to have been harmed by having been sexually abused and Hunter (2008) found that any talk about that not being the case was not accepted by those around them. Thus some women who did not feel badly affected by the CSA did not feel able to speak about their experiences because they did not fit the prevailing view of how women who were sexually abused as children should be. Reavey & Brown (2007) suggest that unless women speak from the position of 'innocent child' they are unlikely to receive the support they may need because they are seen as being rebellious rather than compliant and submissive. O'Dell (1997) purports that the "effects" literature which assume inevitable harm can be seen to reinforce gender roles as men are seen as having power over women/girls which they are unable to resist.

2.2.5.2 Construction of men

According to Little & Hamby (1999), within our society men are often expected to be tough and unemotional and expected not to admit to emotional vulnerability. In this way, they suggest, therapists may "fail to ask about abuse histories with male clients" (p.378). It seems that therapists may not expect male clients to have experienced CSA, which may be because men are generally seen more as perpetrators than victims (Little & Hamby, 1999). This could make it even harder for a man to admit that he experienced sexual abuse as a child. Simpson & Fothergill (2004) suggest that some men may not want to admit they have experienced CSA because they might consider it to have been because they lacked machismo

and thus were weak: not the traditional view of men, and even in the 21st century that view can still prevail (Riley, 2003). Kia-Keating et al (2005) suggest that the characteristics of culturally acceptable masculinity include "aggression, rejection of 'feminine' characteristics, stoicism, preoccupation with sex, being an economic provider, sexuality and being the protector of home and family" (p.170). They also purport that traditional masculinity opposes anything that could possibly be seen as female which men perceive to be linked with passivity and helplessness. Kia-Keating et al (2005) also offer the suggestion that some men who have been sexually abused in childhood react by becoming hyper-masculine: very aggressive, very controlled and unemotional and sometimes abusive to others. The traditional male socialisation that men should not be victims and should have been able to protect themselves, can hinder male disclosure of abuse (Struve, 1990; Sorsoli et al, 2008).

Fisher & Good (1993) suggest that men are less in touch with their emotions than women and therefore find it harder to disclose sexual abuse. McGuffey (2008) purports that masculinity is equated with emotional detachment and that emotions are equated with femininity. If, as Kia-Keating et al (2005) claim, men who have been sexually abused might oppose anything feminine, then it is likely that men will eschew their emotions. Indeed, Dorahy & Clearwater (2012) state that men in their study wanted to be in control of their emotions and avoided them, rather than being at the mercy of them.

It seems that by not asking men about their abuse histories, men are not offered the subject position of "victim" or "survivor". One might almost think, rather, that they are being seen in the position of perpetrator (Sullivan, 2011). Men also seem to be offered subject positions informed by a very traditional view of masculinity and seem to be in the situation whereby the oppressors for them in a patriarchal society are also men as much as they are for women,

and ironically this is the very society they, as men, have created (Sullivan, 2011). Men who were sexually abused as children, then, may be unlikely to speak about the experience because they may fear the response that they would receive, their concern being that others may see them as weak and un-masculine (Dorahy & Clearwater, 2012). Dorahy & Clearwater (2012) also suggest that shame in men who have been sexually abused may not only cause them not to speak about it but to feel that they are not worthy of support. This may impact the likelihood of men seeking help for their CSA experience. In this way many men do not receive help and may instead demonstrate some of the more unhelpful masculine behaviours outlined above.

2.2.6 Paradigms and CSA: From victim to survivor

In some of the literature aimed at those who have experienced CSA, known as 'survivor literature', e.g. *The Courage to Heal* (Bass & Davies, 1988) and *Breaking Free* (Ainscough & Toon, 1993),the term 'victim' is generally replaced by the term 'survivor'. This seems to be because using the word 'victim' emphasises the victim role and makes "the woman feel like she was a passive instrument of her abuse" (Sanderson, 1995, p.27). Sanderson (1995) also highlights that the term 'survivor' emphasises the coping strategies which women used to survive their CSA as well as validating that surviving is an achievement in itself. The label 'survivor' is also seen to allow for a more positive self-image to be developed: one that is empowered and enables choice. The term 'survivor' is now widely used when talking about those who have experienced CSA and carries with it these positive connotations.

Hunter (2010) challenges the dominance of victim and survivor paradigms. Whereas the literature mentioned above, which highlights the effects of abuse, was based on therapists' knowledge of working with clients in therapy, Hunter's study is with people who have been sexually abused regardless of whether or not they had attended therapy. The potential is to

assume that all people who have been sexually abused will experience negative effects, which may not necessarily be the case. Hunter (2010) considers some of the different ways in which people who have experienced CSA have been positioned. She speaks of the victim paradigm of the 1970s when people who had experienced CSA were seen as passive and powerless which was ultimately seen as potentially stigmatising for the individual. Hunter (2010) also speaks of the survivor paradigm beginning in the late 1980s and onwards from the work of people such as Bass & Davies (1988) and Etherington (2000). Within this paradigm, the person who has experienced CSA is seen as strong, courageous and resilient, which allows for the development of the positive self-image mentioned earlier. Hunter (2008) suggests that the 'survivor' label can also be stigmatising because it still anchors the person's sense of self in her abuse and still seems to suggest that CSA defines the person. Orgad (2009), on the other hand, offers the notion that the media gives the position of the 'survivor' moral value and authority and also that trauma is "the envied wound" (p.134). Some might, therefore argue, that far from being stigmatising, the 'survivor' label is something to be held dear. This is clearly a very different picture of the individuals who have experienced CSA: no longer are they passive and powerless but somehow looked up to for their strength and resilience. Hunter (2010) goes one step further and speaks of the "narrative of transcendence" (p.184) in which people who have experienced CSA claim not to want to be defined by their experiences. These people eschew both the label of 'victim' and that of 'survivor'. Hunter (2010) quotes one participant in her study as saying "Like it's not the only thing that defines who I am anymore, and there's so much more to life than that." (p.184). Those who have experienced CSA and have adopted the narrative of transcendence seem to be aware that labels such as 'victim' and 'survivor' carry a lot of meaning with them. As one of Hunter's participants commented: "I want to be able to say publicly that I was sexually abused as a child, and I don't expect you to think any the less of me as a person, or to judge me" (Hunter,

2008, p.400). It could be that the meanings associated with the 'victim' and 'survivor' labels are what led Hunter (2010) to say that by continuing to view people who have experienced CSA as a victim or even a survivor could be to limit their potential because they are not allowed to operate outside of those roles. This is something a therapist may do by operating within either one of these narratives.

2.3 WORKING THERAPEUTICALLY WITH ADULTS WHO HAVE EXPERIENCED CHILDHOOD SEXUAL ABUSE

2.3.1 Approaches to therapy

2.3.1.1 Talking to process the trauma of abuse

Higgins Kessler & Nelson Goff (2006) suggest that it is natural for clients to want to talk about their 'abuse', even though they may find it hard, because it allows for the trauma to be processed. Macdonald et al (1995) suggest that acknowledging the abuse is needed before healing can take place. They also suggest that talking about the abuse, and breaking the secret, is key to breaking its power. A therapist may be the person to whom a client who has experienced CSA can talk. McGregor et al (2006) found that adults who had experienced CSA valued being able to talk about their experience of abuse with a therapist who could cope with hearing it. Cognitive-behavioural approaches also suggest that talking about the trauma event is part of processing it and moving towards recovery(Kennerley, 1999). The idea of there being power in the CSA that needs to be broken, seems to support the harm narrative and also the concept of powerlessness of 'victims' of abuse. If power needs to be broken it suggests that the CSA is still causing harm, with many authors perceiving that to be the case (e.g. Sanderson, 1995; Macdonald et al, 1995). The therapist's role is to help the client break that power, which might be seen to suggest she cannot do it alone and thus to an extent reinforces the subject position of powerless victim. Martsolf & Draucker (2005)

considered a number of different therapies (cognitive-behavioural, interpersonal, psycho-educational, psychodynamic, emotion-focused, cognitive analytic) and modalities (group/individual) which had been used for working with people who had experienced CSA. Their findings suggest that in each case there was a decrease in distress, depression and trauma symptoms as a result of the therapy. All of these therapies were abuse focused, meaning that the client(s) spoke specifically about the abuse as part of their therapy. These approaches are based on the idea that the meaning that a person attached to the abuse and the personal impact it had are embedded in the details of the experience, hence the in-depth review of what happened (Hodges & Myers, 2010).

The approaches which involve talking about the abuse all seem to assume the harm narrative and that to have been sexually abused is to have been harmed (e.g. Sanderson, 1995; Macdonald et al, 1995). However, the assumption that harm is the inevitable result of the experience of CSA has been challenged (O'Dell, 2003). Equally, the value of always speaking about the CSA at all has also been challenged (Warner, 2003). Furthermore, it could be that there are other more pressing issues for an individual to speak about than the abuse that they experienced (Warner, 2003). The therapist's assumption of harm offers a uniform way of viewing CSA (it is always harmful) which then tends to point to a particular way of working that deals with treatment for the CSA (Warner, 2003). The potential danger in this approach is that, whilst it allows the person the freedom to say what she likes about the abuse, it does not allow her the freedom to adopt a different perspective on the CSA other than the one for which she is being treated. Thus the therapy can become more about the therapist's approach rather than the client's needs. In this way the therapy may parallel the CSA because it can be seen as one person using their power over another.

2.3.1.2. The body connection

Some therapists view the re-experiencing of traumatic events, which can happen during abuse focused therapy, to be re-traumatising and therefore inappropriate (e.g. Morrison & Ferris, 2002; Ogden et al, 2006). Thus some therapy, rather than talking about the CSA, focuses on the body and the way in which trauma can have a profound influence on the body and the sensations that the client may feel. Rothschild (2000), Ogden et al (2006) and Levine (2010) purport that post-traumatic stress disorder (PTSD) is not just a psychological condition but has important somatic components. These therapists suggest that traditional talking therapies miss the mind/body connection and that, for the release of trauma, body work is required. In these therapies, the trauma may be spoken about, but is not the focus and speaking of the trauma should never be re-traumatising. It is the role of the therapist to slow the client down if they are becoming very distressed by talking about their experiences (Rothschild, 2000). Releasing the trauma from the body offers the opportunity to do trauma therapy without having to speak about the trauma. Having said that, many trauma therapists agree that some level of cognitive restructuring has to take place to recover from a traumatic experience (e.g. Joseph & Linley, 2005) and it is hard to see how this might happen without some cognitive activity such as thinking, speaking or writing about the experience.

The focus on trauma in the body still seems to support the harm narrative in that there is an assumption of trauma (harm) following CSA. Levine (2010) and Ogden et al (2006) purport that the trauma of CSA is "stored" in the body and needs to be released and without this release it is unlikely that the traumatised person can fully recover. This focus on body work rather than on speaking has the potential to inhibit the client who has experienced CSA from talking about the experience and dealing with the supposed trauma. Much CSA is carried out in secret (e.g. Sanderson, 1995) and not to speak of it may be seen as perpetuating some of

the dynamics of the abuse as it could be viewed as secrecy being maintained. This in turn can feed into the shame that many who have experienced CSA report feeling (e.g. Herman, 2001; Madconald et al, 1995; Reavey & Gough, 2000). If, however, it is accepted that body work is needed but also that cognitive re-structuring is needed (e.g. Joseph & Linley, 2005), then the conclusion seems to be that talking about the abuse and body work can go hand in hand. This may offer a broader approach to the therapeutic work than simply working with one or the other. However, the assumption of harm is still there which in many ways is unsurprising as our culture views CSA as harmful and those who feel unharmed may well not present for therapy (Hunter, 2008).

2.3.1.3. Strengths-based approaches

Other therapeutic approaches are less focused on the details of the trauma itself and many are strengths-based approaches. Hodges & Myers (2010), for example, consider the benefits of a wellness approach to therapy for people based on the Model of Wellness developed by Myers & Sweeney (2004). The therapy considers the whole person and purports that all areas of the individual are inter-connected and, thus, if improvements can be made in one area of functioning, this will lead to improvements in other areas. The therapist identifies areas where the client is strong and works to use the strengths to make improvements in those areas. This will ultimately lead to improvements in other areas too. This approach also focuses on the clients as agentic and the need for them to take personal responsibility for their choices. This differs from more traditional approaches to mental health which tend to focus on treating symptoms, with the person treated not making the decisions about what form the treatment should take. The Satir model for family therapy has been adapted for use with those who have experienced CSA (Morrison & Ferris, 2002) and also focuses on the clients' strengths and capacity to know the best way for them to deal with the impact of the abuse.

Again, detail of the event(s) does not need to be discussed as the therapy focuses on the impact that the event has and not the event itself. A brief on Transformational Systemic Therapy from the Satir Institute claims that "The problem is not the problem, how people cope with the problem is the problem" (p.1) and the therapy aims to help people cope much more effectively with the problem. The client's agency is also emphasised in this therapy.

Post-traumatic growth (Tedeschi & Calhoun, 2004) may be seen to link with the strengths-based approaches. Post-traumatic growth is seen as "the experience of positive change that occurs as a result of the struggle with highly challenging life events" (Tedeschi & Calhoun, 2004, p.1).Highly challenging life events are those which offer significant challenges to the adaptive resources of the individual and to her ways of understanding the world and her place in it. Joseph & Linley (2005) offer the notion that stressful and traumatic life experiences which encompass perceptions of a threat to life, uncontrollability and helplessness are likely to lead to post-traumatic growth. If the CSA experienced is violent and coercive it could well fall within this definition. It is recognised that an event experienced as traumatic is deeply disturbing (Tedeschi & Calhoun, 2004) and that any growth which occurs comes from the struggle to deal with the trauma, not from the actual experience. Any therapeutic work would need to make this very clear because it would be crucial for the client to recognise that the therapist would not mean that the experience of trauma was a good thing, only that good can come from it, if the client so wished.

Although the concept of post-traumatic growth sees the event, in this case CSA, as deeply disturbing (Tedeschi & Calhoun, 2004) the idea of something good coming from it (Sheikh, 2008) might be difficult for the person who has had this experience to accept. Whilst it might be accepted that the CSA does not have to be harmful (e.g. O'Dell, 2003; Card, 2002) if it has

been harmful then the idea of bringing positivity out of it may seem to suggest that it was not actually that harmful. Thus the therapist working from this approach would have to maintain a balance between the idea that the event was disturbing and the idea that the experience of it can lead to growth (Tedeschi & Calhoun, 2004). A traumatised client in this case may be left feeling that it was a good thing to have experienced CSA so that they can grow, which could be seen as being in opposition with their experience of the awfulness of what was done to them. The strengths approaches also seem to emphasise the concept of the client's agency (e.g. Morrison & Ferris, 2002) as if this were a simple uniform concept. As with much western therapy, it seems to take the view that the individual can be worked with in a vacuum and yet we all exist in a social context. The idea of a client being able to choose how to use her strengths could be seen to give her some responsibility for being as she is. From a feminist perspective, this denies the reality of a woman's day-to-day oppression (McLellan, 1999) and the fact that she may not have as many options open to her as this type of therapy might suggest. The strengths approaches which do not include speaking about the abuse can also maintain the secrecy dynamic that comes with CSA as seen in the previous section. Interestingly, not 'allowing' the client to speak about abuse seems to be taking away some of her choice if indeed that is her choice. To do this whilst promoting her agency seems to be a contradiction.

2.3.1.4 Narrative approaches

Narrative approaches to therapy view therapy as a social rather than a psychological process (McLeod, 2006), the goal of which is to understand how the client is interpreting her experience of life and to enable her to re-author a different and more helpful story of her experiences (Phipps & Vorster, 2009). Narrative therapy takes the view that 'reality' is a socially negotiated story (narrative) told by the individual and as such seems under-pinned by

social constructionist philosophy (Phipps & Vorster, 2009). Narrative therapy locates any problem that the client might be experiencing outside of her and thus does not pathologise her as some of the more traditional therapies do. For example cognitive-behavioural therapy (CBT) looks at what the person might be doing to maintain the distress that she may be feeling. Here the problem seems to be located in her cognitions with the results being seen in her problematic behaviours. In narrative therapy, the therapist works with the client to enable her to identify different stories that enable her to see new meanings in her experience, new meanings that she will experience as more helpful and satisfying (White & Epston, 1990). Narrative therapy also positions clients as 'consultants' who can 'teach' their therapists about how certain problems can be overcome rather than as those expected to adopt a supplicant role (McLeod, 2006). Narrative approaches seem, then, to be very collaborative with both therapist and participant being equal participants in finding new meanings for the client that will be helpful for her in living her life. Narrative approaches seem not to make assumptions about the client's experiences but rather narrative therapists are curious about how the client tells her story (McLeod, 2006). Within this the use of language is key, as is the idea of the client being part of a social network rather than a bounded, autonomous individual. Narrative therapists seek to help people by working with the ways they talk about issues and the ways in which they participate in social life (McLeod, 2006). It allows people to speak about whatever they wish and so seems less likely to close down certain avenues of conversation as some other approaches may do.

In working as they do, narrative therapists do not impose any model of therapy on the client and tend not to come to the therapeutic encounter with assumptions about how the client will be or why she will be that way. This seems to avoid some of the possible weaknesses of some of the other approaches to therapy already considered. However, in the 21st century in the

West, the medical model still holds sway and best evidence is generally required for specific treatment to be approved. In the UK this approval is generally from the National Institute for Health and Care excellence (NICE). As narrative practitioners do not hold any single theoretical model to have universal truth that is causally and predictively applicable to certain clients with specific problems (Busch et al, 2011), it is argued that they do not have good evidence and are unscientific. As a result, it is unlikely that narrative therapy would be approved for use in the NHS. Having said that, Shah & Mountain (2007) suggest that the medical model should be about what works rather than necessarily needing to know how or why it works. If it could be shown that narrative therapy works as well as any other therapy, it could thus be allowed to take its place among the more mainstream therapies.

2.3.2 Issues for therapists

2.3.2.1. Boundary issues

According to Harper & Steadman (2003), working with clients who have experienced CSA can be demanding and worrying. Their research on therapist boundary issues when working with adult clients who have experienced CSA delivered two key findings: therapists have anxieties about the 'survivor's' safety and also that they worry about the 'survivor's' feelings. These worries and anxieties may mean that therapists will do their utmost to build a safe, protective relationship with clear boundaries. This serves as an example of safe boundaries to the 'survivor' who may never have experienced these before. However, the worry about the 'survivor's' feelings may lead therapists to feel incompetent (Harper & Steadman, 2003) as they may not feel able to adopt their usual approach to therapy for fear of 'damaging' the 'survivor' further. Working from this position does not offer the client responsibility for herself and does not view the client as an agentic, responsible individual as do some

approaches to therapy. The therapist appears to have taken that responsibility upon herself which does not demonstrate respect for the client as a capable individual.

Anxiety and worry about the 'survivor' may also lead therapists not to hold high expectations for client change. Broomfield et al (1988) found that teachers expected less of children who they knew had experienced sexual abuse. Hutchinson & Lema (2009) suggest that negatively labelling adults who have experienced CSA e.g. "psychologically crippled" (p.10) can lower expectations of those individuals. According to Burr (2003) and the idea of dominant discourses informing action, prevailing views of adults who have experienced sexual abuse must of necessity affect therapists' work with this client group. Thus if a therapist's work is within a 'patient', 'victim', 'survivor', 'individual identity' (transcendence), or 'growth' imperative, their subsequent understandings of CSA may close down avenues of conversation within therapy (Croghan & Miell, 1999; Riley, 2003). For example, if a therapist positions the adult who has experienced CSA as a 'victim', she might not be open to the client who wants to talk about her strengths.

2.3.2.2. Vicarious trauma

Another potential area of concern for therapists is that of vicarious trauma (VT) which may be defined as on-going psychological consequences for therapists who work with those who have experienced sexual violation (Etherington, 2009). People who work with this client group are very directly exposed to the reality of sexual trauma which may highlight their own vulnerability. The impacts of the VT can be on perceptions, emotions and interpersonal relationships (Trippany et al, 2003). Therapists who work in this field can become suspicious, cynical and distrustful due to their empathic engagement with their clients' trauma stories (Trippany et al, 2003). VT can be seen as different from counter-transference which is the

therapist's response to a specific client, whereas VT is more about the result of the work with all clients (Trippany et al, 2003). According to Etherington (2009) VT can be said to occur for reasons relating to the nature and context of the abuse (how violent and/or sadistic was it?), the characteristics and history of the therapist (were they abused themselves? Do they look after themselves?) and the care seeking/care giving dynamic (people's early relationships will affect their way of seeking help as adults). Impacts of VT might include the therapist having her view of the world as a safe place severely challenged. Also in the face of extreme trauma therapists might lose faith in the therapeutic work due to feeling powerless in the face of their clients' distress. Some of the chaos, fear, derealisation that the clients feel may also be communicated to the therapist who begins to feel them too (Etherington, 2009).

In the face of the impacts of VT, one can understand why therapies that do not require a focus on the details of the abuse experience have been developed. If the therapist can work without having to expose herself to the client's trauma then this might be seen as a major benefit as the impacts of VT will not be felt. In addition, if the client is not talking about and/or reliving her distress then she is not being retraumatised. However some clients want to talk about their abuse and feel the need to do so (Higgins Kessler & Nelson Goff, 2006). If a therapist were to insist that the details do not need to be discussed, then she is not allowing the client to be her own agent and make her own decisions. This is where the approach of Ogden et al (2006) and Rothschild (2000) seems to be helpful: the client can talk about what she would like and the role of the therapist is to slow her down when she seems to be getting distressed, explaining that she does not want the client to become retraumatised. Therapists do, perhaps, need to think about what they can and cannot do with regard to working with those who have experienced CSA. They can then refer on if the situation becomes too uncomfortable for

them. Therapists who work frequently with this client group, need to be sure to practise self-care and in particular to have regular supportive supervision (Etherington, 2009).

2.3.2.3 Power issues

The therapeutic relationship is generally not an equal one. Often therapists are perceived as experts by their clients, which is why their clients wish to see them (Guilfoyle, 2002). The therapist has training, qualifications and membership of professional bodies which she needs to have to practise as a therapist. The place of therapy also has its part in the power relationship between therapist and client: therapy happens in therapy rooms in which the person becomes positioned as a knowable 'object'. The therapy room also gives therapist and client subject positions, e.g. the therapist is entitled to ask very personal questions and the client is expected to answer them and in this way become known (Guilfoyle, 2002). These subject positions only exist within the therapy room and do not exist outside it.

Some therapists try to eschew this power by positioning the client as expert on themselves (e.g. Rogers, 1980). His philosophy was that clients have within themselves the ability to guide their lives in a way that is satisfying and socially constructive. The therapist does not know how to do this for the client and her role is to help the client to find her inner wisdom and the confidence to act upon it. From a post-modern perspective, Anderson (2001) also sees the client as expert. Her guiding principle is that "human systems are language, meaning generating systems" (p.346) and therapy is one such system. Language allows people to create more than one reality and the role of the therapist is to be helpful to the client with whatever brought them to therapy. Anderson's (2001) view is that therapy is a collaborative enterprise in which therapist and client become conversational partners and in which the

client's expertise on her life is emphasised and the therapist's expertise on how a client should be is de-emphasised.

Guilfoyle (2002) suggests that working as if the relationship between client and therapist is an equal one is disingenuous because it does not accept the different subject positions and the reasons that clients come to therapy. Warner (2003) purports that identity should not be seen as something definitive and thus claims of expert and 'knowing' how to 'treat' CSA are to be avoided. She puts forward the concept of visible therapy one of the aims of which is to "disrupt operations of power" (p.234), power which is seen as maintaining identity as fixed and often, as in the case of CSA, pathologised. The operation of power in therapy might be seen in the subject positions of client and therapist (Guilfoyle, 2002) and the concept of CSA maintaining women in a position of powerlessness. Thus therapists who 'treat' CSA as a defining feature of a female client keep her in a powerless position (Warner, 2003). Therapists, then, probably need to be aware of these issues and be open about the power dynamic and not try to find a single, simple answer to the treatment of CSA but recognise it as a complex social, not individual, issue.

2.3.2.4 The organisational context

As the participants in this study all worked in specialist services for those who have experienced sexual violation, it is this organisational context that will be considered. Often within these services the person who has been sexually abused is referred to as a survivor (e.g. Sanderson, 1995). The survivor label carries with it particular connotations such as being brave, noble and resilient (Orgad, 2009). So people who have 'survived' sexual abuse might almost be seen to be those to whom one looks up (Orgad, 2009). The corollary of this is that working in a sexual abuse service might be seen as special because one is working

with ‘special’ people. Any therapist who does not adhere precisely to this view might be seen as ‘not fitting in’ or not really understanding the consequences of having been abused and having ‘survived’ that experience. In addition, people who have experienced CSA are often seen as never having been to blame for the abuse they experienced (e.g. Bass & Davies, 1988; Sanderson, 1995; Macdonald et al, 1995). It does seem that when children are abused they generally do not have a choice in the matter (e.g. Sanderson, 1995; Draucker, 1992) but sometimes they might be the one who approaches the perpetrator for sex (Bass & Davis, 1988). The explanation often given by those who work in specialist services is that the child has been groomed and therefore is not at fault for making an inappropriate decision in asking the perpetrator to have sex with her (Bass & Davis, 1988). This may well be the case but could depend on a number of things such as the age of the child and the relationship with the perpetrator. In specialist services the principle of the person who experienced CSA never having been at fault is often ‘sacrosanct’ and cannot be challenged (e.g. Parks, 1994; Bass & Davis, 1988). It, therefore, puts the therapist, who may want to consider what part the child had played, in a very difficult position as she may feel unable to pursue that particular line of inquiry.

The view of the person who has been sexually abused as never having been at fault can also have an impact on the type of therapy used to work with them. Often specialist services work from a person-centred or client-led perspective (e.g. Warner, 2003; Sullivan, 2011). This does not involve the therapist in making any kind of judgements about the person and, being person-centred, the therapy proceeds on the client’s terms and at her pace (Rogers, 1980). In addition, person-centred therapy relies on the concept of organismic valuing process and the client developing congruence between the organism (the person herself) and the self-concept (Wilkins, 2005). This means the client coming to see herself as worthwhile and able to

become who she wishes to be. Other therapies, e.g. Cognitive Behavioural Therapy (CBT) (Beck, 1995) and Cognitive Analytic Therapy (CAT) (e.g. Ryle & Kerr, 2002) look at what the client might be doing to maintain their distress in the present. Potentially this could be seen as coming close to blaming the client for her distress which is something that seems to be taboo in most specialist services. This could leave therapists feeling unable to work as effectively as they might with clients because there are certain aspects of the client's experience, especially in the here and now, that they are not encouraged by the organisation to address. Indeed the therapy may be less effective than it could be if therapists are not able to look at what the client might be doing in the here and now to maintain any distress she may be feeling. By not raising the issue of the client's current choices and behaviours therapeutic change may be slower in coming, as the reliance is on the client's organismic valuing ability (Wilkins, 2005). This may take a long while to be developed in someone who may see herself as worthless as many people who have experienced CSA do (e.g. Sanderson, 1995). As with many humanistic therapies, it also tends to ignore the issue of social context and the fact that the client may have many pressures on her that mitigate against her becoming who she wishes to be (Warner, 2003).

Specialist services also tend to assume that CSA will have been harmful to the person who has experienced it (e.g. O'Dell, 2003) so for therapists who work in such services the expectation tends to be that they will believe that the clients have all been harmed. To express doubts about such harming is as likely to be taboo as is thinking about the notion of blame in relation to the client. This is reflective of the dichotomous thinking that seems to abound in much of society: something is 'this' or 'that' with nothing in-between. For example blame is always the perpetrator's, never the survivor's and there is no blurring of that boundary. Or again, sexual abuse is either harmful (generally assumed) or it is not, with no middle ground.

Finally, in some instances the organisational context follows traditional gender lines and women therapists can be frustrated at not being able to help men because this would be at odds with the agency remit (Sullivan, 2011).

2.4 Summary

The temptation for therapists could be to see CSA as uniform: 'this is how it happens (abuse of power), this is what it does (harm), these are the effects (mental health issues), and this is how it needs to be treated for a woman to 'get better', and I, as therapist, need to maintain my boundaries and be careful not to take on any secondary trauma'. However, this misses the complexity of the issue and also often tends to focus on CSA being an individual problem when it could more helpfully be seen as a social one (Warner, 2003) because of the socio-political aspects involved, such as gendered identifications. The organisational context within which therapists work may actually reinforce this uniform view as people who have experienced sexual abuse may be seen in a particular and similar way, and therapists may be expected to work as if this were the case. Perhaps therapists working in specialist services, rather than assume a way to 'treat' someone who has experienced CSA, might more usefully ask whether 'treatment' is needed at all (Warner, 2003).

CHAPTER THREE – METHODOLOGY

3.1 INTRODUCTION

Rennie (1994) purports that human science or qualitative research is helpful in closing the gap between research and practice in the field of counselling psychology. This is because constructionist inflected human science is about understanding rather than explanation and counselling psychologists tend to work in understanding their clients and not in trying to explain them (Division of Counselling Psychology website, 2011). This leads to the tension in counselling psychology of the scientist-practitioner model. Previously in psychology, science has been associated with positivism (Nielsen, 2007) which explains things and develops laws. This, however, does not seem appropriate to counselling psychology in which practitioners work with people and where reflection and meaning- making are key (Rennie, 1994).

CSA may be seen to have long-lasting effects on those who experience it. Consequences may include depression, interpersonal difficulties, anxiety and self-harming among others (Sanderson, 1995). How professionals understand the concept of CSA will potentially affect how they work with adults who have that experience (Burr, 2003). The aim of this study was to explore the issue of how therapists understand CSA and how this can impact on their practice in working with this client group. The research was undertaken from a social constructionist position. Semi-structured interviews were carried out with eight therapists who worked in specialist services for adults who have experienced CSA. The interviews were analysed using a discursively informed thematic analysis as a way of understanding therapists' engagement with CSA. The aim was for the findings to add to knowledge about

working with CSA and inform practice in working with adults who present with issues relating to having experienced sexual abuse as a child.

Specific questions that were addressed:

1. How do therapists talk about CSA and about adult clients who have had this experience?
2. In what ways can participants' framings of CSA impact on their professional practices?

3.2 REFLECTIONS UPON RESEARCH PARADIGMS FOR COUNSELLING PSYCHOLOGY PRACTICE/RESEARCH

Morrow (2007) suggests that qualitative research approaches are more relevant to the paradigms of counselling psychology than quantitative ones. A paradigm is a set of beliefs that underpin action (Morrow, 2007). In the case of counselling psychology, these beliefs are about the nature of reality (ontology) and how that reality may be known (epistemology). Generally within counselling psychology, practitioners are drawn to ways of viewing the world which reflect an interest in how people construct meaning. Morrow (2007) claims three qualitative paradigms, as does Ponterotto (2005): post-positivist, interpretivist-constructivist and critical-ideological. These will be considered in turn.

Post-positivists believe in a true reality but one that cannot be fully understood (Morrow, 2007). The requirement for objectivity is still a key part of research in this area and Ponterotto (2005) suggests that whilst positivism is about theory verification, post-positivism is about theory falsification. An example of this might be regarding the popular theory that all people who are abused as children go on to abuse others. Finding one person of whom this is not true would falsify that theory. This seems to bring post-positivism very close to the

natural sciences that are about testing hypotheses (Ponterotto, 2005). Post-positivism, then, does not seem to sit very comfortably within counselling psychology because it is less about constructing meaning and more about working with an objective reality, albeit one which can only imperfectly be understood. Its data gathering methods may also be those used within quantitative research (Hansen, 2006). This could include tools such as surveys and psychometric measures.

Interpretivist-constructivists believe that there are multiple realities (Haverkamp & Young, 2007) all of which are equally valid. The world cannot be studied objectively because we have to use language to describe it and so, of necessity, subjectivity enters in to any study (Gergen, 2001). Knowledge can be seen as emerging from interaction between people and so is constructed and must be interpreted. This seems to be more appropriate for the counselling psychology arena, as it is about constructing meaning through interaction. In the therapeutic space it is entirely possible, and even desirable, for the client to construct the meaning of their experience, to understand more about themselves through interaction with the therapist (Draucker, 1992). Data gathering methods are more likely to be interviews and discussions with participants (Cresswell et al, 2007) in order to understand their perspectives on their own realities.

Critical-ideologists accept the existence of multiple social realities, but also believe that there is a 'real' reality which is the product of power and oppression (Morrow, 2007). There is no attempt to be neutral within this paradigm, because the research is committed to social justice. Whilst interpretivist-constructivist methodologies may be used, a common research design is action research. This involves the researcher working with the participants to find a way forward in changing their situation (O'Brien, 2001). The situation is generally one about

which the researcher feels strongly and wishes to see changed, for example, action research to develop training for mental health professionals in working with adult survivors of CSA (Jordan, 2008). Jordan (2008) felt strongly about the need for better training for mental health professionals, so that they might work more effectively with those who had experienced CSA.

The action research design is to plan an intervention, undertake it and reflect on it in an iterative process, ensuring that the interventions are informed by theoretical consideration (O'Brien, 2001). This approach also seems to fit within counselling psychology because it involves participants in the interventions and takes their points of view on board when reflecting and planning further interventions – thus it is about constructing meaning and also constructing the research itself. However, it could be argued that the tension of the scientist-practitioner model, as mentioned above, has been stretched very much to the practitioner, and thus subjective, side of the equation. It could also be argued, though, that this does not matter because subjectivity is part of being human and that to imagine that one can be wholly objective is to delude oneself.

3.3 REFLECTIONS UPON QUALITATIVE RESEARCH IN THE AREA OF CSA.

Qualitative research methods eschew the natural scientific model and are more interested in how people experience and interpret their social world. Social reality is seen as being socially created by individuals (Bryman, 2008). This chapter will now move on to consider some previously undertaken qualitative research.

McGregor et al (2006) and Morrow & Smith (1995) used grounded theory as their methodology. Morrow & Smith's study (1995) was wholly qualitative using interviews and focus groups. A theoretical model for coping with CSA was developed within which there were two key sets of strategies: "Keeping from Being Overwhelmed By Threatening and Dangerous Feelings" and "Managing Helplessness, Powerlessness and Lack of Control" (p.29). McGregor et al (2006), on the other hand, did not develop a theory from their research on asking women who had experienced CSA to talk about their helpful and unhelpful therapy experiences, but claimed instead: "The aim of this research was not to develop new theory but to give a voice to a group that has been under-researched and is often unable to express their view" (p.42). Generally grounded theory is used to build theory from the data obtained (Strauss & Corbin, 1998) which is what Morrow and Smith (1995) have done. However McGregor et al (2006) have not developed new theory and thus grounded theory does not seem to have been appropriate in this case. Thematic analysis (Braun & Clarke, 2006) might have been better suited, as it would still have allowed for the identification of key themes from the data but is not explicitly about theory building as grounded theory tends to be.

3.4 REFLECTIONS UPON EPISTEMOLOGICAL AND METHODOLOGICAL FRAMEWORKS FOR CURRENT STUDY

3.4.1 Theoretical framework

This study was undertaken within an interpretivist-constructivist paradigm (Morrow, 2007) and specifically from a social constructionist position. This is a position that takes a critical stance towards our "taken for granted ways of understanding the world " (Burr, 2003, p.2). It also recognises multiple realities in that each person has their own perception of the world and has their own understanding of it, thus there is not one truth that people all similarly perceive. Language is seen to be the key mediator for perception (Willig, 2008) and thus

language is an important aspect of socially constructed knowledge. The concept to be considered (therapists' understandings of CSA) is most usefully explored from this position because CSA can usefully be understood as socially constructed. In other cultures currently, for example in India or Sierra Leone (The Independent, 2012), and in previously in Western culture an adult having sexual intercourse with a child might not be seen as inappropriate. For example in California, USA in 1889 the age of consent to sexual intercourse was raised from ten to fourteen, in 1897 from fourteen to sixteen and in 1913 from sixteen to eighteen (Dolhenty, 1998). Previously, therefore, in Western culture, sexual activity with young people was not deemed to be entirely unacceptable and the language used to describe the activity would not have included terms such as 'abuse'. However, generally, in Western society now, participating in sexual activity with a child is considered to be totally unacceptable and the idea of 'abuse' is inevitably associated with it.

Herman (2001, p.33) calls the trauma of CSA an "atrocity". As a result of changes in the way CSA in the West is viewed, there have been many ways to conceptualise someone who has had this experience. In the medical model the adult who has had the experience of CSA might be pathologised, due to the sequelae of CSA or the adult who has experienced CSA might be seen as a 'victim' or a 'survivor' (Hunter, 2010). Thus alongside the idea of 'abuse', associated narratives of 'victim' and 'survivor' have emerged as part of the wider CSA discourse.

3.4.2 Data collection

3.4.2.1 Participants and recruitment

The sampling was purposive in order to gain the data required. Therapists who worked in specialist services for adults who have experienced CSA were targeted. This was done by

accessing The Survivor's Trust website which gives details of specialist services available for people who have been raped or sexually abused on their "Find Support" pages at www.thesurvivorstrust.org/find-support . Emails were sent to the organisations, a copy of which can be found at Appendix 1, to see if any of their therapists would like to participate in the research. Therapists contacted the researcher themselves if they were interested and interviews were arranged at a mutually agreeable time and place. Participants were required to have worked in the field of sexual abuse for at least two years in order to have sufficient experience to be able to answer the questions. They were also required to be a member of an appropriate professional body (e.g. BACP) such that ethical practice could be assumed. The initial mailing was to organisations in the South and South East of England, but this did not yield sufficient participants. Thus a second mailing was carried out which broadened the recruitment area to include Bath, Coventry and Nottingham. This second mailing gained sufficient responses to allow the study to go ahead as planned.

Finally eight participants were interviewed: seven women and one man, all identifying as white British. They lived in varying English locations: Bath, Nottingham, Coventry, London, Chichester, Brighton (2) and Portsmouth. Their ages ranged from 32 to 67 and they had been working in the field from between two and more than 20 years and were all still doing so. The participants all worked in specialist sexual violation services and adults who had experienced CSA formed the major part of their case-load. All of them were qualified as counsellors and/or psychotherapists belonging to either the British Association for Counselling and Psychotherapy or the United Kingdom Council for Psychotherapy. The participants came from three different therapeutic modalities: person-centred, integrative and psychodynamic and their experience was either in the not for profit or the public sector. The age range was broad and their levels of experience in the field and their therapeutic model

were varied, however, genders and ethnicities were homogenous. It would have been helpful for the project to have had more male therapists and also therapists from different ethnic backgrounds, however due to the difficulties in recruiting participants at all, the study went ahead with those who had volunteered to be interviewed. A summary of participants can be found at Appendix 2.

3.4.2.2 Ethical considerations

A risk assessment for conducting interviews away from University premises was undertaken and this can be found in Appendix 3. Ethical approval for the study was sought from the University and a copy of this is in Appendix 4. The participants for the study were all volunteers and given clear information about the study, together with a consent form prior to taking part. A copy of the information sheet may be found in Appendix 5. Participants were reminded that their anonymity would be protected and that they could withdraw from the study at any time with no adverse consequences for themselves. They were also advised that they need not answer any question with which they felt uncomfortable. They could give as much or as little information about their clients as they wished but were advised to maintain the anonymity of their clients by not using their names. All of this was designed to help them to feel relaxed about their participation. Once they had agreed to take part the participants were asked to sign a consent form (see Appendix 6) and give this to the researcher at the interview.

3.4.2.3 Interviews

This study was designed to explore understandings, and as such it would have been possible to use structured interviews (Bryman, 2008) such that all participants would have been asked the same questions and their answers could have been easily aggregated. However, this

would potentially have lost a lot of the richness that can come from a less structured interview (Bryman, 2008; Langdridge, 2007) so would not have been useful for the type of data the researcher wished to obtain. Thus semi-structured interviews were chosen as the method of data collection and the schedule was piloted among the researcher's colleagues. The interview schedule can be found in Appendix 7. Basic questions from the schedule were posed to each participant, but subsequent questions depended on initial answers received. The discussions in the interviews were varied and included, among others, meanings of CSA, a participant's therapeutic engagement with CSA, gender, the use of metaphor, abuse as a form of power, society's views of abuse, mental health issues, empowerment of clients and working with distress. There was, thus, both breadth and depth in the data collected. The interviews were conducted in a relaxed and friendly manner and were more of a conversation than an interrogation. The researcher believes, in line with other social constructionist researchers (e.g. Wiesenfeld, 2000), that the interview dialogue is a mutual process in which her subjectivity forms a legitimate part. The interviews, which lasted around 70 minutes, were mainly held at the offices of the service for which the participant worked. One was held at a Regus manned office hired by the researcher for the purpose. Interviews were recorded for subsequent transcription with identifying references anonymised and all participants given pseudonyms.

3.4.3 Data analysis

3.4.3.1 Chosen approach

The chosen approach was thematic analysis informed by discourse theory. Thematic analysis is "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79). Some qualitative methods for example, Interpretive Phenomenological Analysis (IPA), are associated with particular theoretical or epistemological positions (Braun

& Clarke, 2006). Due to its theoretical flexibility, thematic analysis can be used across a range of positions, both essentialist and constructionist (Braun & Clarke, 2006). In this study, thematic analysis was used from a social constructionist position. The thematic analysis was underpinned by discourse theory and the importance of the use of language in how individuals construct phenomena in the world around them. In this case, how the participants constructed CSA. The discourse theory used was informed by the work of Michel Foucault who was interested in the role of language and how it allows us to construct both social and psychological life (Foucault, 1974; Willig, 2008). These constructions can be built into discourses which might be seen as ways of organising knowledge, ideas, or experience that are rooted in language. For example, a discourse of masculinity might be seen in the language used: men might be described as being strong, as providers, as powerful or as aggressive. The use of such language can be built into a way of thinking about men such that this is how they are or 'should' be. Following on from this, discourses also constrain what language is available for use when discussing something. Taking the same example, generally one would not use words such as pretty or weak when discussing a man. So discourses not only give us language we can use when talking about certain phenomena but also language that we cannot. Thus the themes arrived at through the thematic analysis will be based on language that participants have available to them and also that which apparently they do not.

In addition, Foucault (1980) linked together knowledge and power, indeed he seemed to view them as inextricably linked. Foucault (1984) suggests that there are three fundamental factors of any experience: knowledge, power relations and ways of relating to oneself and others. Foucault (1988) further suggests that there can be no knowledge claims without power. It seems then that to have knowledge is to have power and equally to have power one must have knowledge: one cannot exist without the other. Certain knowledge positions, otherwise

known as dominant discourses, become more powerful than others and tend to inform what is acceptable social practice (Wallis et al, 2011). For example medical discourses give doctors power because of their knowledge of medicine: they are able to admit people to hospital and in extreme cases insist on treatment even if the patient does not desire it. Doctors would not have this power without their knowledge. Regarding CSA, the adult perpetrator has knowledge (about sex) and uses that to gain power over the child he abuses. The researcher sees power as part of the CSA dynamic and hence was interested in how this together with knowledge and knowing might form part of the participants' talk about CSA. In addition, therapy as an experience will also have the three factors mentioned above. The therapist's knowledge, for example of psychology or of therapeutic models, gives her the power to manage the relationships both with herself and with the client. The key part of the analysis was to consider how the participants constructed CSA: what language they used and what language they did not. This links precisely with the first research question: how do therapists talk about CSA and about adult clients who have had this experience?

Thematic analysis, then, was chosen as a flexible method for identifying and interpreting themes within the dataset that comprised of transcribed participant interviews. The Foucaldian underpinning focuses these themes within a wider socio-cultural context: the way in which individuals speak about CSA today may be very different from how it was spoken about previously and how it may be spoken about in the future.

3.4.3.2 Analytic procedure

Each of the interviews was recorded and transcribed, some by the researcher and some by a professional transcriber, of whom the participants had been informed. Analysis of the data followed Braun & Clarke's (2006) steps for undertaking a thematic analysis. Identifying the

patterns in the data was undertaken using a theoretical approach, such that the themes are linked to the researcher's analytic interest in the area of CSA (Braun & Clarke, 2006). The research questions were established prior to the interviews being undertaken and was specifically related to how therapists speak about sexual abuse and the impact of these framings on their practice.

The transcripts were read three times each to build familiarity with the data (Braun & Clarke, 2006, stage 1). On the fourth occasion, and in line with Braun and Clarke's second stage, the researcher began coding and arrived at the initial codes (see Appendix 8). These initial codes were those which seemed to be of most interest in relation to the research questions (Braun & Clarke, 2006). There were over 90 initial codes which included therapist issues, client issues, society's views, treatment and interventions and consequences of CSA among others. An example transcript with coding is attached at Appendix 9. The data continued to be examined as the codes were then themed to arrive at 13 initial themes which included concepts such as perceived effects of CSA, therapist perceptions and understandings of CSA, therapeutic approach and the work of therapy (see Appendix 10). On-going reiterations of reading the data and seeing patterns in the data, comparing these to the already identified themes allowed them to be further refined to arrive at the three themes found in the next chapter: Gendered Identifications; Therapist Ambivalence and Disputing the Harm Narrative. Reaching this point was informed by Braun & Clarke's (2006) stages 3 -5 : searching for themes, reviewing themes and defining and naming themes.

This entire thesis comprises Braun & Clarke's sixth stage of thematic analysis , which is writing the report. The second interview question (What is the impact on practice of the participants' framings of CSA?) was answered in Chapter 5, Clinical Implications.

3.5 PERSONAL REFLECTION

Whilst I accepted that meanings associated with CSA can be understood as socially constructed and discursively contingent, I still struggled with the whole idea at the start. Intellectually I could see that a social construction was logical and reasonable but emotionally I rebelled against the idea. I have volunteered and worked for 10 years in a service for those who have experienced sexual violation, initially as a telephone helpline volunteer and for the last three years as a therapist. It felt to me as though I would be saying that my clients are somehow "making it up", that by saying what they have experienced is a social construction, I am somehow saying that it was not real. However, I was somewhat rescued by the title of Berger & Luckman's (1971) seminal work on social constructionism *The social construction of reality*. This suggested to me that there can be a reality but that it is not the kind of reality that is "out there" waiting to be discovered, it is a reality which people build from their experience and knowledge of the world around them. Thus for one of my clients who has been sexually abused, her reality is most probably pretty hideous. She knows that her personal experience of what was done to her was awful and she also knows that society thinks what was done to her was awful because of the language used to describe her experiences. This fictional client may never have told anyone about what was done to her until she came for therapy, but she knows from how this experience is portrayed in the media or in books and by others that it was bad.

My struggle with the socially constructed meanings of CSA has, at times, caused me to want to stop my research project and go back to the "easy" conclusion that CSA is bad, it is not made up and people inevitably suffer from it in more or less the same ways. But I have come to realise that I just needed to be a little flexible: CSA is mostly bad, generally people do not make it up and often they do suffer from it. The post-modernist position does not make

people's distress any less when they have experienced CSA in this culture in the 21st century, what it does do is suggest that in other times and in other cultures the distress might be less because CSA was/is viewed differently. The other point to make is that the "easy" conclusion I spoke about above is hard to get away from in our culture in the 21st century. I think that has also made it hard for me. I have felt at times as though I was swimming against the tide and maybe even letting clients and other therapists who work in the field down by taking the approach that I have. Then I thought "What about those who were sexually abused but didn't suffer terrible trauma, for whom the abuse was not so bad?" In our current climate they may not be able to talk about their experiences (even if they wanted to) because of the reaction they might get that there is only ever one view of CSA: that it is awful, and if they do not feel that then there is something 'wrong' with them. So I came to the conclusion that my position is about being flexible, about seeing other options and not the 'truth' of CSA because there probably is not one.

Actually getting the project up and running was also a challenge. I had thought, somewhat naively perhaps, that people who worked in services for the sexually violated would be very willing to take part in the research, but this absolutely was not the case. The time it took in following up emails with phone calls, only to get a negative response was very frustrating and dispiriting. Mainly I was told that the therapists were too busy to take part in research. My first attempt at recruiting participants, which was done locally to where I live, delivered four people, which was not sufficient for what I needed. I would ideally have liked a balance of male/female therapists but this was not achieved and may be reflective of the actual balance of male/female therapists who work in this field. I was aware that the ethnic and gender mix was not there: the participants were all white and there was only one man, which was another frustration.

3.6 SUMMARY

This chapter has considered some of the key areas of epistemology and methodology used in counselling psychology research and seen how some of these have been used in the area of CSA. It has also outlined the researcher's epistemological position. Consideration was also given to some of the limitations associated with the proposed research and in particular the type of participants recruited. The researcher's consideration of research methodologies which could potentially have been used was demonstrated and explanation offered for why discourse analysis was chosen as the method of data analysis. This is related very specifically to the research questions and seemed to be the most appropriate method to use.

CHAPTER FOUR – ANALYSIS & DISCUSSION

4.1 INTRODUCTION

In Chapter Two it was demonstrated that within the abuse dynamic and within the therapeutic dyad power is a key issue. In the therapeutic relationship it is one that certainly needs to be recognised and addressed. The differences between men and women and how they are socially constructed is also an important issue within the area of sexual abuse and was seen very clearly from the talk of some of the participants in this study. Thus how the participants' talk positioned clients with regard to their gender, together with the impact of abuse on sexuality came together in one theme. Of course, how sexual abuse itself is construed and the perceived impact it can have is also key to both research and therapeutic work in this area. The issue of power between therapist and client was a key issue that came out of the participants' talk, with a particular focus on the ambivalence that participants demonstrated about the concept. This together with therapist ambivalence around responsibility and blame and also the effects of CSA came together in a second theme. The issue of power was seen again in the way in which participants spoke about the work of therapy and the desire to empower their clients, although whether or not this was actually possible did not seem to be considered. The concept of the CSA always being present although not always having the same effect, as well as the uniqueness of clients was seen, together with empowerment of clients, as a way of disputing the often perceived inevitable harm narrative associated with CSA.

This chapter will now go on to focus on the above issues as themes which were drawn from the data as follows:

- Gendered identifications
    - Positioning clients

    - Abuse and sexuality
- Therapist ambivalence
    - Power
    - Common themes: responsibility and blame
    - Effects of CSA
- Disputing the harm narrative
    - Client strengths and empowerment
    - Uniqueness of clients
    - It will always be there

Each of these themes will be addressed in turn.

4.2 THEME ONE: GENDERED IDENTIFICATIONS

In Chapter 2, it was shown from the literature that socially there are different subject positions offered to women and men. Women are often seen as victims or survivors, being defined by the abuse they experienced which is generally seen as harmful (e.g. Sanderson, 1995). Men, it seems, are not offered these subject positions but are seen more as perpetrators than either victim or survivor (Sullivan, 2011). Even in the 21st century it seems to be that women and men are still expected to conform to traditional stereotypes of femininity and masculinity. Having said that, women who adopt the position of survivor can sometimes be seen to be strong and resilient and to have conquered the effects of the abuse they experienced. This use of language is traditionally more associated with men than women. Yet even for men who have experienced CSA, 'feminine' language, for example words such as 'vulnerable', is not generally used. This seems to give men a more rigid way of responding to the abuse that they experienced and often they do not wish to speak about it (e.g. Simpson & Fothergill, 2004). Some of the participants expressed the view that it was harder for a man to

deal with having been sexually abused as a child than for a woman. The way in which men and women are often positioned seems to have played a part in this and this will be considered first. The other key issue for those who worked with men was the difference between men and women in the perceived impact of the CSA on sexuality and this will also be considered.

4.2.1 Positioning clients

All the participants who worked with men perceived that it was 'worse' for a man to have experienced CSA than for a woman. One of the participants, Rachel, spoke of a quote she had read which could possibly be one explanation as to why this might be the case:

Extract 1: Rachel

> Women who have been sexually abused, the abuse makes them feel like an object and, therefore, they know they are women and with men it makes them feel like they are an object and, therefore, they know they are not men.

Atmore (1999) suggests that men have been sexually objectifying women for millennia and thus women have been on the receiving end of male power: it is as if that's just how it is. Rachel's quote seems to support this claim. Among the participants in this study who raised the issue of the difficulties for men of having been sexually abused as a child, the effects of societal stereotypes were much in evidence.

Extract 2: Gabi

> I think in working with men, there's often a perception that it's worse for a man if he's been abused by a woman. And I don't know how that thinking is, but

> perhaps it's also that stereotypically men are perpetrators, that's how society sees them, so there's an assumption that men are abused by men, so for a man to say he was abused by a woman, it may make them feel even more kind of impotent.

Extract 3: Rachel

> They would do anything, I think to deny it, because it just erodes their masculinity. Because men – and this is something I am quite vehement about, that it is harder for men, because people accept that women get raped and that girls get sexually abused because girls are weak. But men – well why didn't they defend themselves even at six years old. Well. You know, he was a boy, why didn't he defend himself? And there's this feeling of 'I should have protected myself' and so the shame is so much greater, it's not just the shame of being abused, it's the shame of 'I am not a man, I could not protect myself' – and 'this doesn't happen to men'. And I do believe it's worse for men, I really do.

It seems that, in the experience of these participants, it is more difficult for men to admit and to deal with the consequences of having been sexually abused as a child. Sorsoli et al (2008) consider the difficulties men experience in disclosing that they had been sexually abused as children. They speak of three types of obstacles to disclosure: personal, relational and sociocultural. Personal obstacles include lack of cognitive awareness, purposely avoiding the material and finding it hard to find the words to express what happened. Relational obstacles are mainly concerned with worry about the reaction of the person to whom one discloses. Sociocultural obstacles are to do with "thoughts that it was unacceptable for men to experience victimisation and if they had, that they were certainly not to discuss those experiences" (Sorsoli et al, 2008, p.341). In Extracts 1-3 it seems that sociocultural forces are

at play. Gabi in Extract 2 talks about society seeing men as perpetrators so that even boys are assumed to have been abused by men. The idea of a boy having been abused by a woman seems to have a bigger impact on a man's sense of himself as "less of a man". Thus the cultural interpretations of masculinity are seen to impact on the man who has experienced CSA.

The cultural stereotypes are picked up also by Rachel who sees that it is accepted that girls get raped because they "are weak". The implication seems to be that somehow it is OK for girls to be sexually abused because 'that's what happens'. McLellan (1999) suggests that western women are brought up with the concept of violence being a normal part of masculinity and is to be expected. She also argues that our use of language avoids the idea that men are to blame for violence against women through use of such terms as 'domestic violence', rather than 'male violence' and 'incestuous relationship' rather than 'rape'. In this way men are not held to account and the status quo is maintained, accepting that girls get raped because they "are weak."

Atmore (1999) purports that most sexual violence follows traditional gender lines: the rapist is in a male body and the victim in a female one. From this it seems to be logical to argue that rape may be seen as a feminising act for the victim and a masculinising one for the rapist. However, she suggests that this might still be seen to be the case even if the sex of the bodies is not male/female. Thus if a man or boy is raped by another man this is seen as a feminising experience for him and men who have had this experience may describe being made to feel like a woman. So for a man to have been abused he is positioned potentially not as a man because "he is not a man, he could not protect himself" (Extract 3). Whereas women can still be positioned as women after abuse because they are conditioned to accept gender

inequalities and male power and nothing has changed that (McLellan, 1999). In summary, then, men are seen as abusers and women and children as victims (Cossins, 2000; Lew, 2004; Dorahy & Clearwater, 2012), thus sexual abuse for women (victims) does not seem to strike at the heart of their [constructed] femininity but it seems that for men (abusers) their [constructed] masculinity is in question (Baljon, 2011).

Women, then, maintain their [socially constructed] femininity but they are also offered other positions: that of victim and/or survivor. These labels carry with them different identities. Use of the word 'victim' might be seen to reinforce and perpetuate the images of women as weak and passive (Gavey, 1999) whereas the term 'survivor' might be seen as offering images of strength and the ability to overcome (Orgad, 2009). The talk of the participants who worked with women tended to reflect both of these labels.

Extract 4: Joy

> One of the most disturbing things is how often they want to feel that they must have deserved it…. I suspect to have deserved it gives them some control and one of the harshest things is of course they had no control. Their autonomy was totally negated and so they have the idea 'I must have been bad' or 'I must have encouraged' or 'in some way it was my dessert.'

Extract 5: Judith

> They often feel like they don't count in things or in relationships. I think that's the message they were given by being abused in childhood….. you know they weren't included in what happened to them, they weren't considered or consulted, something was done to them and so that destroys their sense of self I think.

The notion of girls/women being passive and not having control is evident here, which sits with the idea of women being victims and unable to defend themselves: having to give in to male dominance. According to Gavey (1999) the hegemonic view of sexual violence offers identities to those who are subjected to it and victims are often seen as experiencing psychological problems. This might be seen reflected in Judith's comment about destruction of the sense of self. Other participants spoke of issues such as depression and anxiety which also seem to fit with the identity of victim. Some participants, however, focused more on their clients' strengths which seems to be more aligned to the concept of 'survivorship' rather than victimisation.

Extract 6: Sandra

> There's the courage that people demonstrate, the impact they have on others, their creativity and all sorts of things are again like the stones you put back in the wall [using the metaphor of dry stone walling]….I keep wanting to say the word shining…. some people do shine as a result actually 'cos they have got something they could never have had otherwise.

Orgad (2009) used the terminology of 'the envied wound' for the word survivor and suggested the notion of survivorship being seen as something somehow noble and brave, a notion which seems to be clearly reflected in Sandra's words above. It was often expressed that the work of therapy was to move (female) clients from being 'victims' to being 'survivors' and the participants tended to speak more of their clients as survivors than as victims.

For those participants who worked mainly with women, it seems that the feminine positions were those of victim or survivor whilst the masculine position was that of perpetrator. Positioning female clients in this way seems to maintain the status quo, because it does not appear to allow for male victims or survivors nor for female perpetrators. It also maintains the status quo because it perpetuates the gender dichotomy of male/female without apparent recognition that gender can be construed as fluid rather than fixed (Atmore, 1999).

4.2.2 Abuse and sexuality

Among the participants who worked with men, there was also the feeling that CSA has an impact on the man's sexuality, which was not something raised in the same way by participants who worked with women, where damage to her sense of self was the more frequent concept spoken of by participants.

Extract 7: Gabi

> In childhood sexual abuse, sometimes men feel they were made gay. They're not sure if they were gay or not, so you know your first question about infantile sexuality, I think often they just don't know. You know have they sexualised something that happened to them as a child, were they always going to be gay? It feels like that's a massive issue that continues late on in years and we see clients who identify as heterosexual who are acting out massively with men and they're really confused about it and don't know if it's about their abuse or about their sexuality.

Extract 8: Tom

> Because regardless of whether someone's heterosexual or not there's still a…. it's like well, if they are gay, there's been a….. like "is this what made me gay or am I actually not gay but I just think that's right [being gay] because of what happened to me?"

This seems to be reflective of the generally heteronormative position of society: that female children are abused by men, but for male children to be abused by men creates many more problems due to the potential same sex of perpetrator and 'victim'. In both extracts above there is a sense of the confusion felt by men about their sexuality. In Extract 7 the men who identify as heterosexual and who are acting out with other men "don't know if it's about their abuse or their sexuality". If it were to be about the abuse, their acting out with other men could potentially be to punish them for the abuse experienced. In Extract 8 the confusion is clearly expressed by Tom's words explaining what a client might ask: "Am I actually not gay but think that's right because of what happened to me?" It seems that confusion around sexuality is an important issue for the male clients with whom the participants worked. This too can be seen to link with the masculine ideal common in the Western world and the idea that alternative forms of sexuality other than heterosexuality are not acceptable. The desire not to be seen as homosexual can lead men who have been sexually abused as children to become quite homophobic (Sorsoli et al, 2008).

For the participants who worked with women, shame and blame around their sexuality seemed to be a key issue. This is also seen in much of the literature in which harm, mainly psychological, is assumed (e.g. Sanderson, 1995; Macdonald et al, 1995).

Extract 9: Sheila

> Off the top of my head that seems to be the biggest battle, the blame, the self-blame. Then how that filters through as well, sort of lack of trust of other people… lack of self-confidence, all of those things. Negative self-image. You name it, it's there. And equally I find there's a real struggle with clients where some of the sexual contact has been experienced, initially at least, as pleasurable. So the shame and guilt and my fault really piles on.

Extract 10: Joy

> I think there's reluctance from clients to want to even talk about any pleasure. They often want to believe they are responsible in some way and carry huge burdens of guilt and I think that guilt associated with the body may be another reason why it's territory that's very difficult to talk about.

This shame and self-blame can make it very hard for some women to go on to have a 'normal' sex life (Reavey & Gough, 2000) and thus the experience of women who have been sexually abused as children is to be pathologised through the fact that their sexuality is constructed as 'not normal'. Many 'survivors' link their sexuality to the CSA they have experienced (Reavey & Gough, 2000) and it is as if their sexuality caused the abuse and hence the self-blame of which the participants spoke.

In the western social context CSA is often construed as always harmful and the impacts are often discussed as 'facts' (O'Dell, 2003). Thus women and their therapists are offered only this view of CSA and what it does to those who experience it. So it would not be unusual for therapists to hear about self-blame and shame because that is how women are expected to talk

about their experiences of CSA. Exploring other ways of viewing the experience may be very difficult especially for those who work in specialist services as these participants did. Their organisations may not want them to see other ways of construing sexual abuse or indeed the people to whom it happens.

4.2.3 Summary

Men and women; feminine and masculine – the gendered identifications seen in how the participants spoke about their clients generally tended to support the hegemonic constructions of gender. Having said that, however, some participants who worked with men also talked about female perpetrators which might be seen as reverse of the usual gender constructions . Here the male might be seen as without power or agency, which is usually how women are seen. In addition, it is the female is this particular abuse scenario who has the power, a characteristic most often associated with men. So in the language usually associated with CSA it is generally assumed assume that 'victims' are women and 'perpetrators' are male, but it cannot be represented that simply: clearly men can be victims and women can be perpetrators.

In addition, participants' talk about the sexuality of their clients tended to support the heteronormative view of sexuality in the main. Yet Atmore's (1999) idea of rape being a feminising act for the victim and a masculinising one for the rapist does not support this. The question then might become: if a man is raped, is he feminised and if so is this unacceptable to him? If a woman is a perpetrator of sexual assault does this mean that she is masculinised and is that acceptable to her? There is a further complication in the law (Sexual Offences Act, 2003) in that women are not able to perpetrate rape, as they do not have a penis, only assault by penetration (with an object), so if women are not able to rape can they actually be

masculinised at all? These are difficult questions and ones with which therapists may or may not choose to grapple.

Therapists who work with CSA could be faced with this type of complication on a daily basis. The level of complexity associated with the above may possibly explain why the lure of dichotomous thinking is sometimes so strong. It can be easier to think in terms of masculine/feminine, pleasure/coercion, victimisation/agency and male perpetrator/female victim than to grapple with the complication of all of these being entwined together (Atmore, 1999). It could be, then, that therapists do not always face this complexity and, due to fairly uniform ways of viewing CSA, the specialist services in which the participants worked might not always encourage them to do so.

4.3 THEME TWO: THERAPIST AMBIVALENCE

The word ambivalence may be defined as "the coexistence in one person's mind of opposing feelings esp. love and hate, in a single context" (Concise Oxford Dictionary, p. 39). Or alternatively "having simultaneous, contrasting or mixed feelings about some person, object or idea" (Penguin Dictionary of Psychology, p.26). Therapist ambivalence with regard to CSA and clients who have had this experience was seen through their talk about both CSA how to work with people who have experienced it. Three sub-themes were identified: power, common themes of responsibility and blame and the effects of CSA. Context seemed to be the mediating factor for how each was spoken of.

4.3.1. Power

It was noticeable that power was a major construct associated with the participants' understanding of CSA and how they defined it.

Extract 11: Moira

> On the abuse side, I guess that for me that's any abuse of power. So someone has power over someone, could be a child or it could be an adult. Anyone who's in a position of authority or power over a child. And it's any abuse of power that has a sexual component, so it could be of that sexuality, it could be satisfying their own sexual desires through the child. It could be a number of different things, but I guess the main focus is that it's abuse of power and that has a sexual component.

Extract 12: Tom

> I guess for me it's something about….. anything from abuse of power, so I think going back to something like taking a photograph of a minor, of a young person, for any other reason than it being a photograph of them at the moment. If you're going to use it for different purposes, you know, I consider that to be abusive.

In these extracts the participants might be seen as expressing a negative attitude towards power. It is something that can be "abusive" and is used for the gratification of the perpetrator of CSA. The child being abused is positioned as having no agency and has had choice taken away from her. If the person carrying out the abuse is physically stronger and the abuse is carried out by force, then this may well be the case. However, not all abusers do use force in order to abuse, but may actually be very gentle in their touching (Sanderson, 1995). The participants' talk, however, does offer the notion that children had little choice in whether or not the abuse took place, could not offer resistance and so the potential of victimhood is introduced, in which 'victims' are seen as having no power.

The participants attitude to power, then, seems to be focused on its negative aspects. However, their feelings about it can seem to be more positively aligned in a different context. When considering the work of therapy part of what they focused on was the possibility of their clients having the power to make choices in their lives.

Extract 13: Moira

> Helping the person to come to a place where they accept that they might not be able to understand what went on or they can understand it on their own terms. That can release the emotional impacts and that enables choice for them, that they can make choices about what it is that's happened to them in their life.

The power to make choices was seen by Moira and other participants as a positive and key part of 'recovery' for clients. The notion of client choice though does not seem to take into account the situations in which clients found themselves. Emotional release may be one part of enabling choices as in Extract 13, yet it seems that there is more to it than that. For anyone, making a decision or making a choice is not a simple operation, it is not a simple case of what one does or does not want. Much humanistic counselling focuses on the individual and the personal (Wright, 2009) and some of the participants had been trained in this way. By focusing on the personal though, the social constructions of lives are not taken into account. Thus, in theory, an individual may have personal agency but in practice this may not be the case due to the circumstances in which she finds herself, e.g. financial constraints, housing problems, abusive relationship. These social aspects will impact on the person's ability to exercise her agency. The dichotomy of agentic-passive is an unhelpful concept as issues of agency are rarely so black and white: a person may have some choices open to her but free

choice seems to be rather a utopian ideal, due to the social constraints which affect in one way or another.

Power was also seen as related to knowledge along with the idea of expertise. As was seen in Chapter 2, therapists are in a powerful position due to their knowledge and the training they have received (Guilfoyle, 2002). Having said that the idea of being an expert was not a mantle that the participants wanted to wear:

Extract 14: Sheila

> I suppose I come from the standpoint I'm not an expert on anybody. They know their internal world and I'm there to kind of hear what they're saying and hear beneath what they're saying and I think very often as individuals we speak and we don't really hear what we're saying.

Extract 15: Gabi

> I mean, I feel like the time is led by them in terms of how we work together. I don't have a directive approach in that respect.

The participants here seem to be eschewing their expertise and deferring to their clients. The attitude to power seems again to be more negative than positive, as if it is something the participants were not comfortable with. Perhaps that discomfort comes from a rather polarised approach to the concept of power – either it belongs to one party or the other but not both. Yet can power be seen as the therapist's or the client's? Surely it is more fluid than that and can flow between the two parties and belong to them both.

The power of knowledge may also be seen in the following extracts.

Extract 16: Moira

> And I guess that's where you're working from the phenomenological frame. That's really difficult because you're holding that it's abuse and it wasn't appropriate, but I'm also holding the client's fragility and the client's 'well was it abuse or wasn't it abuse?', holding that at the same time, holding their reality not trying to force them into that reality of 'it was abuse' because of their understanding of it, so that's quite a balancing act.

Extract 17: Tom

> There are some clients who may not think it was abuse so then the relationship is certainly not about me saying 'you were abused'. Often the kind of initial goal in the therapy is to talk about it, often for the first time, for them to work out what the hell happened to them if they are able to.

There is also a tension here that might be seen as linking to Foucault's (1980) power-knowledge concept in which knowledge is seen as an important technique of power. In the therapy situation the therapist has knowledge: what the client has experienced is CSA. The client, however, is not sure about this, so does not 'know' that she has been sexually abused. The therapist thus has power, because she 'knows' it is sexual abuse and could 'make' the client know that she has been sexually abused. There seems to be a strange parallel here between the abuse and therapy. In the abuse situation that adult 'knows' something that the child does not and has the power to 'make' the child 'know' about sexuality by making her participate in some form of sexual activity. In the therapeutic situation, the therapist 'knows'

that what the client has experienced is CSA and has the potential power to 'make' the client 'know' that also. If the therapist operates from the discourse of disclosure – that it is important to talk about the abuse, then they may well use their power as described. Context, however, is important and the therapist may use their power, to give the client knowledge such that they have power to accept that what they experienced was abuse and go on to change positively. In the abuse scenario any change which occurs as a result of the new knowledge is most likely to be negative. The tension of the therapist knowing the client has experienced CSA and the client not knowing and how to manage that power balance was specifically noticed by Moira and Tom.

Power was a key concept in participants' understandings of what constitutes sexual abuse, and that the misuse or abuse of the power/position is a major part of CSA. This power is linked with knowledge: the adult who abuses has power because he has knowledge of sexuality and sex that the child does not or is not supposed to have. Attitudes to power were mixed suggesting an ambivalence about the concept. Power was seen as negative, positive and perhaps a little uncomfortable dependent on the context: in the hands of the abuser it was negative, in the hands of the person who had experienced CSA it was positive and in the hands of the therapist it appeared to feel a little uncomfortable.

4.3.2 Common themes: Responsibility and blame

Much of the abuse literature of the 1980s and 1990s (e.g. Bass & Davies, 1988; Draucker, 1992; Sanderson, 1995) recognises that blame and responsibility are issues with which the client has to grapple and with which the therapist needs to help. Further research (e.g. Reavey & Gough, 2000) has also shown that many survivors of sexual abuse, especially women, are likely to take on some blame for what was done to them. As was seen earlier, for women the

idea of blame seemed to be related to their sexuality and especially if they had experienced some form of pleasure during the abuse (Extracts 9 &10). Joy in Extract 10 and Sheila (Extract 9) both mentioned the concept of self-blame, with Joy saying that her clients "want" to feel responsible and "want" to feel that they must have deserved it. This seems to link with Reavey & Gough's (2000) work on survivors' constructions of self and sexual abuse in which they note that very often the survivors with whom they spoke did not apportion responsibility for their abuse to the person who had perpetrated it. Instead, these women often looked at their own part in what had happened to them. Reavey & Gough (2000) suggest that women do this because they speak from a position within discourses as women with all the social constructions that go with being a woman: for example that being a woman equals being passive and powerless. Thus if, as a child, she had fought back or screamed then the abuse would not have happened and as she did not do so, she is to blame. In addition women's survival strategies, e.g. dissociation or self-harm are often seen as "mad or bad" (Reavey & Warner, 2001, on-line) and so women are also seen to blame for being how they are following the experience of CSA.

The notion of blame however was not solely explicitly linked with sexuality. Participants saw that some of their clients generally blamed themselves and found it difficult to believe that it was not their fault.

Extract 18: Sheila

> More often than not working with adults and they know it wasn't right and they still blame themselves and they know it wasn't really their fault but the feeling is, actually yes it was.

Extract 19: Judith

> I think most of them understand it or view it through the perspective that they played a role in it. And so are very isolated, I think, the majority because of the shame, so they feel different to other people.

This does, however, seem to link with the gendered perspectives on CSA and that women may be seen to blame because they are women and did not fight or scream to stop the abuse. It also links in with the perceived 'differentness' of women who have been abused (Reavey & Warner, 2001, on-line). This 'differentness' is what produces mental health diagnoses and allows for therapeutic intervention, because somehow women who have been abused as children are not 'normal'. This can also be seen to link with comments from some of the participants who worked with men, who also saw that the effects of CSA made their clients feel as though they were different because they were not like "real" men:

Extract 20: Rachel

> It just erodes their masculinity…. It's not just the shame of being abused it's the shame of "I am not a man, I could not protect myself" and "This doesn't happen to men".

Men also can be seen to blame for how they are after the abuse as their responses to it might equally be seen as mad or bad, e.g. depression or substance misuse which was mentioned by some participants. Thus the medical or psychological perspective tends to pathologise those who have been sexually abused as children by giving them mental health diagnoses and subsequent treatment. It is as if the 'problem' is a personal mental health one rather than a

social one. The feminist perspective would refute this, seeing CSA as a social and political problem, potentially needing social and political action (Lamb,1999a).

Some participants tended to explain the way in which their clients self-blamed by using object relations theory which "places relationship at the heart of what it is to be human" (Gomez, 1997, p.1) and emphasises our need for others. Thus for a child it is important to see adults as good and safe as that is how she needs them to be for survival:

Extract 21: Sandra

> For instance self-blame is often a safer place to be living from: must have been something to do with me, must have been my fault, to sort of retain the good object concept of the person who you need to be a good person… they need to be retained as a good person as long as possible really.

This, of course, is a psychological explanation and so comes from a position of expert knowledge but helps the therapist to maintain a picture of the client as not to blame and also allows for her to see the client as reasonable for blaming herself. In the recovery literature (e.g. Bass & Davies, 1988) blame is always seen to be the perpetrator's and never the child's who has been abused: blame should always be laid at the door of the abuser and children can never be implicated in what was done to them sexually. Therapists may actually experience some ambivalence about this claim as they may see that, at times, children may have participated in what was done to them sexually. Lamb (1999b) gives the example of a young girl inappropriately touched by her grandfather and who knew that this would happen when she went to sit by him. She chose to view this touching as "an acceptable and enjoyable experience" (p.124) even though she had "a deep sense that a wrong doing was taking place"

(p.124). This gave the young girl a sense of control over the situation and when her mother discovered and ended what was occurring the young girl felt that she was made "a helpless victim without any control over what happened to [her]" (p.124). As was seen in Chapter Two and Section 2.3.3.4, in specialist services the concept of a child never having any blame for what was done to them tends to be seen as sacrosanct. Adopting this approach however can leave the child exactly as the helpless, passive victim that it would generally be preferable for her not to be. Perhaps, then, rather than telling clients that they had no part to play in having been sexually abused, it might be more helpful for therapists to explore what the value of holding that view might be for their clients.

4.3.3 Effects of CSA

4.3.3.1 Effects of CSA are negative

Although CSA is generally considered to be a traumatic and negative experience, as was demonstrated in Chapter Two, Section 2.2.2, the participants spoke about some clients for whom the experience of CSA was not reportedly wholly negative:

Extract 22: Rachel

> I have one client who said that it was never that bad for him because it was the only time that he got any affection from his father. So he valued it because it was the only time he got any affection.

Extract 23: Judith

> And I think there can be aspects of abusive relationships that clients feel very positive about and that they can take positive things from, so it's sort of no good

> separating out what was right and maybe that can be part of the process of them figuring out why that's so confusing.

It seemed that there could be positive aspects of abusive relationships, for example as seen in Extract 22 feeling affection from someone. It can be quite common for children to still love the parent who sexually abused them and this can cause confusion when they become adults. Some of the confusion possibly is having to accept good and bad in the same person: e.g. that a father was a really good father in some respects but really not a good father when he was abusing his child. Here the participants seem to be expressing the ambivalence that their clients feel about the CSA, but participants had no ambivalence about its effects themselves:

Extract 24: Gabi

> I've never thought about there being positive effects, because that feels like quite a perverse idea.

Extract 25: Rachel

> No, I don't believe abuse can ever have any positive effects whatsoever. I mean, certainly some people who have been abused have come out fighting and determined to make their way in life and succeed but they're the sort of people who would have done that anyway I'm sure. And there are better ways of making a child determined to succeed. I cannot see that abuse can ever have any, *any* positive effects whatsoever.

Although Gabi thought of the idea of positive effects as perverse she was open to considering this and did recognise that the experience could make the person stronger. She used the idea

of a woman who had been abused becoming a "hard core warrior woman". However, she also said that the idea of positive effects for her made it feel like one would be saying that the CSA was OK, which it was not. Rachel was not open to the possibility of there being positive effects, despite having had a client for whom the experience was not wholly negative. Although she accepted that some people who had experienced CSA might "come out fighting", she was actually very vehement about there being no positive effects and it seemed that she was not open to accepting the experience of one of her own clients. It seemed these participants took the position that CSA and its effects are wholly bad. This reflects a dichotomous way of thinking, which seems to be found in much of the abuse literature, (e.g. Bass & Davies, 1988; Sanderson, 1995; Macdonald et al, 1995) and does not allow for a more nuanced way of considering the phenomenon. Holding such dichotomous views may lead to the therapist closing down some avenues of communication with her client, for example not allowing her to explore where she might have experienced some of what happened positively. It seems that the therapy then would be more likely to follow the therapist's agenda rather than the client's. This would keep the client in the status quo of hegemonic discourse around CSA rather than allowing her to construct her own new narrative.

4.3.3.2 Was it even CSA?

Whilst the participants, when talking about CSA, expressed their clients' ambivalence about the effects, this was also expressed about whether or not what the clients had experienced was CSA.

Extract 26: Moira

> And I guess that's where you're working from the phenomenological frame. That's really difficult because you're holding that it's abuse and it wasn't appropriate, but I'm also holding the client's fragility and the client's 'well was it abuse or wasn't it abuse?', holding that at the same time, holding their reality not trying to force them into that reality of 'it was abuse' because of their understanding of it, so that's quite a balancing act.

Extract 27: Tom

> There are some clients who may not think it was abuse so then the relationship is certainly not about me saying 'you were abused'. Often the kind of initial goal in the therapy is to talk about it, often for the first time, for them to work out what the hell happened to them if they are able to.

Here the participants seem to be expressing the client's ambivalence towards what happened to them – was it abuse or not? The participants expressed their own ambivalence towards telling the client that 'yes it was abuse': they did not want to do so because of the client's fragility and because it is not their role to do so. However there was also the feeling that it was abuse and inappropriate and if that is seen as a 'truth', then surely the client needed to know about it?

'Having a lot of balls in the air', is an idiom which is often used when there is a lot going on as there is in Extract 26, yet Moira's words seem to suggest the opposite of this in that she is "holding" a lot of things, including the client's fragility. The use of the word 'holding' seems to imply protection or keeping safe: it is what parents do for children when they are hurt or

scared. Moira also did not want to force the client into another reality than their own – so again there is the sense of protection and being gentle with the person. Yet the balance between this and wanting the client to understand that they have experienced abuse, as this may ultimately help them, is a delicate one. Tom is more clear that his job is not to tell the client that he has been abused if this is not how he would name it. He would, however, work with the clients to try to help them establish for themselves what happened, which implies that it is acceptable for the client never to want to name their experience as abuse. Telling the client that what they had experienced was CSA might be seen as a use of power and one which might be seen to replicate the abuse dynamic: the client would be made to know something that they had not previously known in one case about sex and in the other about the nature of that sexual experience. This may be why these participants were ambivalent about telling their clients their (therapist's) views of what they (clients) had experienced.

4.3.3.3 Can effects of CSA be positive?

Aside from the idea that CSA can offer pleasurable moments as was mentioned in extracts 9 and 10, some participants when asked if the effects of CSA were always negative, seemed open to the possibility that there could be positive ones:

Extract 28: Sandra

> Well I can certainly think of quite a lot of clients for whom it's been extremely distressing and painful, and the cause of a lot of difficulties. But it's made them people who are really richly resourced and who care about others, fight other people's battles and all sorts of things…. They have got something they could never have had otherwise….. and wouldn't have seen themselves as overcomers in any way.

Extract 29: Sheila

> I can't say that I see much positive. Having said that, I hesitate, because I think… well I suppose the reason I do counselling is because my belief is that if somebody can come out the other end of it, then they have survived through it and they can be a stronger character in many ways, so as I said earlier, it's one I really struggle with because it's part of who they are… I do see the process of kind of coming through it as actually being stronger in some ways.

Sandra's and Sheila's comments could be seen to link with the literature on post-traumatic growth, which refers to "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedesechi & Calhoun, 2004, p.1). Joseph & Linley (2004) suggest that it is important to include the potential for positive outcomes when considering reactions to trauma and not just focus on the negative. These authors make clear, however, that a traumatic event itself cannot be perceived as positive but that the struggle with processing the attendant trauma can lead to positive outcomes in terms of post-traumatic growth. This is what the participants' talk seems to refer to: that there is the potential for positive to come from having been abused, but that the abuse itself cannot be seen in a positive light. Certainly, Sandra's use of the phrase "richly resourced" seems to suggest something of the positive psychological change mentioned by Tedeschi & Calhoun (2004). Sheila seemed particularly to struggle with the idea of positive coming from CSA and her hesitancy seemed to reflect the ambivalence that she felt. Both these participants, however, perceived that the clients had something that was 'good' that they would not otherwise have had: being "richly resourced", "being stronger". Yet there was a real reluctance to admit the potential positive and one wonders whether the fact that they worked in specialist services, in which CSA tends to be seen as universally bad, contributed to this. Extracts 28 and 29 also

seem to contradict the notion that CSA inevitably causes harm that lasts for an extremely long time, if not forever.

4.3.4 Summary

The participants held ambivalent views about power which was seen as alternately good, bad and uncomfortable dependent on the context in which it was being used. It was generally seen as good in the hands of the abused as it enables them to take some control of their lives. However, in the hands of the perpetrator of abuse power was viewed negatively, particularly as CSA was perceived to be a significant abuse of power. Some of the participants specifically alluded to the power in the therapeutic relationship and expressed a level of discomfort in that and preferred to see the client as expert rather than themselves. Yet clients go to see therapists because of their perceived expertise (Guilfoyle, 2002) and thus for a therapist to eschew this expertise, which gives them power (Foucault, 1980) could be seen as counter-productive: why should the client go to someone who does not have the required power as they could be seen as not having the required knowledge? It is understandable though that the therapist does not wish to position herself in a one-up position with regard to her client as this could be perceived as patronising. Thus there is a real tension to be managed by therapists when considering such a complex concept as power.

There is more tension to be managed when considering the notions of responsibility and blame. The participants generally saw the client as never to blame for the CSA she experienced. This uniform view, however, could potentially take some power away from the client, as she was not given the opportunity to have had any control over the abuse situation and was maintained as passive and powerless. As was seen above, this idea of passivity and powerlessness gets “turned on its head” when related to gender and the ways in which men

and women may be talked about in opposite terms, with him being the powerless victim and her being the powerful perpetrator. However, why should women only be powerful as abusers, surely they could be allowed choice in a situation which, in turn, implies some power? The notion of guilt and shame may be why therapists encourage their clients to rid themselves of any responsibility, as these are often seen as toxic emotions (e.g. Bass & Davies, 1988; Sanderson, 1995). Yet not allowing the client to choose to frame the experience as in some way pleasurable or chosen (e.g. Lamb, 1999b) could be seen as a continuation of disempowerment when usually therapists wish to do the opposite.

As was seen in Chapter Two, Section 2.2.4 there is often seen a need for CSA to be seen as harmful in the long term , especially by the legal system. Thus therapists may often feel that they have to support the notion of harm and indeed CSA is generally seen as harmful (e.g. Draucker, 1992). Some of the participants were vehement that CSA was always harmful, but some of them spoke of their clients having "something" they would not have had they not experienced CSA: a strength of character and a real resilience. Thus it could be seen that CSA is not always and forever harmful: it is not that simple. So, these mixed feelings about CSA being harmful that were expressed by some of the participants suggest that the harm narrative can be disputed and it is to this notion that the thesis will now turn.

4.4 THEME THREE: DISPUTING THE HARM NARRATIVE

The notion of CSA causing long lasting harm has been clearly seen from the literature review and certainly some of the participants viewed CSA as wholly negative and harmful. However, if there are potential positives that can arise from the experience, as was seen in the previous section, then perhaps one cannot assume that CSA is inevitably and always harmful. Indeed, Levett (2003) suggests that women who have experienced CSA are no more

psychologically disturbed (harmed) than women who have not had that experience. From the literature review it was also seen that hegemonic perspectives of gender tend to identify women as passive and helpless and therefore unable to 'fight back' against the person who abused them. This might also be seen as true for children, whether boys or girls. Yet the participants in this study spoke of their clients in ways that disputed the notion of inevitable harm, for example they spoke of their clients' strengths and their unique ways of responding to the abuse they experienced. This chapter will now look at ways in which the participants disputed the harm narrative.

4.4.1 Client strengths and empowerment

A brief search on the internet shows that many counselling organisations/therapists see empowerment as a key issue for therapy. Simply put, empowerment might be defined as 'becoming powerful' (Skills You Need, on-line). The participants in this study saw that their clients had been so disempowered when the abuse was happening and so wanted to offer them a way of becoming more powerful.

Extract 30: Moira

> Helping the person to come to a place where they accept that they might not be able to understand what went on or they can understand it on their own terms. That can release the emotional impacts and that enables choice for them, that they can make choices about what it is that's happened to them in their life.

Extract 31: Judith

> So I think that being able to sit with that [distress], no, not rescuing, although that can be really difficult for me, I don't know that how empowering… trying to

> support the client to feel more powerful in their life… I think that's one of the most important bits for me.

Moira seems to focus on the concept of empowerment providing choices for the person. These choices can relate to what it is that has happened to them in their life. This implies that someone who has experienced CSA can make decisions about what that means for them. This allows them to choose not to be defined by the CSA and not to allow others to define them by it either. This could be seen to link with the concepts found in narrative therapy which sees therapy as a social process rather than a psychological one and in which the client can "construct different or preferred relationships with other individuals, groups or institutions" (McLeod, 2006, p.202). Judith also sees empowerment as important and she went on to say that it was to allow people to find their own way through the experience. Children who experience CSA are inherently powerless (Morrow & Smith, 1995) and that feeling of powerlessness can persist into adulthood. So enabling clients to feel powerful can be a way of giving them back control over their life and what happens in it. By seeing their clients as more powerful and not defined by the CSA, participants are suggesting that the harm is not inevitable and long-lasting; it can be left behind as changes are made. However, as was seen in earlier in this chapter (Section 4.3.1) choosing is not a simple concept and there are many things that can constrain a person's free choice.

Alongside the concept of empowering clients was the idea of helping them to see what strengths they have. Helping them to see where they have strengths can help them to believe that they can be empowered.

Extract 32: Joy

> So it seems really important to work in the present a lot and reinforce their strengths in the present, so that in a way anything that might undermine their memory of how it was, is sort of balanced.

Extract 33: Sandra

> Working on the person's resourcefulness really. How resourced are they? What have they got that works? What do they do well? Thereafter once we've established the relationship, it'll be how well they're coping and try to work on their strengths as being part of what we need to utilise.

Joy's talk of balancing in Extract 32 could be seen to recognise that not everything in a person's life was bad. Although the CSA might have been very negative, the clients do have strengths and positives in their life now to counteract that. Sandra specifically referred to the person's resourcefulness and finding out what worked for the person and thus how they could continue to build on that. The implication in these extracts is that a person finding and using their strengths enables them to be empowered. Clients can be encouraged to construct their own ways of being that position them beyond the therapy room and no longer in a power dynamic. Giving clients back power, however, can be a difficult undertaking due to the different positions of therapists and clients. Therapists are in a powerful position partly because of their knowledge but also due to the material structures within which they work, e.g. organisations, consulting rooms (Guilfoyle, 2002). As was seen earlier, some of the participants recognised this power potential and were active in wanting not to have that power.

Saha et al (2011) suggest that finding a positive sense of self enables people generally to cope better with their emotions and with life. Working with people's strengths seems to be a way of them developing that more positive sense of self, so working in the present to reinforce strengths (Extract 32) might be seen to be very important. There is also the implication that in so doing the assumed harm will lose some of its power to keep on hurting the person.

4.4.2. The uniqueness of clients

In the literature review, section 2.2.2, it was shown that there can be mediating factors for the effects of CSA. These factors have an impact on the level of harm that a person might experience. As Hunter (2008) found in her research, some people who had early sexual experiences claimed not to have been harmed by them at all. The participants in this study also mentioned the uniqueness of their clients and that the impacts were not all the same for everyone. There was talk of the impact depending on many things:

Extract 34: Moira

> I think there'll be varying degrees of how far the scar is healed over but that will depend on coping strategies. It'll depend on whether it's the first time or there were lots of different times.

Here Moira makes the point that how much the abuse affected a client might depend on how often it happened. Linked to this, in the literature it is also suggested that the level of force involved, the age of the child when the abuse happened and who the perpetrator was can all have an impact on the level of effect (e.g. Crome, 2006). This is a move away from the often expressed view that CSA is always extremely damaging and certainly disputes the

experiencing of an extreme level of harm. Moira also talked of coping strategies and this was echoed by Sandra.

Extract 35: Sandra

> I think they're copers, they often have used the strength they needed to cope when things were bad and using those talents and abilities, possibly unwittingly to be helpers…. Out there helping people, being busy, possibly taking [a toll on] their well-being, looking after others…. Sometimes people displace a great deal of distress by working it out in a fairly heroic way or something.

Extract 36: Moira

> In my experience I guess there's levels of functioning aren't there? That some people may be very high functioning, some people might be, er, lower functioning – I don't like that term, but….. function less well in their environment and the fact that they have those things to process, on some level has to have an impact.

Dependent on their coping strategies people who have experienced CSA might go on to help others. The fact that they are identified as having strengths, talents and abilities (Extract 33) which have helped them to cope suggests that there is not only harm in their lives from having experienced CSA. Moira's talk of levels of functioning suggests that those who were functioning well may experience less harm than those who were functioning less well. This is supported in the literature, for example Mannon & Leitschuh (2002) offer the idea that the effects of CSA are influenced by how well the child was functioning in emotional and social terms before it happened. In addition, Feinauer et al (2003) also identify that there are

personal characteristics or resources that can allow abuse to be experienced with less distress than those without these resources may experience. A uniform perspective of the harm caused by the experience of CSA is challenged in extracts 34-36. There is a range of things that mitigate the effects of the CSA and thus assuming that it is always harmful is an unhelpful position to adopt.

4.4.3 It will always be there

Having looked at the factors that mitigate the effects of CSA, it is pertinent to note that some of the participants in the study focused on the idea that the effects of the abuse could not be taken away: it could never be as if it had not happened.

Extract 37: Gabi

> Because I guess my perception in terms of how I think about the work is that you're never going to take away what happened and perhaps a realistic goal might be that you start to understand yourself better, you start to notice triggers and be able to manage them better and have a better support system, but it's never going to take away what happened.

Extract 38: Sheila

> Because I think sometimes, when people come to counselling, they hope they can forget it. And actually to forget wouldn't do justice to the pain it causes for me.

Gabi spoke of a realistic goal being for the client to understand himself better and manage situations better, this together with the idea of the impossibility of it being as if the CSA had not happened suggests that she may have had clients with this as their goal. However, the

perceived damage caused by the abuse means that this could never be the case. Sheila picks up on the idea of wanting it as if the abuse had not happened and suggests why it would not be good to forget the abuse even if one could. In these extracts the feeling is of something that is wrong and damaging and which causes a great deal of pain: such pain that even though the effects of the abuse might be able to be dealt with they can never be forgotten. A link to the harm narrative is seen here but not in the manner of the harm lasting forever: the memory stays but the harm can be overcome. This is a move away from the generally held view, that is represented in the media, of the harm being long-lasting such that those who have experienced CSA can never really 'get over' it. The disputation of the harm narrative, then, is that the harm can indeed be overcome and people who have experienced CSA can 'get over' it.

4.4.4 Summary

The participants in this study all expressed the view that harm was caused by the experience of CSA: a view which may have come from the environment of the specialist sexual violation services within which they worked. In addition, the way that CSA is generally portrayed in the media also tends to assume that it is always harmful, as was seen in section 2.2.3. Again, however, it is not that straightforward: as Levett (2003) purports, women who have experienced CSA tend to be no more psychologically damaged than many other women who do not have the experience and some of the participants in this study were open to that being the case. One participant talked about the assumption of harm and the perception among some agencies that if someone has experienced CSA then that must be what has to be addressed in therapy. However, if someone has also experienced a recent bereavement or lost their job, then that might be currently much more 'harmful' for them. So the notion of harm does not have to be seen as uniform and furthermore it might be seen as a many layered

phenomenon and the therapist should not assume which layer needs to be worked with at any one time.

Some of the participants' talk also disputed the harm narrative in that they saw a client's experience as more than simply abuse and that there were positive aspects in their lives too. It is easy for the abuse to become all-pervading and all that a client's life is about, yet the positive aspects have helped the client to develop strengths and resources. So not only might there have been positive experiences in a child's life, even if they were being sexually abused, that should not be discounted, but there are positive aspects to the adult's life too. These positive aspects allow clients to work in therapy and "come out the other end" (Sheila) without all the pain and hurt although the memory of what was done to them remains part of their life narrative.

4.5 ANALYSIS – CONCLUDING THOUGHTS

Working from a social constructionist position questions taken for granted ways of viewing the world and what happens within it (Burr, 2003). Therefore, taking a social constructionist position, as the researcher has, with regard to CSA questions taken for granted ways of viewing that phenomenon. In the literature review of Chapter Two, and in particular 2.2.2 and 2.2.3, it was demonstrated that CSA tends to be seen as uniformly harmful and that the negative effects are seen to be very long-lasting. The researcher's role was to question these taken for granted ways of viewing CSA. Questioning taken for granted ways of viewing CSA was seen in feminist constructions (section 2.2.4), some of which questioned the harm narrative. Challenging some of the paradigms within CSA (section 2.2.6) such as the role of 'victim' or 'survivor'(e.g. Hunter, 2010) also questioned the taken for granted ways of viewing CSA and those who had experienced it.

The above analysis has focused on ways in which taken for granted ways of looking at CSA might be questioned, as well as considering therapist constructions of CSA and their clients who have that experience. Taken for granted ways of looking at gender tended to be supported by the participants in this study. Those who worked with men expressed the view that it was worse for a man to have been abused as a child than for a woman because of the impact on the development of his masculine identity. Those who worked with women did not seem to question gender identity which perhaps implicitly supports traditional views of women being passive and weak. The notion of individuals having no responsibility or blame for their abusive experience also supports the notion of passivity and helplessness, yet the idea of people having had some responsibility seemed to be an anathema to some of the participants. Allowing those who have been abused to frame themselves as having had some part in what happened to them, also allows them to frame themselves as having had some control, which is not at all a usual way of viewing the dynamic of CSA.

The idea of people who have been abused having had some part in their experience might be seen to link with the notion of power. Generally people who are abused are perceived as having had no power, so participants in this study tended to want to work towards empowerment for their clients. That they wanted to do so suggests that they did not take the view that CSA was always and forever harmful. There was a general view that CSA was indeed harmful, but there was also the expression that it was possible to process that harm and not be harmed forever. This suggests that in their construction of CSA, possibly together with their construction of therapy, the participants did not all take the hegemonic view of CSA as generally presented in society.

A uniform view of CSA was supported in some ways by the participants, in that it was seen as harmful and individuals who had experienced it were seen as powerless and without responsibility. However, some participants also recognised the potential positive aspects of the abused individuals life: both that her life was not only about abuse when she was a child and also that her life now was also not only about abuse. There was also the challenge from one participant to the notion that sexual abuse is the worst thing that can happen to someone. The concept of an individual who has experienced CSA having a strength of character and a resilience that they may not otherwise have had was also expressed by some of the participants in the study. All of these aspects and ideas challenge the taken for granted ways of viewing CSA and its effects.

Some of the participants in this study did not question taken for granted ways of seeing the world, indeed they supported the commonly held views about CSA and those who had experienced it. However, some of the participants did challenge those views, which suggests that they might not close down conversations about blame or responsibility, that they might not even assume that the CSA is what must be spoken about if there are other things that the client wishes to work on. By adhering to the dominant views of CSA, therapists who express the desire to empower their clients, might actually be taking agency away from them by closing down certain avenues of conversation, certain ways of being. Questioning those dominant views is not about saying that CSA never does harm or that it is OK but it is about not assuming things about people and their experience. By not making those assumptions, therapists can truly be open to their clients and make the therapeutic process as transparent as possible.

CHAPTER FIVE – CLINICAL IMPLICATIONS

5.1 SUMMARY OF THE ISSUES

This study has considered a range of the literature on CSA and also examined how the participants in this study spoke about this phenomenon and their clients who had experienced it. At this point, it would seem appropriate to summarise the understandings and issues which were discussed in the previous chapter.

The ways in which therapists position clients has an impact on the way in which they work with them. There was strong potential for therapists to maintain the status quo regarding gender relations and identity as McLellan (1999) claims that mainstream therapy does. Some of the therapists in the study held the view that being sexually abused was worse for men than for women because of the ways in which society constructs gender identity. This will have implications for how they work with those men and for how change in the lives of those clients might be achieved. Equally how women are positioned will affect how they are worked with in therapy. The possibility for them to be denied any responsibility for the abuse they experienced as children may uniformly present them as passive and powerless.

Following on from this, there was a level of ambivalence in how the participants saw some of the issues surrounding CSA, in particular issues of power and how it is used by therapists, as well as whether or not clients could become powerful. This links with the concept of responsibility and blame, because if clients are held never to have any responsibility for the CSA they experienced, they may be held in a position of having had no power, so there is then the question of how can they become powerful or be empowered. In the organisations within which the participants worked the idea of clients having had any responsibility at all seems to have been unacceptable: perpetrators are to blame for CSA and not (never) the

person who experienced it. This in turn links with the views on the effects of CSA. In much of the recovery literature (e.g. Bass & Davies, 1988; Ainscough & Toon, 1993) the effects are seen as uniformly negative and yet some of the participants, reluctantly saw that their clients could gain something from the experience. Their reluctance possibly sprang from the organisational context within which they worked and the generally held perspective that CSA is always and uniformly harmful.

The notion of those who have been sexually abused being able to gain something from the experience seems to mitigate against the idea that CSA is always and inevitably harmful. In the way that some of the participants spoke of their clients, it was possible to see that there was some disputation of the harm narrative that is generally associated with CSA. The concept of clients being well resourced with strengths was mentioned, as was the unique way in which they responded to what was done to them, with particular regard to factors that mitigated against the severity of harm. It was seen as wholly possible to work with a client's strengths and resources to enable her to become more powerful in her life. Having said that, at times it was seen that engagement with the concept of agency was from a dichotomous position: agency is either possessed or not, rather than reflecting the nuances of the issues around power and decision-making.

5.2 CLINICAL IMPLICATIONS OF THE ISSUSES RAISED

The way in which someone thinks about an issue and the way in which they construct that issue will strongly influence how they respond to it (Burr, 2003). Thus how a therapist construes CSA will strongly influence how they respond to and work with it. This chapter will now move to examine the implications of what the participants said about CSA and their clients who had that experience and also suggest some practice recommendations for

consideration. In particular the chapter will look at some or all of the following in relation to each of the themes identified in the analysis:

- How the different constructions of CSA and the positions these offered to clients and to therapists (participants) affected what could and could not be spoken about in therapy, including the perceived uniformity of the CSA construct.
- Participants' understandings of distress and the 'expert' position that some of them took up to reduce this in their clients.
- Issues of agency and responsibility and how participants engaged with these.
- The impact of organisational context.

5.2.1 Gendered identifications

In some of the literature on male sexual abuse (e.g. Simpson & Fothergill, 2004; Little & Hamby, 1999) there is the suggestion that disclosing CSA is more difficult for men because society tends to expect them to have been its perpetrators rather than its victims. In accordance with this view, some of the participants theorised that having been sexually abused as a child was worse for a man than for a woman because the perceived impact on his gender development was so much worse than for a woman. This links with the concept of agency because the idea seemed to be that men in society are expected to be powerful and able to protect themselves, even as boys, whilst women are expected to be passive and powerless. Thus, for the participants who construed CSA as worse for a man, it was because it is somehow more shaming for a man to admit that he had been abused as a child than for a woman. In the CSA scenario children of either sex might be seen as being powerless (e.g. Sanderson, 1995; Macdonald et al, 1995). Being positioned as having had no agency with regard to the CSA can also mean that participants' clients might be positioned as having had no responsibility for what was done to them. This construction is likely to close down any

possibility of talking about the how the client might choose to view the abuse other than as a dreadful experience over which they had no control. As was seen in the last chapter, Lamb (1999b) presents the example of a young girl who chose to view the abuse as an enjoyable experience because *it gave her a sense of control over it.*[Emphasis added].

Whilst a therapist might not overtly tell a man that CSA was worse for him than for a woman, that belief is likely to inform the therapy that she conducts (Burr, 2003). It was seen in section 2.2.5.2 that men find it difficult to disclose experience of sexual abuse as a child (e.g. Sorsoli et al, 2008). Thus if a therapist were to communicate, albeit implicitly, the view of CSA being worse for a male client than for a female client, it could potentially add to the shame the man experiences and stop him from speaking out as he might wish to. Potentially this could lead to him 'dropping out' of therapy and not getting the help that he went for. One of the participants who worked with men who have been sexually abused raised the issue of premature endings of therapy and one might wonder if these endings occurred not only because the men found it hard to speak about their experiences but also because they were inhibited from doing so by their therapist's assumptions.

The idea of pleasure in the experience of CSA was raised both by participants who worked with men and those who worked with women. When it was suggested to one participant that a young woman who had experienced CSA at the hands of her mother had enjoyed some of it (in particular watching pornography), the participant said that the young woman was defending against the awfulness as a self-protective strategy. There seemed to be no possibility that this statement of enjoyment could be taken at face value. This participant seemed to use her expert position and knowledge as a therapist to decide what the experience of the client 'really' was. Were this young woman to have been this participant's client she

might well close down any talk of enjoyment and thus some of her clients' experiences might not be open for exploration.

In section 2.2.5.1 it was seen that women are often positioned either as victims or as survivors. The position of victim tends to imply powerlessness and distress whereas the position of survivor tends to imply somehow having overcome the victimisation (e.g. Bass & Davies, 1988) through personal strength and resilience. Some of the participants' engagement with distress was from the perspective of trying to reduce this in their clients and move them from the position of victim to that of survivor. The focus was often on internal strengths and resources and how these may be used to reduce the individual's distress. The potential here is for conversations about the awfulness of the experience (if indeed it was experienced that way) and distress to be closed down and the client feeling that she "has" to move from victim to survivor. This way of working tends to offer only these two positions to individuals who have experienced CSA and does not allow for people who do not wish to be labelled with either (e.g. Hunter, 2008). It could mean that conversations that do not fit with either of these labels may well not take place and, thus, therapists could miss the opportunity to hear and understand what is important to their clients.

5.2.2. Therapist ambivalence

One of the key issues was that of power, with therapists having differing perspectives of the concept depending on whose hands the power was seen to be: simply speaking, it was 'good' in the hands of the client, 'bad' in the hands of the perpetrator and somewhat uncomfortable from the perspective of participants. With regard to therapist power, organisational context is important as this tends to emphasise the therapist's potentially powerful position: she has degrees, possibly other qualifications, a consulting room, a professional identity, all of which

demonstrate her knowledge and confer a level of expertise (Guilfoyle, 2002). Many organisations also carry out measurements of clients' progress during therapy which means that the therapists must demonstrate expertise through clients' improvement in therapy. In this way they [therapists] can be seen to be successful. Measurement, which is usually by questionnaire, assumes a measure of success that will fit for all the people who go through a particular service: they all have to complete the questionnaires. In order for success to be demonstrated, therapists may use the power of their position to adopt a way of working that delivers the required outcome in order to be 'successful'. One cannot assume that this is always the best thing for the client and may close down avenues of conversation that might mean the required adjustment is not achieved. These occluded avenues of conversation could be exactly where the client would like to go.

The participants in this study seemed to want to eschew the power associated with their position, yet the fact that they adopted a position of encouraging choice and empowerment in their clients suggests that they did actually use the power associated with their position. The perceived uniformity of CSA can be linked with the concept of therapist power: CSA is construed in a particular way, generally as extremely harmful with that harm being long-lasting and very distressing for the individual who has experienced it. There is, therefore, an approach to therapy which aims to reduce the individual's distress and develop her strengths and resources to allow her to move from victim to survivor. The therapist uses her knowledge and hence her power to work towards this happening. This way of working does not allow for other constructions of CSA to be worked with. Thus conversations about it "not having been that bad" are not likely to be held, along with those that consider the power and agency of the person having been sexually abused.

The concept of the agency of the person who has been abused also links to the notions of responsibility and blame. As was discussed in section 4.3.2, many women, in particular, tend to blame themselves for the sexual abuse they experienced as children. The participants in this study took the view that their clients were never to blame for the CSA they experienced without apparently realising that this could actually deny those clients the very power and agency that they desired to give them. The position the participants took tended to be that when they were children being sexually abused, their clients were innocent and powerless and to a degree had remained in that powerless position or else why the need to empower them? Adopting this position would potentially close down conversations about the client's responsibility at the time of the abuse. If a client was 'allowed' to have some responsibility, she could see herself as not totally powerless and out of control which might help her to develop a sense of agency in the present if necessary. It seems, though, that participants' engagement with notions of agency and responsibility were around the possibility of their clients, as adults, developing these abilities but that they did not seemingly have as children.

The perceived negativity of the CSA experience was one that the participants all shared and this links with the idea of irreparable harm as discussed above. Having said that, some participants were also open to seeing their clients having something that they would not otherwise have had. This does allow for a more nuanced approach to CSA and rather than closing down avenues of conversation around the CSA experience could allow for ideas of it "not being that bad" or "I am not that damaged" to be spoken of. The participants who spoke of the potential positives did so somewhat reluctantly, as if they should not have been expressing such thoughts. Yet the very fact of them being open to other than the usual constructions of the total negativity of CSA means that they would probably offer their clients a wider repertoire of options for talking about the CSA that they had experienced.

5.2.3 Disputing the harm narrative

The generally held view of CSA is that it does much harm which has long lasting effects on the person who experiences it (e.g. Sanderson, 1995; Bass & Davies, 1988; Macdonald et al, 1995). Clinical research also argues that CSA has major negative effects on those who experience it. For example, Alexander et al (1989) suggest that depression, fearfulness, social isolation, difficulties trusting both men and women and an increased risk of victimisation are likely in those who experienced CSA. Levett (2003), however, suggests that women who have been sexually abused are no more psychologically damaged than women who have not had this experience. It was seen in the last chapter that all of the participants saw CSA as being harmful, but there was also a disputation of the harm narrative through the focus on client empowerment, client strengths and their unique response to their CSA experience.

In Extract 30, Moira suggested that clients can make choices about what happened to them in their life, which must, by necessity, include CSA. This seems to link with the idea in the last section that individuals who have experienced CSA should have the freedom to frame the experience as they wish and that this might help them to deal with the issue. Thus a client might choose to say that the CSA had not been that damaging (e.g. Hunter, 2008) and for the therapist that could be acceptable. The therapist could choose to use her knowledge and therefore her power to 'make' the client understand the damage that was done to her, but this could be seen as paralleling the abuse dynamic. Therefore, it would possibly be more beneficial for the client if the therapist were to work with the client's view and accept that she experienced little harm. This could open up some very different conversations than those associated with the assumption of harm and may lead to the question of whether any therapy is needed at all.

The participants in this study understood that CSA was harmful to clients and led to distress. They also spoke of working with their clients to identify their strengths and to empower them to become who they wanted to be. The assumption here is that it is not acceptable for clients to be distressed and thus working with their strengths to move them to a more positive outlook is seen to be warranted. Whilst CSA is believed to be harmful, there is also the implication that the harm does not have to be long-lasting because therapists can work with client strengths to help them to become distanced from the harm and live their lives in a more positive manner. The issue here is that the agenda for therapy may become the therapist's rather than the client's. So the participants who did not want to accept the power position in the relationship may find themselves doing so anyway as they decide how the work should be undertaken and where the focus should be, (that is moving away from assumed distress).

It has been suggested that the experience of CSA produces loss for the individual and that this loss is similar to that usually associated with bereavement (e.g. Dale, 1999). Generally it is accepted that it is important to grieve (e.g. CRUSE) which often involves expressing distress. It might be seen as important, then, that people who have experienced CSA are allowed to express their distress and that talk of strengths and empowerment does not stop this from happening. In the previous section the notion of measurement was raised and many therapy organisations have some form of this to demonstrate that there work is effective. The idea that improvement must be seen to be happening so that the organisation can claim success in its work may well have an impact on the work of the therapists in dealing with a client's distress. This may be particularly pertinent when the therapy is time limited. The client must be seen to have improved and therefore the therapist cannot allow several sessions for grief work, but may be expected to move the client away from distress so that the measure shows an improvement in her mood at the end.

Therapeutically, there seems to be a real tension here: CSA is perceived as harmful and for some therapists the harm was seen as inevitable and long-lasting. This harm is also viewed as very distressing for clients. However, there is also the need from an organisational perspective to move clients away from the distress. If this can be done then the implication is that the harm may not be so long-lasting and the corollary of this is that maybe it was not so bad in the first place. The issue is: how does the therapist hold the notion that the harm is so awful and long-lasting with the idea that in 18 or 20 sessions the client should not be experiencing the level of distress that they were when they arrived in therapy? Perhaps the therapist has to be more open to allowing the client to define the harm and to accept at face value those who say that "it really wasn't that bad". For those clients for whom "it really was that bad" perhaps staying with the expression of distress rather than focusing on strength and empowerment might be a useful thing to do, if necessary referring them to a longer term service.

5.3 RECOMMENDATIONS FOR PRACTICE

5.3.1 Power positions and being 'expert'

Guilfoyle (2002) suggests that therapist power must be made explicit rather than ignoring it and then possibly engendering client resistance, which has the potential to hinder the work of therapy. The most appropriate approach for a therapist to take might be to allude to the issue when they accept a new client on their caseload. She would perhaps not explicitly say that she knows she has more power than the client but she could talk about the way in which she works. In this way she could be explicit about not giving herself "expert" status and explain why she does not do this, which would be to do with the notion of a client being their own best expert. The notion that the therapist 'knows' and the client is 'known' might be seen as part of the subject positions of the therapeutic relationship. In traditional therapy, for

example psychoanalysis, the therapist was very much positioned as expert and the one who 'knows' to the extent of 'knowing' the client's unconscious (e.g. Lemma, 2003). The idea of the therapist 'knowing 'something that the client does not was highlighted in Section 4.3.3.2 in regard to the therapist's knowledge that a particular experience was 'abuse'. In the way, then, that the therapist might wish to allow the client to be her own best expert, she may also wish to encourage the client to define what happened to her rather than offer what she, as a therapist, 'knows'. Some clients want to ascribe power to the therapist and do not think they can be their own best expert. In this case, the therapist may need to be open about her qualifications and knowledge but be explicit about her role as facilitator rather than advisor. This was seen among the participants in the study who saw their role as helping people to work out "what on earth's happening here" (Sandra).

It is important, therefore, for the therapist to have a keen awareness of the power issues associated with the therapeutic relationship. When contracting with clients she can explicitly address the power issue by explaining how she works and why. It would also be important for the therapist to continue to monitor herself throughout the therapy to be sure that she is maintaining a collaborative, dialogic way of working. Feeling resistance from the client can offer opportunity to explore whether or not there are unacknowledged power differentials at play (Guilfoyle, 2002). Possible power differentials can be dealt with by the therapist being open to discuss them as she explores the process of therapy with the client.

5.3.2 Post-modern approaches to therapy

Unlike the traditional approaches to therapy, post-modern approaches do not diagnose or judge (e.g. Warner, 2003). Instead the therapist is open to the client and to her reality. The therapist, therefore, needs to challenge her own assumptions about CSA and the impact that it

can have on an individual and be open to the possibility of it having less (or even more) of an impact than she might imagine. The work of therapy is to help the client to change her reality if she so wishes. Narrative approaches are concerned with understanding the person's story of her life and helping her to rewrite that story. This means allowing the client to have her own frame for her life and changing that frame as she desires. Thus if a client frames herself as having some responsibility for the sexual abuse she experienced, rather than say that she did not, the therapist could allow her [client] to maintain that frame if she so wishes and if it seems helpful to her. Furthermore if the client's reality is that the abuse was not that harmful to her, it is entirely appropriate for the therapist to accept that reality and also question if therapy is really required.

In working with those who have been sexually abused it is important that the therapist does not pathologise the client or focus solely on her problems (Woodward & Joseph, 2003). Hearing the client's story and the meaning which she assigns to it is important if that is what the client wishes. This can help the therapist not to make assumptions about what the experience of having been sexually abused might mean to any one individual. Positioning the client as expert is not usual in traditional therapy but is a key part of post-modern therapies and can be part of the client finding their strengths and being empowered (Anderson, 2001). There may be clients who do not wish to speak about their experiences but simply wish to focus on how they would like their lives to be different. Therapists who work with models that have protocols for disclosure of CSA may not be comfortable with this but solution focused therapy works in exactly this way (e.g. Hinton, 2011).

The post-modern therapies appear to encourage therapists to leave aside any preconceptions they might have about an issue and to hear the client's story. They may then work with their

clients to rewrite the story as the therapeutic dyad co-constructs new possibilities for how the client's life might be (e.g. Anderson, 2001). This seems to be a preferable way of working with someone who has been sexually abused as a child. Traditional therapies risk seeing the client in a certain way – often ill rather than just distressed. Their protocols may risk 'making' the client 'do' things or 'be' a certain way. Many clients who have experienced CSA have possibly been 'made' to do enough in their past. On the other hand, the openness of the post-modern approach does not make assumptions about the person's experience and so may work too for those who do not feel that the CSA did them major harm (Woodward & Joseph, 2003).

5.3.3 Organisational context

As was shown in section 2.3.2.4 the organisational context can have a significant impact on therapy for those who have experienced CSA, particularly if the organisation is a specialist sexual violation service, as was the case in this study. Often these organisations tend to adopt a uniform view of CSA as harmful and position the client as never having any responsibility for the CSA that they experienced. Perceiving CSA is as a uniform experience can potentially lead to only one way of engaging with it which often supports the assumptions that therapists might make about the nature of the effects of the experience and the sexually abused person's part within that. The likelihood is that this does not leave space for the sexually abused person who does not feel that they were harmed by the experience. It also means that the person who frames their responses to the CSA in the way that means they had some responsibility for it, may well be persuaded to eschew this reality and accept that they had no part to play and were, indeed, passive and powerless.

In engaging with clients who have experienced CSA, organisations also tend to adopt the strengths approach to empowering them. This is because they have to have success measures in place to show that they are making a difference in the lives of those people they claim to be helping. So whilst they accept that CSA is very distressing, some specialist organisations try to move people on from their distress when it might be more appropriate to allow their clients to grieve.

If organisations, and therapists within them, truly wish to offer unconditional positive regard (Rogers, 1980) to clients, they perhaps need to accept clients' realities and not impose 'expert' views of CSA on them. They need to work with clients in the ways that clients wish and have a transparent view of therapy and the processes that happen within it (Warner, 2003).

5.3.4 Levels of complexity

As has been shown, CSA is a multi-faceted and multi-layered phenomenon. Dichotomous ways of thinking are not helpful when dealing with people who have had this experience. It would be easy to represent CSA as 'bad' (rather than good), and those who have experienced it as having been powerless rather than allow them to frame some agency in the matter. This, though, is much too simplistic an approach, albeit one which some of the participants in this study seemed to have adopted.

When engaging with someone who has been sexually abused understanding the levels of complexity involved is key. For example, a therapist who wishes to work towards empowering her client needs to recognise that agency is not simply a matter of having choice or not. She also needs to realise that in a social context choice is not that simple and there

may be many things in a client's life that constrain her choices. This means that working with the client to identify the strengths that will help her to be empowered to choose is not sufficient. Exploration would also need to be made of the context of the client's life, the options that she might have open to her and the consequences of pursuing any of those options, both for the client and for those around her.

It is also important for therapists to be able to work with ambivalence and uncertainty. This would involve the need to engage with the client's possible ambivalence about what she experienced and not impose her therapeutic assumptions. For example the client may have very ambivalent responses to the person who abused her, especially if it was a family member (e.g. Sanderson, 1995). The therapist's view may be that the client should think badly of the perpetrator, yet this may well not be the case. The need to report a perpetrator for what s/he did could seem to be a straightforward issue to a therapist, yet the client may not wish to do that and again the therapist could avoid expressing her own views on these issues and help the client to explore hers.

Working with CSA clients can be a difficult undertaking and it is important for therapists to realise this and to ensure they take good care of themselves so that they can be there to help their clients. Acknowledging the difficulties and the complexity associated with working with people who have been sexually abused is not so that a therapist can make herself feel special, but so that she can ensure that she never ceases to focus on those complexities. In this way she may always be aware of her assumptions and remain open to the realities of her client's experience without ever trying to change those realities other than in ways the client would like.

5.4 FINAL THOUGHTS

In summary, it seems that therapists who work with people who have been sexually abused could usefully recognise and put aside their own assumptions about the phenomenon. They need not to assume and prioritise one way of engaging with CSA and the people who have experienced it but could make themselves truly open to their clients' realities and ways of framing what they have experienced. In addition to this, therapists need to be very aware of the power dynamic within therapy and make this and the therapeutic process as transparent as possible such that the abuse dynamic is never replicated.

CHAPTER SIX – CONCLUSION AND REFLECTIONS

6.1 Summary of study

This study has adopted a social constructionist position to explore therapists' understandings of CSA. The researcher was interested in how these understandings were demonstrated in the ways in which the participants spoke about CSA and their clients who have had this experience. She was also interested in what impact the participants' understandings had on their therapeutic work.

Most of the participants' talk supported the harm narrative associated with the phenomenon of CSA: they all thought it was harmful. Having said that, the notion of clients' uniqueness and strengths offered disputation of the harm narrative. Participants also refuted the idea that any harm caused was inevitably of long duration. However, the possibility that people could experience CSA without trauma and its attendant problems as was suggested by Hunter (2008) was not acknowledged. There was, therefore, a definite acceptance of the harm of sexual abuse and also the view that the harm did not have to last forever and that clients did not have to be defined by the fact that they had experienced CSA

Linking with the story of the harm associated with CSA, some participants could perceive no possible positives associated with the experience. Others, however, saw that, awful though the abuse was for their clients, grappling with and overcoming the trauma offered them something they could not otherwise have had: a degree of both strength and character, as well as empathy and compassion for others who 'suffer'. This links with the notion of post-traumatic growth, and the idea that the positives of the trauma experience should be sought rather than simply focusing on the negatives and personal pathology (Joseph & Linley, 2005).

Post-modern therapies, such as narrative therapy as explained by Wallis et al (2011), seem to link with the concept of post-traumatic growth. These therapies do not see problems as residing in the person as in some traditional therapies. Indeed, the post-modern therapies separate the problem from the person such that the person is not pathologised. Whilst the participants in this study were not post-modern therapists, some of their ways of working seemed to fit with this approach. Some spoke of focusing on the client's strengths and did not see her responses to the CSA she had experienced as abnormal. Participants also spoke of the client not having to be defined by her experience but could choose now how to be and could redefine herself through the co-constructive work of therapy. However, there seemed to be little recognition of the social constraints that might affect someone choosing how she wanted to be.

The key points for clinical work arising from the research were for the therapist to ensure transparency regarding the power dynamic in therapy and for the focus to be on the client's reality together with an openness to her frame of reference. When considering the power dynamic in therapy, it is important for the client to be positioned as expert and for the therapist to be 'not knowing' (Anderson, 2001) The therapist's role is that of facilitator, helping the client to work out what is happening for them and how they would like that to change, if at all. The therapist's role is also to help the client make the desired changes. This links with narrative therapy as explained by Wallis et al (2011) in that the client can be helped to create a different narrative and potentially a reality with which she is more comfortable. In addition to this, it was identified as important for therapists to recognise and understand the complications and complexities associated in working with those who have been sexually abused. There is also the need for a move away from dichotomous thinking and assumptions and for an understanding of the social contexts within which clients live.

6.2 Reflections on advantages and limitations of the chosen method

I wanted to explore how therapists understood CSA and that exploration could only occur by considering how they spoke about it as a phenomenon. Thematic analysis is a method that allows for themes within the data to be identified and these are seen as the key issue for analysis. The thematic analysis was underpinned by discourse theory which considers the ways in which people speak and what they might mean by their utterances as significant: it considers the language that they use and do not use. The social constructionist approach used for this study is concerned about how people think, the language they use to construct social phenomena and what they then do (Burr, 2003). This was exactly my concern: how do therapists talk about their clients, demonstrating their thinking and how does this affect what they do: their practice? Thus it seemed to me that the key advantage of using a discursively informed thematic analysis as a method was that it matched very well with the aims of my research.

One of the key limitations of my method, as with any qualitative research, is the dominance of the quantitative paradigm in the field of science. Psychology presents itself as a science and its frequent focus on the quantitative paradigm could mean that any suggestions for change arising from qualitative research might go unconsidered. Despite a chapter on clinical implications, I am not claiming that those implications offer a way in which therapists 'should' practise. I am offering instead ways of thinking about practice for them to consider based on analysis of data obtained from a relatively small, and not representative, sample. Counselling psychologists who position themselves on the scientist end of the scientist-practitioner continuum may not be satisfied with that. Another potential limitation is that questioning taken for granted ways of viewing the world and phenomena within it can at times make the analysis appear to be critical of the participants' talk (Guilfoyle, 2002). No

such criticism is intended, but the work could be read in that way and so alienate some readers.

6.3 Limitations of the current study and suggestions for further research

The participants in the current study were therapists working in specialist services for those who had been sexually violated. All of them had worked regularly with adults who had experienced CSA. I chose this sample because I wanted people who had the experience to have really considered the issues and who would be able to answer the questions. It could be seen as a limitation, however, that I did not interview therapists who worked in other services, including the NHS. Therapists from these more generalist settings would be in a different organisational setting from those in specialist services and could work with clients who had experienced CSA but without them forming their main caseload. These two differences could mean that they may talk very differently about those who had experienced CSA. This could have given a different perspective to the data and it could have been interesting to analyse and highlight any differences. So, were I to do it again, I would consider recruiting more widely.

The gender issue was very specifically raised by the participants who worked with male adult survivors of CSA. They were very forceful in their statements about how much more difficult it is for men to admit they have experienced CSA and deal with it than it is for women. I have wondered whether it might have been more useful to have focused solely on male abuse and to have gone into a great deal of depth about how that might have been socially constructed by therapists. There could be potential here for further research by focusing on therapist constructions of male CSA and links to social constructions of masculinity.

6.4 Reflection on my part in the interviews

I had intended for the interviews to be informal and friendly as I think this approach is more likely to encourage the participants to talk and thus deliver a breadth and depth of rich data. Indeed the data used in the thesis are only a tiny part of what I obtained. As far as I was concerned I went to each interview with a notion of equality with the person I was interviewing. I did not wish to be in a one-up position or for my interviewee to be one-down. This might be seen to parallel therapy, when the therapist does not want the client to be in a one-down situation nor herself to be one-up. However in therapy this situation can still occur due to the client putting the therapist one-up and herself assuming the one-down position. I realised that there was potential for my participants to be concerned that I was going to judge their work and potentially to feel threatened by that. They could potentially put me in a one-up position because I was carrying out research for a professional doctorate.

When designing my questions, I tried for them to be as neutral as possible to try to avoid participants thinking they 'should' answer in any particular way. I also tried to ensure that in any supplementary questions asked I maintained this approach of neutrality. However I think, at times, that I did lose some of that neutrality because I was so interested in what the participants were saying and was moved to express my agreement where, indeed, I did agree. This could have had the potential of keeping us with a particular line of discussion because the interviewee may have 'felt the approval of the researcher'. In turn, this could have meant that the opportunity for discussion in another area was missed. I think it was a fine balance between conducting a formal interview and having a discussion between colleagues. I wanted to have the discussion because I was aware that interviewing formally might place me in that one-up position, but maybe I was placed there anyway just by virtue of what I was doing.

I was aware that there was humour in many of the interviews and they were often more a discussion with a colleague than a formal interview. I think precisely because of this there was more opportunity for co-construction of phenomena and I am not sure that this is necessarily a problem in this type of research. However, going back to the notion of researcher approval, perhaps it did mean that there were some things I did not get to hear about.

6.5 Reflection on my personal learning as a clinician

My interest in CSA sprang from my work as a telephone helpline volunteer with a sexual violation service. Many of the callers were adults who had been sexually abused as children and who seemed still to be suffering as a result of what was done to them. When I started to train as a counselling psychologist it was with a view to working for this service as a face-to-face therapist, which I have been doing for the last few years. My initial position on CSA was directly informed by the harm narrative. I had read quite a lot of the 'survivor literature' and found it difficult to perceive CSA in any other way than as harmful. I was, however, able to see that adults who had experienced CSA could use it to become stronger, so was drawn towards the notion of post-traumatic growth. In undertaking this research, I have come to take a more flexible stance on CSA and no longer assume this it must be damaging for the individual who experiences it, although it often is. I have realised that I need to approach my clients with a more open mind and seek what the experience means for them rather than make any assumptions about it. The reading I have done about narrative therapy and dialogic therapy, in particular, has had quite an impact on me. I have been able to help clients to see that they do not have to be defined by the experience but can choose their narrative and build their life and experiences around that. I had one client who said that she was totally defined

by the abuse she had suffered. I was not sure that this was so and asked her to consider other parts of her life and how these might impact on how she defined herself.

I have not generally seen myself as the 'expert' in the therapist role and have been uncomfortable with therapies that do seem to put the therapist in the expert position. However, I am not sure I have ever thought about making the power dynamic explicit in the way that Guilfoyle (2002) suggests and this is something that I want to think about more. Generally it might be seen that there is a strong power dynamic at play in the abuse situation and, as I mentioned above, there seems to be a strange parallel between that situation and therapy. It is important as a therapist that firstly I do no harm and I may do so without realising it if I don't pay sufficient attention to the power dynamic and the potential that it has to hurt if misused (even if unintentionally). As Foucault claimed, power can be used for good (1980) and it is domination which is inappropriate and clearly I would not want to exercise that . I do believe that undertaking this research has been a major learning experience clinically as well as academically and I intend to continue to read and hopefully grow and develop as a therapist in the areas about which I have spoken.

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Appendix 1

Good morning,

My name is Lynn Suter and I am a post-graduate student on a Professional Doctorate in Counselling Psychology degree at the University of East London. I am conducting a piece of research as part of my professional training, which is looking at how therapists understand childhood sexual abuse(CSA) and how this understanding affects how they work with adult survivors of CSA. This project has been given ethical approval by the University Ethics Comittee. My research supervisor is Dr Mark Finn and his email, should you wish to contact him, is m.finn@uel.ac.uk .

I am currently working at Lifecentre (www.lifecentre.uk.com) in West Sussex, a rape and sexual abuse support service, and have interviewed colleagues there to pilot my interview questions. I would, however, like to speak to others outside my own organisation, hence my approach to you to see if any of your counsellors/therapists would like to take part. I will be interviewing participants to ask about their experiences of working with adults who have experienced CSA, thinking about how they view the client, how they view the client's experiences and their hopes for them in therapy. The pilot interviews have taken between an hour and an hour and a half. I would expect to conduct them at a mutually agreeable time and place with the emphasis being on it working for your counsellors/therapists.

My aim is to obtain my doctorate and to become a chartered counselling psychologist. Once that is in place, I hope to be able use my research findings to write papers for other professionals who don't specialise but who will come across people who have experienced CSA. My reason for wanting to interview therapists who work with CSA, therefore, is that I want to be able to disseminate some best practice so that those who have experienced CSA might receive greater understanding and, as a result, better care.

I look forward to hearing from you and hope that some of your counsellors will be able to take part in this research. Just to say that the University servers do not accept all email addresses easily. If you should receive an email undeliverable message, please resend to my personal email which is lynn.suter@virgin.net – thank you.

With kind regards

Lynn Suter

Appendix 2

Participant Summary

Pseudonym	Age	Ethnicity	Sex	Length of time working with CSA	Sector	Professional affiliation
Sandra	65	White British	Female	20 plus years	Public & Not for profit	BACP
Sheila	57	White British	Female	14 years	Not for profit	BACP
Tom	32	White British	Male	4 years	Not for profit	BACP
Joy	67	White British	Female	4 years	Not for profit	BACP
Judith	36	White British	Female	7 years	Not for profit	BACP
Rachel	66	White British	Female	2 years	Public & Not for profit	BACP
Moira	42	White British	Female	8 years	Public & Not for profit	BACP & UKCP
Gabi	39	White British	Female	6 years	Not for profit	BACP & UKCP

Appendix 3

University of East London

Doctoral Degree in Counselling Psychology

Risk assessment for interviews that are being conducted away from UEL.

Title of study	Location(s) of interviews	Name of local contact (if available)	Severity of hazard (H, M, L)	Likelihood of hazard (H, M, L)	Risk (H, M, L)	Approved (Yes/No)
An exploration of therapists' understanding of child sexual abuse and the impact of this on their practice with adult 'survivors': a discursively informed thematic analysis.	Charity offices or Commercial manned and serviced offices		Low Low	Low Low	Low Low	

Trainee: Lynn Suter Signature:
Date

Director of Studies: Dr Mark Finn Signature:
Date:

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

MS LYNN SUTER
96 ROSE GREEN ROAD
BOGNOR REGIS
WEST SUSSEX
PO21 3EQ

Date: 9 May 2011

Dear Lynn,

Project Title:	***A DISCOURSE ANALYTIC EXPLORATION OF THERAPISTS' UNDERSTANDING OF CHILD SEXUAL ABUSE AND THE IMPACT ON PRACTICE WITH ADULT 'SURVIVORS'***
Researcher(s):	***LYNN SUTER***
Supervisor(s):	***MARK FINN***

I am writing to confirm that the review panel appointed to your application have now granted ethical approval to your research project on behalf of University Research Ethics Committee (UREC).

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approval is given on the understanding that the 'UEL Code of Good Practice in Research' (www.uel.ac.uk/qa/manual/documents/codeofgoodpracticeinresearch.doc) is adhered to.

Yours sincerely,

Merlin Harries
University Research Ethics Committee
Email: **m.harries@uel.ac.uk**

Appendix 5

UNIVERSITY OF EAST LONDON

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

Dear Participant

In keeping with the UEL School of Psychology's ethics procedures, the purpose of this letter is to provide you with information about my research study so that you can make an informed choice about whether or not to participate in it.

I am a post-graduate student on a Professional Doctorate in Counselling Psychology degree and am conducting a piece of research as part of my professional training.

My research is about therapists' understanding of childhood sexual abuse (CSA) and will be conducted from a social constructionist position, i.e. there is no one thing which specifically defines CSA, but it is something that we each have views on due to our own knowledge and experience.

I will be asking you about your experiences of working with adults who have experienced CSA, thinking about how you view the client, how you view their experiences and your hopes for them in therapy. You will not at any stage be asked about specific clients and should you wish to give any specific examples, these should be anonymised.

It is acknowledged that CSA and your work in this area are sensitive issues, as such your safety and comfort will be respected at all times.

If you choose to participate, it is anticipated that the interview will take around an hour to an hour and a half. It will be like having an informal chat about your work and you may choose not to answer certain questions. In addition you will be able to stop the interview at any time without consequence to yourself.

The interview will be audio-recorded and the recording will be transcribed into written format. The recording will only be heard by the researcher and possibly by an independent stenographer who may undertake the transcription. The interview may also be transcribed by the researcher and which case only she will hear it. While you are being asked to provide your name for the purposes of consent, your identity will be protected. Extracts from the transcript of your interview will also be

seen by the research supervisor for the study and its examiners. Any material from your interview used in writing up the study will be anonymous and you will not be identifiable. Once the research study has come to an end, the recording of the interview will be deleted.

If you agree to participate, you have the right to withdraw at any time without explanation or consequence. You are not obliged to take part in the study.

Please feel free to ask me any questions. If you are happy to continue, you will be asked to sign a consent form prior to the interview.

Please retain this letter for reference and thank you in anticipation of your participation in the study.

Lynn Suter

LYNN SUTER

Feel free to ask me any questions. I can be contacted on lynn.suter@virgin.net or u0821520@uel.ac.uk or 07711 277229

Project supervisor: Dr Mark Finn, School of Psychology, University of East London, m.finn@uel.ac.uk

Appendix 6

UNIVERSITY OF EAST LONDON

CONSENT FORM FOR:

A discourse analytic exploration of therapists' understanding of child sexual abuse and the impact of this on their practice with adult 'survivors'.

I have read the information sheet about the research study in which I have been asked to participate and have been given a copy to keep. The nature and purpose of the research have been fully explained to me, and I have had the opportunity to ask questions and discuss the details of the information provided.

I understand the nature of my involvement in the study and am confident that my participation, and all the material resulting from it will be dealt with in the strictest confidence.

I understand that only the researcher will have access to my personal details and that the project supervisor and examiner(s) will only be able to read extracts from the anonymised transcript of my interview. It has been explained to me what will happen to the data once the research study has been completed.

I hereby fully and freely consent to participate in the study. Having given this consent I understand that I have the right to withdraw from the research study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's name:

……

Participant's signature:

……

Researcher's name:

……

Researcher's signature:

……

Date:…….

Appendix 7

Interview Schedule

Firstly I need to collect some basic personal information, so that I can contextualise my research:

- Age
- Ethnicity
- How long have you worked with CSA?
- Have you worked mainly in the private or public sector?
- What part(s) of the country have you worked in?
- What professional bodies are you accredited by/do you belong to?

- I'd like to start by gaining an idea of how you understand the concept of child sexuality – what do you think about it?

- What do you understand by CSA? What constitites abuse for you? How do you think being a counsellor affects this understanding?

- From your experience and perspective, how do you think your clients understand CSA and what constitutes abuse for them? Are there similar themes in their understanding or are there variations? Do you have examples?

- How do you understand the adult who has experienced CSA? Has this changed over time and if so how? Are there other ways of understanding the adult who has experienced CSA?

- How do such clients understand themselves in your experience – what are some of the variations you have encountered?

- Can you tell me how you approach working with clients who have experienced CSA? How might some of the variation you spoke about affect that?

- How do you feel when an adult client discloses details of the CSA?
  - What specific things affect your feelings if anything? Why do you think that?

- What sorts of things affect your view of the CSA a client has experienced?

- What effect do you think the CSA has had on your clients? Is it always negative?

- What kind of movement do you hope for there to be in therapy? What kinds of changes do you hope to see in your clients?
  - What sorts of things influence your view?

- What do you think the future holds for your clients?
  - How do you view their potential?

- How do you decide on what direction to take the therapeutic work?
  - What are your priorities for the therapeutic work?

- How has your view of CSA changed since you started working with adults who have had this experience? How has your view of how these clients are best supported changed over time – if at all?

Appendix 8

Result of initial coding

Memory
Current crises
Paeophilia
Client response to CSA
Therapeutic relationship
Coping strategies
Survival strategies
Self-concept
Client perception of self
Imagery
Perpetrator/abuser
Perpetrating cycle
Imagery
Not having to name details
Impact of disclosure on therapist
Positive movement
Positive development
Using experience constructively
Physiological responses
Hope for therapy
Importance of therapist's hope
Client potential
What affects potential
Client's view of potential
Support for clients
Role models
Priorities for therapy
Client presentation
Therapy as journey
Child sexualisation
Peer pressure
Impact on public behaviour
Disclosure of CSA – being believed
Public disbelief
Therapist input to client understanding
Therapist view of CSA survivor books
Legal definition
Statutory rape
Human potential
External agency response to abuse
Client priorities for therapy
Dissociation
Sexual identity
Sexism
Value of therapy
Grooming
Need for drama
Client vulnerability
Client avoidance
Problems woking with sexual issues
Response to idea of positive effects
Impact of job on therapist's life
Gender issues
Understanding clients
People who have experienced CSA
Positives of CSA
Consequences of CSA
Mental health services
Tasks of therapy
Dealing with anger
Dealing with hurt
Inappropriate treatment
Trust
Client's world
Client control
Cultural issues
Impact of one positive person
Therapist intervention
Individual's change
Post-traumatic growth
Therapist response to CSA
Therapist response to client processing
Use of language
Change in therapy
Resilience
Client's capacity for relationship
Pleasure in CSA (physiology)
Specific interventions
Use of supervision
Timescale of therapy
Empowerment
Impact of being a therapist
Variety in CSA stories
Age of client when they present
Theoretical approach
Education about CSA
Parental attitude
Trauma
Safety
Confusion around sexuality
Not labelling
Importance of believing
Making client safe
Client "testing"
Erotic transference
Client minimisation

Appendix 9

MOIRA

LYNN I need to do some personal bits to contextualise my research

MOIRA Sure.

LYNN So I'm afraid I'm gonna have to ask how old you are.

MOIRA I'm forty..... Oh damn.... Forty-two – I keep forgetting how old I am. [Laughter]

LYNN 42 – a mere babe. [Laughter] And it sounds like you've worked in this field for about 7 or 8 years?

MOIRA Yes about 8 years. I guess when I started in my first [inaud] it was with deaf people who were survivors. Abuse is quite prevalent in disabled communities.

LYNN And have you worked mainly in the private sector or public sector or not-for-profit?

MOIRA Generally our work has been in the not-for-profit, voluntary sector, but I have also done some work funded by the NHS and that has mainly been work with deaf people.

LYNN And has it mainly been in this area?

MOIRA With xxxx it's been the this area but with the NHS I have gone all over the country.

LYNN Oh wow – so you sign?

MOIRA Yes my parents were both deaf so I learned it then. I did a formal qualification alongside training as a therapist. One of my first paid jobs was signing [inaud]

LYNN That must have been interesting.

MOIRA Yes and I have just done a 3 year diploma course teaching counselling to deaf people as therapists because of all the counsellors we had only a small proportion were deaf and we wanted to get more deaf counsellors.

LYNN Wow. So, just wondering which professional body do you belong to?

LYNN Wow. So, just wondering which professional body do you belong to?

MOIRA I am a member of the BACP, I'm UKCP registered. My Masters was Humanistic [inaud] and I identify more with person centred..

LYNN Although my doctorate has been CBT and psychodynamic I originally did some person centred training.

Therapeutic approach

MOIRA Yeah

LYNN The psychodynamic [inaud] there are bits of it I can buy into completely and other bits, I just think [inaud]

MOIRA I think it can inform your practice overall can't it?

LYNN Yeah.

MOIRA But I wouldn't say I'm purist person centred, I incorporate other models, but I guess it's about how it resonates with the core

LYNN Yeah. So is it OK if I just crack on with the questions?

MOIRA Yeah, absolutely.

LYNN So the first one is..... just a little minor question [Laughter].... I'd like to start by gaining an idea of how you understand the concept of child sexuality.

MOIRA Child sexuality – OK.

LYNN And what you, kind of, think about it.

MOIRA Mmn, [pause] I guess we could go psychodynamic with that one couldn't we? It is a life force, the sexual.... The sexual component is a..... is part of the life force. I guess, erm, I don't know how to define it. I guess I would define it as a drive, as they might do in psychodynamic terms, but that is part of the individual overall, so it's one of lots of different drives, so it's not the dominant drive, but it is a biological drive.....

Child Sexuality

LYNN Mmn

MOIRA ..... that needs to be satisfied and I guess that is there from birth.

LYNN Mmn

MOIRA Erm [pause] but..... it's how that's handled is really important and really key. So – where a child is starting to become aware of their sexuality, erm, it's important that it's really held, really honoured... as normal first of all [inaud] I guess I would see it as part of the individual's overall biological drive but that needs to be nurtured in the light of the developing self, if that makes sense.

LYNN Yes that makes complete sense to me. And linking with what you said about it being nurtured and everything, kind of links in to my second question in a way, which is what do you actually understand by childhood sexual abuse?

MOIRA Yeah.

LYNN And what constitutes abuse for you?

MOIRA Yeah. On the abuse side, I guess that's..... for me that's any abuse of power. So someone has power over a someone, could be a child or it could be an adult..... anyone who's in a position of authority or power over a child.

LYNN Yeah.

MOIRA And it's any abuse of that power that has a sexual component, so it could be of that sexuality, it could be satisfying their own sexual desires through the child. It could be a number of different... different things, but I guess the main focus on that is that it's abuse of power and that has a sexual component. That's not necessarily physical touch but it... it has some kind of sexual component.

LYNN Mmn. Yes that... what you've just said there makes me think of a client that I've been working with who..... whose special time with mum was to sit curled up on the sofa together and watch TV.

MOIRA Yeah.

LYNN But mum was playing her pornographic films.

MOIRA Yeah, absolutely. So that is an abuse of power that the child isn't able to choose.....

LYNN Mmn.

MOIRA ..... whether they watch pornographic films. And actually it's not appropriate for them to... to watch that. They haven't consented to that, so it is abuse of power....

LYNN Yeah.

MOIRA ..... taking place there. Even though there's no physical sexual contact going on.

LYNN Although mum did do that too.

MOIRA Yeah, yeah.

LYNN Which won't surprise you [laughter].

MOIRA But even separately to that.....

LYNN Yeah, absolutely.

MOIRA .... That is a sexual abuse.

LYNN Yeah.

I'm just wondering whether you think being a counsellor has affected your understanding and, if so, how?

MOIRA I think prior to being a counsellor there was, er, an idea that, erm, maybe that it did involve sexual contact, that it would be about penetrative sex maybe or,er, other sexual act. But actually having trained and gained that awareness that actually it's wider than that, there's more to it – it is about abuse of power that involves sex or sexuality somewhere. Er, so I guess you could widen it out. So you could even maybe say that mocking somebody for their growing sexual orientation could be sexual abuse couldn't it an abuse of power that involves sexuality? Erm, so that's one aspect of it: it's not necessarily, er, physical to get some kind of gratification from it. I think the other misunderstanding that I picked up at some point was the misuse of the term paedophile and sexual abuse.....

LYNN Mmn.

MOIRA ..... that... that the term paedophile is someone that can only get their sexual gratification through, er, through children and that is... that is quite rarely the case, which

is something that maybe I'd not, I'd not realised before. You hear the term paedophile bandied about in the press and…….

paedophilia

LYNN Yeah.

MOIRA …. children bandying the term about without an actual understanding…….

LYNN Yeah I think that's absolutely true.

MOIRA ….. of that term. And actually a paedophile, if I'm honest, is not necessarily an abuser that's the other thing, because…. just because someone gets their gratification from thinking about it doesn't necessarily mean they're gonna follow through on it….. they might be in control, not appropriate but in control.

paedophile

LYNN Yeah

MOIRA So I guess the other thing that's widened out for me is an understanding of how widespread the problem is.

T's understanding of CSA

LYNN Yeah.

MOIRA And kind of the feeling that the statistics that are quoted are only the tip of the iceberg. And I don't know the actual statistics but a big percentage of people with mental health problems have experienced some kind of abuse. But then, thinking about that, there are the people who must not have come forwarreally neen impacted and the problem's really, really widespread.

Impact/ consequence of CSA

LYNN Oh yeah, I think that's very true.

OK so from your experience of working with this client group how do you think they understand what's happened to them and what constitutes abuse for them?

MOIRA I think it can really vary through from understanding and splitting off from it to confused feelings of loving the parent but also knowing that what's happened is… is wrong. I don't think there's only one answer to that really. [inaud] … people come to start when the person's died and then there's no closure [inaud]

C's understanding of CSA

I guess it's more for me of coming to terms with not understanding rather than understanding the experience…. that people will search for an understanding but that

work of therapy

MOIRA

closure can only really happen when you accept that there's something there not to be understood. Does that make sense?

LYNN Yeah, it makes complete sense.

MOIRA Yeah, so that, erm, when you actually get to the point where you can go "What they did was wrong. I can't understand their motivations for doing it" and anger starts to be released in that respect in some kind of existential kind of anger of "Why did it happen to me?" But it did and it's only at that point that you can actually move on and go "OK it happened" but along with that is all the impact of it isn't there?

LYNN Mmn.

MOIRA You know the, erm, distress that goes along with it, which in my experience does tend to alleviate when you get.... get to that point. So when you get to that point and go "Urgh, urgh, urgh, urgh....Well actually I don't know why that person did it, I don't know what motivated them and it wasn't my fault", then there is some kind of release and generally some.... some relief of symptoms, you know, that they might be experiencing.

LYNN Mmn.

What sorts of things do you think your clients.... you know, what constitutes sexual abuse for them? Is it the same as... as what constitutes sexual abuse for you do you think?

MOIRA I guess the fact that clients come to us through ISAS, or clients come to me through ISAS, I guess that means that... that they... they recognise that they've been abused.

LYNN Mmn.

MOIRA Erm, I wonder if there's kind of a spectrum of how badly people think they've been abused: "Well he only touched me once" or erm, erm, "He touched me on the breast" or "he didn't penetrate me so that's not abuse", so there's kind of that uncertainty as to what abuse is.

So I wonder if it's a kind of clarification or more of saying well actually that was an abuse of power. And I guess that's where you working from a phenomenlogical frame, that's really difficult because you're holding that it is abuse and it wasn't appropriate, but I'm also

holding the client's fragility perhaps and the client's "Well was it abuse or wasn't it abuse?", holding that at the same time, holding their reality.... tensions for therapist

LYNN Mmn.

MOIRA ...not trying to force them into that reality of it was abuse, because of their understanding of it, so that's quite.....

LYNN Mmn.

MOIRA ..... a balancing act.

LYNN A lot of tension there.

MOIRA Yeah, it's a bit of a balancing act isn't it? Erm, but what's important for the client is that whatever happened, it's had an impact on them and if it's..... if it didn't.... even if it felt OK at the time, if it doesn't feel OK now then it's likely to be abuse.

LYNN Mmn.

MOIRA And I guess though that all that confusion is still mixed up in it isn't it?

LYNN Yeah. No, I know what you mean. I had a client who, in my...in my book, her ex-partner raped her, without the shadow of a doubt. But as far as she was..... she couldn't use that word, couldn't say that.

MOIRA Yeah.

LYNN And I wonder how much of that is, kind of, them wanting to minimise it and make it not as awful as it was.

MOIRA Mmn.

LYNN I don't know. Client response to abuse

MOIRA Frame it in a manageable... in a way that's manageable.....

LYNN Yeah.

MOIRA .... for them. So in terms of how they, they define it... I guess there's a component of not knowing you've abuse until you've been told. 'Cos when there has been Client understanding of CSA.

that abuseof power, there's all the messages that are "This is OK" and "Don't tell anybody" and "If you do tell somebody….." or it's "You're really special", "This is really special".

LYNN Mmn.

MOIRA So, so there is that confusion of meaning anyway isn't there....

LYNN Oh, yeah.

MOIRA ….in the grooming process? So to actually support the client to come to their own definition and their own understanding that they were abused feels really important and not: "you were abused and that was really wrong". Even that feels like a really fine….

LYNN Yeah.

MOIRA …. fine, gentle line to tread. But ultimately the part of them that still loves the person or feels special [inaud]

LYNN Yeah. [Laughter]

Ok, so thinking about an adult now who's experienced childhood sexual abuse, what's your understanding of them as an individual. How do you understand them?

MOIRA [Pause] I guess again, I work with each individual [inaud]

Working with them from a phenomenological frame to try to understand what their [inaud] Not necessarily the event and very rarely talking about the event or events that have happened. Talking about what are their experiences of life now, of living and trying to get a sense of what life is like for them [inaud].

Yes there are elements where training can support that understanding so I might try to understand them in terms of their relating to me. So it might be that even in terms of the number of sessions or the frequency of sessions, there's a kind of…. We can get so close and no further. So there might be a lot missing, er, of sessions, er, and still the need for distant contact: text or phone call just to show that you're still there, but acknowledging they are overwhelmed by the closeness of what's happened to them. So, I guess trying to see how they see the world but also how they relate to me and how the abuse has had an impact on their relating back to me in that field [inaud]

LYNN Yeah. Do you see it..... I am just wondering about it affecting their relationships in the here and now. I'm just wondering whether you see that as always the case, that it has that kind of impact?

MOIRA I guess there will always be.... er, I think they'll be varying degrees of how far the scar is healed over but that will depend on coping strategies. It'll depend on whether it's the first time or there were lots of different times.

Yes, so I think in my experience it does have some kind of impact on relating whether it's finding a partner who's like that or they draw a protector to them. But generally we aim to see, with some processing, how it's impacted their relationships whether it's still [inaud].

So I guess there's always that impact. I think, er, well in my experience I guess there's levels of functioning aren't there? That some people might be very high functioning, some people might be, er, lower functioning I don't like that term, but..... functioning less well in their environment and the fact they have those things to process, on some level has to have an impact.

LYNN Yeah – you mentioned, er, mental health, that often people with mental health issues have been abused. Do you think..... I'm just wondering where the mental health issue fits into the impacts of what people have been through.

MOIRA Yeah..... I guess my first understanding of mental health issues is that they're rooted in the actualising tendency so that any adaptation that the person has shown is an adaptation, so it's how they learned to manage what was going on for them. So whether that's, erm, dissociating because the situation was too much to take on or whether that's something that's diagnosed as a borderline personality disorder..... is that still in DSM?

LYNN Well, they're calling it all kinds of things, but it's still there.

MOIRA It's still there [laughter]. Whether that manifests in that kind of diagnosis, for me it's about how that's adapted them to be able to survive their circumstances. And for me it feels like a really positive thing 'cos it's enabled them to get as far as they have and it's, um, maybe about being in the same environment where they can see that those strategies might always be with them, but there are situations where they might be able to let go of some of those strategies. So I don't know if you've seen Margaret Warner's stuff about fragile process and dissociative process?

LYNN Yes I have, a little while back.

MOIRA Yeah, that's how I prefer to think of it. That they've had to be so defended that they're not able to let anybody else in or that they've had to split off because they can't hold all the information [inaud 8 secs] So I'm..... that gives me hope to think of it in that way because it's like they've.... the strategies they've created have helped them to survive. And it might be that they still need those strategies for the rest of their life [inaud]. But if you can switch the frame from "You've got a mental illness" to "Look how wonderfully adaptive you are to have been able to cope", I think that can be helpful in itself. [Laughter]

Survival strategies

LYNN I hate the term "mental illness".

MOIRA Yeah.

LYNN Um, just recently, a couple of months ago, I don't know if you've come across it.... the editors are Stephen Joseph and.... someone whose name escapes me.

MOIRA Is it Worsley?

LYNN Yes that's it.

MOIRA Big white book.

LYNN Yes, isn't it fabulous?

MOIRA Yeah and there's a Margaret Warner chapter in there.

LYNN That's it, that's where I've read it. Yeah, I thought it was fabulous. And I wish our.... I just wish that the NHS would see it that way.

MOIRA Well Joseph and..... well Stephen Joseph certainly worked at Nottingham University, so they're doing the..... work in trauma centre on post-traumatic growth.

LYNN Yeah.

MOIRA And that really makes sense to me as well, but it's.... it's the [inaud] the self-concept, that actually when you have a trauma, the self-concept gets shattered and then we've kind of got to put it back together again. And we can either put it back together as it was or we can reconstruct it in a new way that can add huge strength to the self-concept.

Metaphor

Self-concept

LYNN Yeah.

MOIRA It's exciting [Laughter]

LYNN Marvellous. Um, in thinking about working with adult clients who've experienced childhood sexual abuse, can you tell me how you approach working with that client group.

MOIRA The first word that immediately came to me is carefully. [Laughter]

LYNN Yeah.

MOIRA I guess I'm always really mindful of space and boundaries, um physical space and consistency and, erm, I guess there's an element of – I'm not saying this doesn't happen with other clients – really paying attention to the metaphors that they use, how they refer to themselves, so whether they, erm, say I or they say she or he, in kind of indicating how far they distance the abused part from themselves, how they bring the abuse and the abused part of themselves into the room. Umm, whether..... and I guess that's quite dynamic and it's different in all cases but there might be times where you have to acknowledge that it's in the room but they don't want to look at it right now. Erm, it's almost like it's an entity in the room.

LYNN Mmn.

MOIRA I guess that's..... thinking about it..... I've not really thought about it in that way, but it is like it's there and it's in the room and it's an entity in the room and the fact they.... they come specifically to talk about that or come to therapy to choose to talk about it but it's there in the room and it's like an object that's..... it's an object that needs to be treated with respect. And what's really important is that the client is in control of how it's treated.

LYNN Mmn.

MOIRA So.... they might bring it and then they might take it away really quickly and acknowledge that but [inaud] or it might be that it's in a box or it might be that it's not safe or it might be that you need to work with it metaphorically to enable the person to feel safe to be able to talk about it. I've had experience of, not necessarily sexual abuse, but working with clients who've actually brought metaphors and not realised that it's related to their abused self, and actually just working with the metaphor can be really healing, not even knowing what the content is.

LYNN Mmn, Mmn.

MOIRA So I guess that gives me hope as well, that the person.....that the actualising tendency, that we're presented with whatever we are able to work with, but I guess the care of the therapist in holding that really informs it and honouring that and being mindful of not only distance from the client but distance from how the abuse is in the room. Does that make sense?

LYNN Yeah.... No it does.

MOIRA It's a bit metaphorical really but it does feel like it's an object that's in the room, a metaphor that's in the room and actually allowing the client to be in control of that feels really important.....

LYNN Mmn.

MOIRA ..... because of that abuse of trust that's occurred before.

LYNN You mentioned there having worked with metaphor. Can you think of an example of that at all?

MOIRA Err, let me try and think of an examples of it that maybe we'll be able to use it without compromising er.....

LYNN Yeah, 'cos clearly I don't want to know any things that I shouldn't.

MOIRA No, no absolutely. Erm, so there might be cases where, erm, the client mentions the... mentions it, looking at where it is and then glances away from it and you've got the kind of sense that it's over there. And it's like "Well I've got a sense that it's over there, but what do we need to do with it?" "Well I need to shut it away in a box." So the client might come up with the metaphor, "So can you imagine doing that?" So I let her imagine herself putting it into the box. "Well what do you need to do with the box?" "I need to lock it away or need to compartmentalise it or....." There was one client where we literally had to put it in a box..... the client brought a letter of disclosure to the therapy and was so traumatised by doing so that we literally put it in a box.

LYNN Mmn.

MOIRA And unfortunately that therapy ended prematurely, so I was left holding the box, so that was a metaphor of her abuse that I was left holding.

LYNN Mmn.

MOIRA And I had to take.... to check out with her whether she wanted it back or take that to supervision and say "OK what do I do with this that I'm literally left holding". And, erm there might be times where a client has brought erm... [pause] ...where I might invite a client to come up with a metaphor and then come up with something. Or I might invite... say "What exactly is that... what does it look like?" and someone comes up with something and I really don't know what that means but it feels really important. So just staying with that, the relevance of it becomes evident later, that it's almost like they're.... the part of them that's not able to verbalise the abuse is, er..... has built a narrative that they're able to cope with.

LYNN Mmn.

MOIRA So maybe it's a pre-verbal self or it's a self that, er.... it's appropriate to use metaphors or telling.

LYNN Yeah.

MOIRA So it's an earlier part of the client that can't rationalise it but it's rationalising a story sort.... Does that make sense?

LYNN Yes, yes.

MOIRA That... that really creative part of themselves has done that but yet their adult mind can't understand, but they know that it feels right that these metaphors that are coming.

LYNN Mmn.

MOIRA So..... But always honouring what the client needs to do with it. Quite often I might..... there's an accompanying kind of sense, that you're accompanying a metaphor as well, so it might be having a safe person alongside them so they can look at it as a child in the session so to speak. So they might feel about five, you're opposite a child of five..... just checking out that they're still in contact with you and what.... how they might want you to respond to the child but also contacting an adult part of them, saying "OK what would the adult part of you..... how would the adult part of you respond to the child?" So they can think of those aspects as well. So actually balancing again, a child part, a metaphorical part and an adult part in the here and now.

LYNN You mentioned earlier about when you were doing this [Laughter] about it being like the abuse was almost an object in the room.

MOIRA Yeah, yeah.

LYNN Do you think the clients see it like that?

MOIRA I think they can. Erm [Pause] I think abusers can definitely become objects or... or... in terms of flashbacks abusers might definitely be there. It's a really good question. [Pause]

I guess the only times I've ever worked with it in that way is when the clients brought the metaphor. So it won't be a kind of "Well I'm gonna force you now to... to... erm, to think of a metaphor" but just inviting it quite spontaneously. The question was about whether it's in the room though wasn't it? So it's an object in the room.

LYNN yeah – whether the client understands it that way.

MOIRA I'm not sure, I guess it's the er.....

LYNN You know because we all hear about the elephant in the corner that we ignore.

MOIRA Yeah.

LYNN And I wondered if that was kind of the sense of it or whether it was something different?

MOIRA I guess the cues that I might , that I might get that make me think "Yeah, maybe they're....." It, it does feel like it's in the room is where people might be looking over to the chair for example and I'm like "Look at the chair – yes she's there". And... and then there's an abuser in the room and we might show them out of the room or work with it in the room or kind of subtly noticing that there's kind of glances over there when we're talking about the abuser. It's like "So is it in the room? Well where is it in the room?" So.... there might be instances of that, where the clients kind of go "Well it's over there" and so what do we need to do with that? Erm [inaud] there was something.... that the abuser might be there, the.... noticing the glances but then I'm thinking about physical proximity. So erm, in space is there in the room, in that physical proximity between me and my client is dependent on what's comfortable for them and that's dependent on the abuse perhaps.

384 So if I notice my clients like this [pulls back] then I know that I need to be physically a bit
385 further away.....

386 LYNN Mmn.

387 MOIRA ..... from them. So in that sense it's very much there as a presence in the room.

388 LYNN Yeah.

389 MOIRA Not necessarily as an object but as a boundary or a... erm, sense or a
390 metaphor, for me it's definitely in the room but I would always check out with the client
391 [inaud]

392 LYNN Mmn. You might say to the next one that it doesn't happen very often from
393 what you said earlier, but erm.... how do you feel if..... when an adult client discloses
394 details of the childhood sexual abuse?

395 MOIRA It's difficult in terms of erm [inaud] difficult areas because you're always mindful
396 that if the client were to decide that they wanted to pursue any kind of legal action later
397 then the fact that they've spoken about details [inaud]. So in that sense I try and always
398 make that part of the contracting process [inaud] "It's up to you whether you want to tell me
399 details but I'm more interested in the impact it's having now." And actually for some clients
400 to know that they don't have to talk about the abuse can be a real relief. They're afraid
401 they might be pushed or forced into talking about the abuse which I think can be abuse
402 itself.

403 LYNN Oh yes, absolutely.

404 MOIRA And that has become part of the therapy.....It's like "I'm noticing you're talking
405 about it, is this OK?" Even talking about..... I mean, I always think of it as a web that
406 whatever.... or it's like DNA that whatever we're talking about, it's gotta be affecting..... at
407 some point....

408 LYNN Mmn.

409 MOIRA ... there's gotta be a connection back. So I..... whatever we're talking about I
410 try to go "OK, how does that link?" Erm, so I guess it's problematic in the sense that the
411 legalities of it. I'm always really clear and say that we don't have to talk about the actual
412 event but if you want to..... and there are those occasions, should you decide.

LYNN Mmn.

MOIRA Sometimes the abuser might have died or they might have started or finished legal proceedings. I guess that's negotiated on an individual basis. But I guess it's more..... it is a real problem but, a lot of clients.... I think they need to know that they don't have to talk about it. And sometimes they come with an expectation.....

Not talking abt details

LYNN Mmn.

MOIRA .....that they have to talk about it as an event but to find that I'm more interested in how it impacts them than the actual event sometimes..... I really think there are some who want to give names and places and what do you do ... then what do you do with that? It's really difficult to hold the names and places that you've been given [inaud]

Work of therapy

Impact of disclosure on T

LYNN Have you ever been shocked by something someone had said? In terms of what they have gone though?

MOIRA Yes lots of times. Erm..... and balancing that... that shock.... mediating might be a better word....[pause] mediating your response to the shock feels really important, in a way that they might not interpret it as shock or disgust at.....

LYNN Mmn.

MOIRA .... them, being really open and transparent about that. I think more often I've been able to stay present in the.... in the sessions and that helps, to be quite a grounded presence but the impact comes afterwards.

LYNN Mmn.

Impact of disclosure on T

MOIRA Erm like noticing sometimes, some quite strange responses even down to having nightmares and.. and... and having impacts that are outside of the session and going "Oh my God, could this be linked to this particular client or whatever? Waking up one time I had feelings that I was being dragged out of bed by my feet and erm.. feeling as though everything in the room has split, so they were a mirror image. So I kind of had to go "Oh OK, could this be to do with this client? Could they have observed their abuse through a mirror and that's what's going on for me?"

LYNN Mmn.

MOIRA So I'm picking up really subtle cues and just being mindful of the fact that what might be going on for me outside could be as a result of what's going on in sessions.

LYNN Mmn.

MOIRA Noticing that but kind of looking on... It kind of comes with the job doesn't it? It enhances my understanding – if I [inaud] But in some senses I guess it could be useful for the client to see it is a real shock [inaud] It's something that wasn't appropriate. So I guess it's [inaud]

LYNN Yeah, 'cos I can see..... I mean.... Some of my clients... the fact that I might not kind of overtly show shock or upset or whatever, but just the fact that you can sit there and say "I find that absolutely awful" or "I find that quite upsetting....."

MOIRA Yeah.

LYNN ..... can be quite helpful for the client.

MOIRA I mean..... it's appropriate to actually hear somebody say "It's wrong" – can be quite powerful I guess.

LYNN What.... I mean we've kind of touched on some of the effects the abuse might have had on your clients, but, just thinking about again what the effects are..... are they always negative?

MOIRA I guess from.... [pause], in terms of, erm, you are affected by events, but I think a move to that place of being a survivor can be really positive. So that seeing yourself as a survivor rather than as a victim probably is really positive. Just trying to think..... I mean theoretically nothing's positive or negative is it?

LYNN Mmn.

MOIRA It's what..... it's what it is. Without knowing what it is from experience, positive and negative of that, that has shaped your personality and your mind – those aspects of the self or often people are working with different aspects of themselves. We might work with how part of themself can support them in a particular situation. "So OK, what can that bit of you that settled for rebellion to your mum and dad, how will that be able to help you in this situation that you've just told me about....

LYNN Mmn.

MOIRA .... over here?" So actually get a dialogue going between the parts that have maybe previously been perceived as negative and actually saying "well, these... these aspects are there for a reason and they....". The idea of the actualising tendency.....

LYNN Yeah, yeah.

MOIRA Erm..." and, and they've supported you this far, can they still support you and can you work with these aspects of yourself? So that you know, this is.... you.... you maybe thought they were never gonna go away but you can learn to manage it, you can learn yo manage these aspects of yourself [inaud]. So I guess it's about dialogues, it's about learning how to relate to all the components of you, where it's left you and learning to manage ~~jow~~ how it's left you – in a constructive or less constructive way. Seeing: "I can use this constructively or I can use it negatively or destructively."

LYNN OK thank you. Mmn, just thinking about the therapy, I'm just wondering what kind of movement you hope for, what kind of change maybe?

MOIRA [Pause] I guess there is always the hope... the hope that you'll get there. Erm, the clients might not see the hope at all but you're holding the hope for your clients. Erm, I guess in reality there can be forward movement, there can be backward movement, there can be staying the same and not getting anywhere. So I think hope is always there but... but learning that whatever happens happens, forward movement, backward movement or whatever it is.

I guess the hope for me would be in terms of what I spoke about just now: helping the person come to a place, um, where they accept that they might not be able to understand what went on or they can understand it on their own terms. That can release the emotional impacts and that enables choice for them, that they can make choices about what it is that's happened to them in their life.

LYNN Mmn.

MOIRA As it's... it's on that basis that they can make choices that are appropriate. They can make choices about their therapy. I guess that's a kind of enacting ground isn't it? That they can make choices about what's going on for them in therapy.

LYNN Mmn.

Impact of therapy

499 MOIRA Because choices had been taken away from them. They might want to invent
500 those choices, if not [inaud]

501 LYNN Do you always have hope for your clients or are there ever have clients where
502 you think "I don't see how this client can ever move or change"?

Hope for therapy

503 [Pause] I guess there's always hope, sometimes frustration [laughter] and um, there's
504 sometimes despair, but I don't see that as the opposite of hope. I guess..... I guess along
505 with the hope comes the reality that they can choose..... they can choose what it is that
506 happens...

507 LYNN Mmn.

508 MOIRA ..... is going to be. And I s'pose in the end there's two choices of where they
509 come to and if that's a choice to be destructive to their self, that's really impactful.... But it's
510 their choice to stop holding and I've had to keep holding that hope.

511 LYNN Mmn.

Importance of hope

512 MOIRA Because if I put the hope down [inaud] And the trust in the actualising
513 tendency I guess is the key to that, that that is what you aspire to and can continue...
514 [inaud] that they might get through it. But I am always explicit about my hope and it's the
515 balance of being there in the hopelessness. Someone once described it as, er, er, if you're
516 in a room that's got no doors, or behind a screen in a room with no doors..... it's quite
517 important that I can at least see a door or a window, so that we can get out of it if the client
518 comes in.

519 LYNN Yeah.

520 MOIRA It's no good if I have no hope.

521 LYNN No indeed [laughter]

522 Just wondering what you kind of think the future holds for your clients, what their potential
523 is?

524 MOIRA For individual clients you mean? Or for anyone that's survived....?

525 LYNN Just thinking of some of the clients you have worked with.

526 MOIRA [Pause] I guess I think about, er, human development, brain development,
527 brain plasticity when I think about that. That there might be deeper [inaud], that there might
528 be aims that haven't developed in the way that they might have done or..... But that there
529 is always that plasticity there so that things can be learned in a new way. That we can't
530 ever go back and change the past but we can learn to think about it in a new way.

531 LYNN Mmn.

532 MOIRA I guess, thinking about it, it's choices [inaud], it's down to individual choices. I
533 don't see that those choices have to be in any way restricted by the fact that you're a
534 survivor.....

535 LYNN Mmn

536 MOIRA ..... of sexual abuse, but it might impact on the kind of odds that you might be
537 able to do all [inaud] but in trainee therapists that [inaud 40 seconds - but to do with trainee
538 therapists who had been abused succeeding as therapists and being very good therapists]
539 Again, I think it's again about new ways of relating to self.....

540 LYNN Mmn.

541 MOIRA .... and other people , to your environment, so learning new ways of relating
542 that take into account the here and now of the ..... of the situation. Actually you're not
543 being abused... Or I **am** being abused and I need to find a different way to... to respond to
544 it. So a lot depends on, um, how the person responds to themself [inaud]

545 LYNN I'm particularly interested that you said something like being a survivor of
546 abuse shouldn't constrain them in any way in effect. Because the reas.... part of the
547 reason why I put that question in about their future, their potential is because there's quite
548 a bit of research done with children, don't know whether you're aware of it, where if a
549 teacher knows that the child has been experiencing abuse, they lower their expectations
550 for that person, which I think is so sad.

551 MOIRA Yeah, absolutely and I think it's a similar situation with, er, I mean it's changing,
552 but with deaf people perhaps. Whereas the deaf person might not see themself as able to
553 have a good job or whatever ....

554 LYNN It's just awful ins't it?

Difficulty of RMs for PP who have experienced CSA

555 MOIRA But where are the role models again? I've spoke to someone at a conference
556 recently who worked in Canada with deaf children and, it's a different area, but, erm, she
557 was saying that if the role models were there..... Where are the deaf firemen, where are
558 the deaf...? That would be a physical difficulty to have a deaf fireman, but actually
559 supporting these people to see if they can achieve their dreams. Something that's
560 happened to you shouldn't restrict you. That's interesting though that lowering of
561 expectation because you've been abused.

Work of therapy

562 LYNN Yeah, we can't really expect too much from you.

563 MOIRA Yeah absolutely. And maybe the education part is actually teaching people as
564 they engage with it about the adaptive systems that people have [inaud] but having
565 difficulty engaging with it..... This person, this is their way of dealing with that situation to
566 survive until now.

linked to potential

567 LYNN Yeah, absolutely.

568 MOIRA And we need to support them to find a new way of relating to people in their
569 environment so that they can go out and achieve that potential that they've got [inaud] But
570 I've got potential that I want to..... It's not about saying I can do anything but saying within
571 the limits of what is there, within the limits of potential, what can you do?

Work of therapy

572 LYNN Yes and it's about, I suppose for me, it's about not saying your potential's only
573 this big [indicates size] when actually it could be that big [indicates size], let's look at that
574 big.

575 MOIRA Yeah.

576 LYNN I mean, clearly it's not that big [indicates size], you know what I mean?

577 MOIRA Yeah, yeah.

578 LYNN You know it's that kind of thing. Umm thinking about the actual therapeutic
579 work, you were saying you kind of approach the work carefully.

580 MOIRA Yeah.

581 LYNN How do you decide your priorities or **the** priorities for the work?

582 MOIRA [Pause] I guess that happens well it does actually... that happens throughout
583 as part of my job. We might talk about a priority at the beginning, and I want the client to
584 do that and they say they want to work on self-esteem. And then as we go on there might
585 be other stuff and it's about holding that and saying "OK this is what we said at the
586 beginning, do we need to re-contract that?" So I see contracting as an on-going process
587 rather than something you do at the beginning: "This is what we're gonna work on boom-
588 boom". I guess it's being realistic about what you can achieve as well.

Priorities for therapy

589 LYNN Mmn.

590 MOIRA For example: "I want to feel fantastic about it."

591 LYNN Mmn.

592 MOIRA And actually that's never gonna happen. You might want to create different
593 strategies but you are what you are [inaud]. So I think being realistic about what actually is
594 achievable is important [inaud]. So I see contracting as an on-going process to try to
595 assess what's realistic for this client in this timeframe. So, yes it depends on individual
596 cases as well, so you can't necessarily say "OK we've got 26 session, that feels realistic
597 for us to work on that" but you don't know what's gone on.

Priorities for therapy

598 LYNN Is that how many sessions you have?

599 MOIRA Umm, it's.. it depends. I think they work on 6, 12, or 24 sessions. So you might
600 get shorter term clients or longer term clients.

601 LYNN But it sounds like you're contracting with the client all the while about priorities.

602 MOIRA Absolutely, because the priorities shift. And you need to be aware of.... is that
603 pointing to the priority that was there before? Or like "When we started, this is what you
604 wanted to..... wanted to talk about, wanted to process, is that something you still want to
605 do or is this new thing that's come up more important bearing in mind how many sessions
606 we've got left? Do we go back there or do we go up this side road that we've found?

Priorities for therapy

607 LYNN Mmn.

608 MOIRA And again, making your client very much in charge of that..... that process feels
609 really important.

focus on client

610 LYNN Yeah.

MOIRA It's not about "You said..... and that's what we will talk about" [Laughter]

LYNN Do you think your view of childhood sexual abuse had changed since you started working with adults who have experienced it?

MOIRA [Pause] Not so much of as.. of abuse. I guess there's a kind of.... I don't know how to describe it.... In some ways I guess it ..... it may..... This wasn't your question by the way.

LYNN That's fine.

MOIRA But, erm, there's a kind of,erm [pause] it does make you thankful for your own life, things that you.... that you have. And sometimes it can make you review er... particularly when it's depth work with survivors. It can.... in my experience make you less tolerant of more superficial things that people might want to process. So I guess it's a balancing act. You really have to hold the fact that..... well this is as important as that for this person, so erm... I guess we can talk about this topic that we're on.

Impact of hearing abt CSA for T

I guess there's a bit of an existential kind of despair that goes on there as well. That it's "Gosh, I'd never really realised how widespread this was, that impact that it has on people", whilst you still hold on to that faith in humanity, to the side of that there really are some shit things people do.

LYNN Mmn.

MOIRA And that can be really, really horrible to come to terms with, I mean the horrible things that people do to each other. Watching films about concentration camps and the impact that that has on you: "Oh it's only a film", but no, it's not only a film is it? It's not only a film, it's reality, it's what actually happened and for these guys to accept the reality of what actually happened to them.... it's not a film at the end of the day. So that kind of shit happens. It sounds a bit dismissive but [inaud] and the horrible choices that people make to do the most awful things.

LYNN And since you started working in this field have you changed your view at all about how this client group is best supported?

MOIRA The answer's yes. I guess the twangs for me are when you hear about somebody and the moves towards more short term work because when I started working, my contract was 4, 5, 6 months and now it's 6 weeks [inaud]. And I think you can do a

Wk of therapy

good contained piece of work within 6 weeks but you have to be really careful who you assess and put into those slots. There has to be some responsibility about extending because the depth of trauma that might be experienced doesn't feel like it can be contained.

work of therapy

LYNN We just changed our..... We used to just do 24 sessions at LifeCentre where I work and that's just been reduced to 18.

MOIRA [Inaud]

LYNN I have one client – an old lady actually although she doesn't look like an old lady – who had been tortured and abused by her first husband and you think, how can I do that in 18 sessions? So I get the 24 [laughter]

MOIRA And I guess there's um in those kinds of cases where you might actually forget it's about them – how come you can only have 6 sessions [inaud] In my experience, even when I have 6 months' work it's about "This journey isn't ended for you, you need somewhere to go."

work of therapy

LYNN Absolutely – and with this lady we know that but she won't go anywhere else, so she can come back to us after a 6 month break [inaud]

MOIRA 'Cos I guess the attachment is there. It's really special if she'd not had that before.

LYNN No and she hadn't because her childhood..... So although she wasn't sexually abused as a child she was physically abused for a long period of time which is probably why [inaud].

I've asked all my questions. Is there anything else I should have asked that I haven't or that you'd like to add?

MOIRA I don't think so. I think the thing that strikes me is the impacts on the worker.... it's really hard... it's really distressing sometimes [inaud] The need to take a break is the key – to reconfigure myself.

Impact of hearing abt CSA on T.

LYNN I did that last summer. I took 3 months off. Thanks so much for your time.

MOIRA I hope it's been useful.

669 LYNN Very useful.

670 MOIRA How many appointments do you have.

671 LYNN You're number 9.

Appendix 10

RESEARCH DATA – INITIAL THEMES

THEME: Hoped for outcomes for therapy using therapist perceptions of client potential
(Considers what expectations the therapist has for therapeutic change to happen and includes how they perceive the client's potential for change/improvement)

THEME: Perceived effects of CSA
(The effects are more specific things such as depression, use of alcohol and drugs etc. rather than the more global impacts such as broken sense of self, including thoughts on positive/negative effects)

THEME: Perceived impact of childhood sexual abuse
(This is seen as more "global" than the effects of CSA. So it might include things such as the impact on the self-concept, more whole person type issues, includes mediators of impact)

THEME: Society and external agency views of childhood sexual abuse
(How those who don't work in this field might perceive CSA as well as society's stereotypes around CSA)

THEME: Therapist perceptions of gender when considering childhood sexual abuse
(*Gender seems to be a big issue when considering CSA. Generally females are victims and males are perpetrators – so what about male victims? And who are the perpetrators?)*

THEME: Therapist perceptions and understandings of childhood sexual abuse
(One of the key issues in how therapists in this field work is their understanding of what CSA is, so this is an important THEME. Includes how their perception may have changed since being a therapist in this area.)

THEME: Therapist perceptions of child sexuality
(Thinking about whether therapists accept that children have and are able to express sexuality, includes views on innocence and sexualisation)

THEME: Therapist responses to hearing about CSA
(This differs from therapist perceptions of CSA which might include generic responses, this is more to do with how they feel when hearing about CSA from a client in the room.)

THEME: Therapist understanding of the client(s)

(Therapist understanding of the client based on their existing knowledge and how they perceive the client understands him/herself, includes survival strategies)

THEME: Therapeutic approach
(This is about how therapists approach working with this client group and how it might be impacted by their understanding of the issues, includes the therapeutic alliance)

THEME: Therapist's view of how the client understands the childhood sexual abuse they have experienced
(This is what the therapist notices of how the client represents the abuse they experienced. It contributes to the therapist's understanding of CSA, but seems important enough to be separate)

THEME: Use of metaphor
(Several of the people interviewed used metaphor and imagery in speaking to me and also in working with their clients, so this seems to be an important way of managing the issues associated with CSA)

THEME: Work of therapy
(This is more specific than approach which tends to be fairly high level. This might include specific things that therapists do such as use art or sand trays)