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Therapy for adult victims of childhood sexual abuse in a district setting

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Sexual abuse of children by family members varies in its incidence depending on the reports used but its presentation among the adult population has largely been under-reported and unrecognised by mental health workers. Since 1984 we have become increasingly aware of survivors of childhood sexual abuse within our own district service presenting initially as psychiatric cases and more recently seeking help directly for the distress which their childhood experiences have caused them. Gradually we have come to recognise the persistent negative effects of this trauma and have attempted to evolve a model for therapy which deals with this and is suitable for use within a district psychiatric service. The pattern of therapy follows the usual psychotherapeutic rules in that it is on a one-to-one basis at the same time and same place each week. It differs, however, in that the therapist is active and when necessary, directive. Our experience has taught us that each patient will present with certain common basic issues that need to be worked through. We have recognised that to do this work sensitively and efficiently it is important that all the relevant questions are asked and feelings explored. We have evolved a list of themes which we expect each therapist to cover during the contracted sessions. We believe that this ensures work is carried through to resolution. If any of the points on the list are omitted then a patient's ability to be free from the past might be impaired. The majority of our patients have been dealt with as out-patients or in a community setting, but a number may already be within the in-patient unit or day hospital setting, and, for a few, attendance at the day hospital is arranged whilst undertaking individual therapy.

Patients

Assessment

The patients are referred for consideration for therapy to the consultant psychiatrists associated with this work and are seen by one of them for initial assessment. This assessment is used to obtain a brief outline of the story and also as an opportunity to determine that the patient does want to undertake some form of psychological work on the issues linked to their abuse and that they will be able to tolerate the pain and distress that this work is likely to cause. The patient must understand there is a connection between their present symptoms and distress and the story that they are revealing. Following assessment the individual is placed on the waiting list and later allocated an individual therapist.

Therapy

The therapist meets with the patient to decide the number of sessions and agree arrangements, usually at the same time and same place one hour weekly for ten to twelve weeks. The aim is to work through the issues that an individual raises and that are identified by our experience as important; this includes a recapitulation of the childhood experience and exposure of past feelings and present distress, working through the issues to resolution, thus freeing the patient from the distress of the past and enabling him/her to make choices about the future.

Sequence of therapy

Initial stages

The initial sessions are an opportunity for therapist and patient to get to know each other. The primary task is to agree the contract and to fill in some of the background; perhaps to draw up a family tree either in the session or as homework so that the members of the family who may have some part in the events are identified, and the relationships between them and the generations are understood. At this time there is an opportunity to identify other episodes of abuse, e.g. rape or within a marriage, that may have occurred later in the individual's life.

Abuse

Therapy then moves on to dealing with the details of the abuse – who perpetrated the abuse, for how long, what occurred, possible coercion, how it stopped, were there any attempts at revelation. Patients may find it difficult to reveal the full extent of the abuse at this stage and many have repressed the details. Only during the course of subsequent sessions are they able gradually to fill in the whole picture, so that

these are issues that may have to be worked over frequently. Individuals may have only fleeting visual memories which as the work progresses they are able to extend, or they may find it difficult to identify by name the individual concerned because of the powerful feelings still present and the coercion that was applied in their childhood.

Perpetrator

During therapy the perpetrator has to be identified and the relationship to the victim explored. The patient inevitably struggles to make sense of why he/she did it, why he chose him/her. This work reveals feelings of rage, pain, confusion, and often sorrow for the loss of childhood or of a relationship. The sessions may include exploration of the present relationship or difficult feelings if the individual is now dead. Patients are encouraged to write and bring to the sessions letters to the perpetrators identifying their own feelings and saying to them what they may never have been able to clarify in the past. This is an attempt to help them summarise and externalise feelings that have been suppressed for a long time. Those who find it difficult to write may be encouraged to talk to the empty chair, or if appropriate, to visit the grave, or undertake other strategies, which have included art therapy and make a model.

Mother

In the majority of our cases the perpetrator has been the father or stepfather, and the mother is a crucial individual. In those in which the perpetrator is outside the family, the mother is joined by the father in the need to work through the issues that surround attempts by the individual to tell of his/her experience. The responses of mothers range from acknowledgement and protection for the individual through denial of events, to collusion with the perpetrator. For many of our patients their attempts to tell were ignored or denied and as a result these issues remain unresolved until the present. Therapy reveals immense anger towards this mother and pain at the absence of parenting. There are implications for the present relationships within the family and for the patients' own experiences of difficulty when they themselves become mothers and have problems dealing with their own children. Again, in an attempt to help them summarise their feelings and to deal with their difficulties, they may be asked to write a letter to their mothers and bring them to the sessions, or to use one of the other strategies to help them identify their feelings. Sometimes this had led to individuals finding it possible to share in the present some of the stories from their pasts with their own mothers.

Patient

Throughout sessions, issues are raised by the patients about themselves and their part in these stories. For any one individual a particular aspect of these issues may be the paramount preoccupation. The issues can be any of a number. Patients ask: why me?; as they try to understand why they were treated in this way. They often see themselves as dirty, damaged, different, their self-esteem is low, they find it hard to assert themselves and they remain victims.

Gradually they confront the issue of responsibility and are encouraged to place it where it firmly belongs – with the adults. Our work assumes that in any relationship between adult and child, the adult must bear the responsibility for that relationship, and much work must be done in the therapy transferring that sense of responsibility from the adult victims, still with their childhood view, to the adults responsible for perpetrating the abuse. Another powerful emotion that has to be worked with is guilt – "my fault" – and sometimes "my failure to protect others in the family".

The patients have to discuss their own sexuality and particularly the difficulties that they have experienced in sexual relationships, difficulty in distinguishing between the sexual relationship in childhood and the repetition of this act within their present adult relationships. If they are able successfully to separate these episodes, then often the sexual difficulties current in their relationships will end without further therapy. Often partners inadvertently contribute to these difficulties by unknowingly repeating acts that in the past have been the forerunners of abuse. Individuals need to be warned that working through this therapy may have implications for their present circumstances, particularly their sexual relationships, and the understanding of their partners is needed until therapy ends.

Case histories

Maureen

Maureen initially presented aged 25 with eating difficulties which had persisted for some years. At the initial contact she was married with one son of 18 months whom she described then as a difficult and demanding child. Maureen was the only girl in a family of four. There had been problems throughout her parents' marriage and they had eventually parted when Maureen was an adult. During her initial period of psychiatric care Maureen revealed that her elder brother had had a sexual relationship with her during her adolescence but she felt that she had come to terms with that and did not wish to discuss it. In spite of treatment the eating difficulties persisted, as did the problems within her own marriage, but the family moved out of the area and contact was lost.

Maureen reappeared two years later, when she was again pregnant. She was given continuous support throughout her pregnancy and following delivery, and through the

development of a postnatal depression. This ongoing relationship eventually led Maureen to be able to identify earlier problems in her childhood and feelings that she had possibly suffered abuse at the hands of her father. As a result of this, individual therapy was arranged with one of the sex abuse counsellors and during the course of a number of sessions Maureen was gradually able to uncover slowly and with great difficulty some visual recollection of her early experience of abuse, and working through these issues she was able to distance herself from the overwhelming feelings that the memories of her father engendered in her.

When followed up six months later Maureen had become independent and confident. Her eating problems had lessened and her relationships had improved.

Ending

As the therapy sessions are accomplished and the end approaches the therapist and the individual review the work that they have done, identifying the changes that they have been able to make and some work is done towards aims for the future. At this time arrangements can be discussed identifying other issues that may have been uncovered but need to be dealt with elsewhere in the out-patient clinic or through marital or family work.

The therapists' group

The therapists who have come to work with adult survivors of childhood sexual abuse come from a variety of backgrounds, but they have some experience of counselling and have worked as individual or group psychotherapists, and may have been involved in psychodrama, family therapy or art therapy. They wish to work in sex abuse counselling and are prepared to work in this brief way and feel able to tolerate the pain and distress that this work engenders.

All the therapists attend a supervision group which provides a focus for dealing with administrative issues and allocation of cases, but more importantly undertakes close supervision of the work done and provides an opportunity for the therapists to deal with the issues raised in therapy. Usually therapists are asked to join the group because they wish to undertake work with a specific patient that they have met in their clinical work. They then can choose to remain within the group or not as they wish when their work has been completed. Some individuals, because of clinical commitments, have moved in and and out of the group. The contract between the therapist and the group is that the therapist stays with the group throughout the period of the patient's therapy contract. The group meets weekly for $1\frac{1}{2}$ hours.

The group also extends an invitation to others from other settings to join a single session to learn more of the working model, or for an individual to join for a series of sessions for education and support. The role of supervision by the group is crucial to our work because the work itself engenders powerful and difficult feelings. The supervision group enables the feelings of disbelief and revulsion to be contained and to be checked out. It forms a safe place for individuals to express the anger and pain experienced in the work they are currently doing. It allows for examination of the confusion that arises in therapy sessions, a place to deal with the anxiety generated, and a place to explore the secrecy that so often surrounded the abuse. At times the therapy feels difficult and daunting and the therapist feels deskilled. The group is essential to help deal with this and to affirm the competence of the individual. The patients have so often in their childhood had no experience of parenting and within their therapy they are given access to an individual who will provide them with a model of care, to support and encourage, establish boundaries and to affirm success. In order to sustain this, therapists need a safe place to go to work through their own issues and to have their own experience of support.

Results

To date, over 150 abuse survivors have been identified in our current psychiatric cases. Contracts have been offered and worked through with 50% of these patients. We have been most impressed with the impact that this therapy has had on our patients. The data from this work are now in the process of being formally analysed, but an initial questionnaire sent to 59 patients in Spring 1988 resulted in a 70% response, with 80% of the respondents reporting a marked improvement. The most common improvement had been in self-esteem, and this had also been clearly visible in dress and posture, as well as in the spontaneous statements offered such as: "I have a right to make choices now"; "I don't feel soiled any more", and "I can control my life now"; "I no longer feel guilty"; "At last I can be myself".

Comments

The ordered and patterned approach to this type of therapy helps to resolve the chaos that such experiences create for both patient and therapist. We have discovered that by developing a formal list of issues that need to be covered in each therapeutic contract, the therapist and patient always have a route to follow, and the close supervision of the group ensures that no one gets lost following that route. The active sense of direction, support and trust engendered by the group helps the patients to replace feelings of hopelessness and depression by anger and optimism, enabling them to work through the past issues to freedom. As a result, the abuse experience is put away and no longer remains the focal point in their lives. This method of working does not follow a medical model and can be used in many settings by people with experience in either psychotherapy or counselling, in both the voluntary and statutory sectors.