

## Survey of Practitioners Providing Therapy for Survivors of Sexual Abuse/Assault in Aotearoa/New Zealand

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### Abstract

Providing therapy for survivors of sexual abuse is a complex area of therapeutic practice. In order to identify the processes that mental health practitioners in Aotearoa/New Zealand use to identify mental injury due to sexual abuse, and their approaches to treatment, a nationwide survey was undertaken. Six hundred and ninety-five surveys were mailed to practitioners. One hundred and sixty-six questionnaires were returned, a response rate of 24%. Both qualitative and quantitative questions were included, seeking information on practitioner demographic characteristics, as well as their practice modalities as sexual abuse/assault counsellors. Emerging themes are presented and discussed briefly. Information generated via the survey has provided a strong local contribution to the development of best-practice guidelines for counselling survivors of sexual abuse in Aotearoa/New Zealand. These were released in June 2008.

Childhood sexual abuse (CSA) and the short- and long-term sequelae experienced by survivors of sexual abuse are significant societal problems. It is difficult to ascertain accurately how many people are affected by CSA due to variations in the definition of sexual abuse, low reporting rates, and the diffuseness of psychological symptoms that are characteristic of such abuse (Briere & Scott, 2006; Ferguson, 2003; Heflin & Deblinger, 2007; Johnson, 2008). However, recent prevalence estimates in New Zealand range from around 24% to 30% for females and 6% for males (Fanslow, Robinson, Crengle, & Perese, 2007; Ferguson, 2003).

Research indicates that CSA can lead to both short- and long-term impaired psychological functioning. Adverse effects can include depression, anxiety and fear, self-destructive and suicidal behaviour, social isolation, sexual dysfunction, low self-esteem, substance abuse, eating disorders, and other symptoms of personality and psychiatric disorders (Callahan, Price, & Hilsenroth, 2003; Draper *et al.*, 2007; Duncan *et al.*, 2008; Fergusson, Boden, & Horwood, 2008; Haller & Miles, 2004; Holzer, Uppala, Wonderlich, Crosby, & Simonich, 2008; Kaplow & Widom, 2007; Lemieux & Byers, 2008; McCrae, Chapman, & Christ, 2006). The experience of CSA is also associated with a greater likelihood of being sexually abused or assaulted later in adolescence or adulthood (Briere & Scott, 2006).

Survivors may experience a variety of traumatic stressors, including the set of symptoms associated with post-traumatic stress disorder (PTSD): re-experiencing the trauma, avoidance and dissociation, and hyperarousal (Briere & Scott, 2006). While there is no evidence of a specific post-sexual-abuse syndrome, 50% of affected children show symptoms of PTSD, and 32% to 48% meet the full criteria for a diagnosis of PTSD (Heflin & Deblinger, 2007). Feelings of helplessness and cognitive misattributions, along with abuse-specific internal attributions due to CSA, are associated with increased levels of long-term distress (Heflin & Deblinger, 2007).

However, the above symptoms are not specific to sexual abuse. They also occur due to other forms of trauma (Briere & Scott, 2006), abuse (Draper *et al.*, 2007; Fergusson *et al.*, 2008; Gibb, Chelminski, & Zimmerman, 2007; Hunter, 2006; McCrae *et al.*, 2006), and life contextual stressors (Hunter, 2006; McCrae *et al.*, 2006; Noll, 2008). Moreover, Heflin and Deblinger (2007) argue that these symptoms are not necessarily experienced by all survivors. It also needs to be noted that the most essential evidence for determining the presence of sexual abuse is disclosure by the survivor.

Factors explaining the differential effects of CSA have been identified as the level of emotional connection between an abuser and a survivor, the numbers of perpetrators, the duration and frequency of the abuse, the level of force or invasiveness involved in the abuse, the cognitive attribution style of a survivor, the quality of support provided by a child's non-offending parent, and the level of family functioning.

The developmental stage of a child at the time abuse occurs can also impact on later psychosocial functioning and symptomatology (Noll, 2008). The literature has reported on impaired development of secure attachment (Cook *et al.*, 2005) and lifelong difficulties in negotiating stable interpersonal relationships (van der Kolk, 2007). Survivors with a history of complex trauma in childhood are also likely to fail to develop the capacity to regulate internal experiences and self-soothe, resulting in

behavioural and emotional pathology (Cook et al., 2005). Some survivors display “*sleeper effects*” of trauma, and negative effects may not manifest themselves until they are triggered by salient developmental issues such as sexual identity, romantic relationships, sexual activity, and becoming a parent (Briere, 1992).

Heflin and Deblinger (2007) have noted that little formal training is available for professionals working with survivors of sexual abuse, and clinicians can find themselves poorly prepared to conduct therapy focused on abuse and its sequelae. They also suggest that clinicians may experience personal discomfort, which can compromise their response to disclosures, and decrease the likelihood of identifying a history of sexual abuse. Factors involved in practitioners’ reluctance to ask about abuse include the presence of more pressing issues, fear of disturbing clients, client diagnosis of schizophrenia, biological etiological perspectives, and fear of inducing “*false memories*” (Young, Read, Barker-Collo, & Harrison, 2001). However, most of the literature strongly suggests that direct inquiry is essential to the identification of CSA survivors, the formulation of appropriate diagnosis and treatment plans, and possible prevention of further victimisation (Heflin & Deblinger, 2007).

Personal biases and common misconceptions may also influence professional attitudes regarding the therapeutic management of sexual abuse. Along with the affect heuristic, which can result in clinical decisions being made on the basis of rapid and automatic affective responses (Garb, 2005), social and gender biases have been identified in the literature. Misconceptions also occur regarding the prevalence of CSA, the perceived credibility of memories associated with CSA, and the non-offending mothers of survivors (Gore-Felton et al., 2000; Heflin & Deblinger, 2007).

Practitioners from a variety of disciplines and with differing levels of experience provide counselling for children and adults who have experienced sexual abuse/sexual assault in Aotearoa/New Zealand. Northey (2004), however, has noted that more research has focused on psychiatrists and psychologists than on marriage and family therapists, social workers, and counsellors. In order to address this imbalance, a survey was generated to gain an understanding of the experiences and challenges faced by practitioners from a variety of disciplines working in the complex area of sexual abuse/sexual assault in Aotearoa/New Zealand.

The survey was designed to ascertain practitioners’ understandings of the effects of sexual abuse, the processes they use to identify mental injury due to sexual abuse, their approaches to treatment, and factors that either facilitate or act as barriers to effective therapy. This article describes the results of this survey, and is based on the report by Taylor, Harvey, Mortimer, Campbell, and Woolley (2006).

The ultimate aim of the survey was to provide New Zealand-based information to be incorporated into evidence-based recommendations for practitioners to (a) improve the identification of different aspects of mental injury that result from the experience of sexual abuse, and (b) enhance the effective delivery of therapeutic interventions for survivors of sexual abuse (Rāranga Whatumanawa, 2008).

## **Method**

A questionnaire was developed to determine practitioners' perceptions of the effects of sexual abuse, assessment techniques used to establish mental injury, and the range of treatment approaches utilised. Closed questions were used to obtain demographic data, and open questions were used to elicit written responses describing therapists' understanding of the effects of sexual abuse, information about how they work therapeutically with clients, and difficulties they encounter in their practice.

Prior to the survey being posted, a nationwide road show enabled the researchers to introduce and discuss the project with key stakeholders. Potential participants were identified through lists of Sensitive Claims practitioners registered through the Accident Compensation Corporation (ACC) to work with survivors of sexual abuse (ACC, 2005). Following these information sessions, a pre-survey letter was mailed to practitioners, and in a second mailout, an information sheet about the wider project accompanied the survey questionnaire. A thank you/reminder postcard was subsequently mailed to practitioners who had not returned their questionnaires after three weeks. Of the 695 mailed surveys, 166 questionnaires were completed and returned by practitioners, constituting a response rate of 24%.

Section A provided quantitative data about demographic characteristics of practitioner respondents, as well as their practice in the field of sexual abuse/assault. This was analysed using the Statistical Package for the Social Sciences (SPSS), Version 13.0.

In Section B, open-ended questions granted practitioners freedom of response, eliciting a broad range of qualitative information about their perceptions of the effects of sexual abuse, their approaches to assessment and therapy with sexual abuse survivors, and barriers experienced in their practice. With this data, a qualitative analysis was carried out using the computer software programme NVivo, as well as a paper-based thematic analysis. Each practitioner's responses were sorted into main themes, then resorted into sub-themes. Illustrative quotes, capturing the essence of the themes indicated by most practitioners, have been presented, wherever possible, as written by the respondents in order to preserve their voices. While the survey relates

to therapeutic practice with people who have experienced sexual abuse and/or sexual assault, the term “sexual abuse” will be used in presenting the results.

## Results

### *Demographic characteristics*

Respondents represented a range of primary discipline areas, as indicated in Table 1. Most of the respondents identified themselves as European New Zealanders, with New Zealand Māori and other ethnic groups also represented, albeit in smaller numbers. Respondents worked in various locations nationwide, incorporating a range of therapeutic practices (as seen in Table 1), and belonged to a variety of professional associations, including the New Zealand Association of Counsellors, the New Zealand Association of Psychotherapists, the New Zealand Psychological Society, the Aotearoa/New Zealand Association of Social Workers, the New Zealand College of Clinical Psychologists, and the New Zealand Association of Child and Adolescent Psychotherapists.

Practitioner experience ranged from 3 to 40 years ( $M = 17$  yrs,  $SD = 7.7$ ). Experience as sexual abuse counsellors averaged 15 years ( $SD = 7.6$ ). The bulk of respondents indicated being registered with ACC for an average of 10 years ( $SD = 5.1$ , range 0–22; 1 person had missing data). Counsellors were currently seeing an average of eight Sensitive Claims clients ( $SD = 6.5$ ; 9 had missing data). Most practitioners had small caseloads of sexual abuse survivors, although a few (2%) had very high caseloads (30 or more). Of note was the fact that the latter were not the practitioners who had been working in the area the longest amount of time.

As can be seen in Table 2, practitioners primarily worked with a diverse range of clients in terms of gender, age, ethnicity, and the nature of the sexual abuse.

### *Sexual abuse—meanings and effects*

The meanings and effects of sexual abuse were identified through two open-ended questions: (a) Question 16: “The experience of sexual abuse means different things to different people. As a professional, what are the key thoughts that come into your mind when you think about what the experience of sexual abuse means?” and (b) Question 17: “When people have experienced sexual abuse, they are affected in different ways. What do you think are the most critical consequences affecting individuals who have been sexually abused?”

Responses varied from a few lines to comprehensive lists, reflecting a range of understandings and perceptions. Thematic analysis identified three main themes: *damaged lives, loss, and factors that influence the impact of sexual abuse*.

**Table 1:** Characteristics of respondent practitioners

<b>Practitioner characteristic</b>	<b>Percentage</b>
<i>Primary discipline area</i>	
Counsellor	53.0%
Psychotherapist	35.5%
Psychologist/clinical psychologist	6.6%
Child psychotherapist	3.6%
Social Worker	0.6%
Physician	0.6%
	Total 100%
<i>Ethnicity</i>	
European New Zealander	60.2%
New Zealand Māori	1.2%
New Zealand Māori/European	0.6%
Pacific peoples	0.6%
Other ethnicities	25.9%
	Total 88.5%*
<i>Primary therapeutic practice</i>	
Psychotherapy	24.1%
Cognitive behavioural therapy <sup>a</sup>	13.9%
Post-modern/narrative <sup>b</sup>	10.2%
Eclectic <sup>c</sup>	10.2%
Humanistic/person-centred	9.0%
Self-psychology/object relations	6.6%
Transactional analysis	5.4%
Gestalt	3.6%
Psychoanalytic	2.4%
Mindfulness-based	1.8%
Art therapy	1.8%
Bioenergetic analysis	1.2%
Neurolinguistic programming	1.2%
Existential	0.6%
Trauma models	0.6%
Play therapy	0.6%
Drama therapy	0.6%
Developmental-based therapies	0.6%
Miscellaneous	3.0%
	Total 97.4%*

*Notes:*

a Includes cognitive therapy and rational-emotive behaviour therapy.

b Includes metaphor-related therapies.

c Respondents reported a variety of practices.

\* As a result of some data being missing, percentages do not add up to 100%.

Table 2: Caseload Composition

Percentage of Practitioners working with each client group	Client characteristic
	<b>Gender</b>
43.4%	Male
96.4%	Female
	<b>Age group</b>
16.3%	Children (up to 10 yrs)
36.1%	Adolescents (11–17 yrs)
95.8%	Adults (18 yrs and older)
	<b>Ethnicity</b>
98.2%	Pākehā
63.9%	Māori
21.1%	Pacific Island people
12.0%	Other
	<b>Occurrence of event</b>
99.4%	Historical
50.6%	Recent
	<b>Type of sexual abuse</b>
96.4%	Sexual abuse
73.5%	Sexual assault (e.g. rape)

*Note:*

Practitioners often responded to more than one category within a single characteristic, therefore percentages within each characteristic do not add up to 100%.

**Damaged lives**

Practitioners reported that sexual abuse had a damaging effect on an individual’s development, health and well-being, and social functioning. Words such as “wounded,” “shattered,” “disrupted,” “ruined,” “distorted,” “broken,” and “impaired” were used to describe the impact of abuse, giving rise to the notion of damage. Sub-themes of *damaged development*, *damaged health and well-being*, and *damaged social functioning* were also identified.

Damaged development—Some respondents advised that individuals were impaired developmentally, for example, “emotionally stuck at an earlier age,” and that there was “disintegration in their development.” According to respondents, people may

experience disruptions to any or all of the following areas of development: “relationships,” “sexuality,” “physicality,” “cognition,” “education,” “moral issues,” “emotions,” and “identity.” For example, one practitioner linked attachment issues and emotions by reporting “when sexual abuse has occurred in the absence of secure attachment, a child often has difficulty regulating feeling states, often at an earlier stage of social or emotional development.” Furthermore, damaged identity was expressed in terms of “erosion of self-esteem,” “it results in existential issues [that impact upon a person’s] sense of self and meaning of self,” “disconnection from peers—I’m no longer the same,” and “loss of connection between self and the world.”

*Damaged health and well-being*—Practitioners focused mostly on the psychological domain rather than on physical disorders or impairments. In relation to the latter, attention was drawn to self-inflicted physical harm or potentially harmful behaviours that resulted from the trauma of abuse. Examples included “tension reduction activities such as drug and alcohol abuse, self-harming and physical violence,” “prostitution, promiscuity,” and “the physical expression of the inner angst.”

Some practitioners explained that mental health problems were often adaptive behaviours that in turn became disorders. Furthermore, existing mental and physical health concerns could be exacerbated. Mental health issues reported included anxiety disorders, mood disorders, obsessive-compulsive disorder, somatic and personality disorders, psychosis, delusional thinking, post-traumatic stress disorder (PTSD), complex PTSD, suicidality, cognitive distortions, and eating disorders. Other psychological issues mentioned were fears, lack of trust, anger, co-dependency, denial, and a feeling of being different.

*Damaged social functioning*—Within this sub-theme, respondents noted that sexual abuse survivors often developed difficulties with intimate relationships, family interactions—in fact, all types of relationships with other people. One respondent expressed the problem this way: “The inability to form close intimate relationships with a partner, friends, or even their own children.” Difficulties relating to others were believed to have arisen from issues of “power and control,” “broken trust,” “being exploited and being betrayed,” “feeling isolated,” “being alienated,” and “being stigmatised.” The understanding that disrupted attachment resulting from abuse by a parent could also lead to impaired social functioning was raised. Following sexual abuse, children were seen as particularly vulnerable to misunderstandings and confusions in developing relationships. “Distortion of perception of relationships and roles” was one comment.

Others included, “client has had her trust exploited and betrayed,” “may have difficulty trusting,” “sexual abuse confuses a person’s thoughts and feelings about sexuality,” and “difficulties with enjoying sex.” The probability of disruption to a child’s schooling and not being able to have “normal childhood experiences” was understood to hinder normal social functioning.

Overlap and links between the three sub-themes are apparent with respect to relationships and identity. Impairment of, or disruption to, an individual’s development and the ability to have normal childhood experiences are linked to psychological problems. These were identified as difficulty in trusting other people, experiencing confusion about sexuality, having problems with parenting, and so forth. All these difficulties, along with many other outcomes of sexual abuse, can arguably affect a person’s sense of identity. Practitioners spoke of “changed self-concept,” “low self-worth,” “low self-image,” and “shame and guilt,” along with other concepts relating to a sense of being different and being marginalised. Respondents expressed how, in differing ways, the experience of being sexually abused can threaten a person’s sense of identity.

### *Loss*

The experience of sexual abuse was conceptualised as a loss relating to factors fundamental to a person’s health and well-being. The concept of loss was understood to have long-term consequences for well-being. Sub-themes of *personal losses* and *social losses* were identified.

*Personal losses*—Some practitioners used phrases such as “degradation of a human being that causes loss of sense of self,” “a loss of hope and trust,” “utter confusion,” and “an undermining of human potential” to illustrate these understandings. The personal sense of loss revolved around identity, self-esteem, dignity, control, safety, potential, and the ability to lead a productive and normal life.

*Social losses*—Social losses related to relationships with family, friends, community, and employment.

In the present context, the concept of *loss* can also be conceptualised as an outcome of *damaged lives*.

### *Factors that influence the impact of sexual abuse*

Respondents pointed out that the effects of sexual abuse were different for each person. Outcomes were understood as being dependent, in part, on the characteristics of the individuals, their families, and the attitudes that a person’s culture and society have

toward sexual abuse. As such, sub-themes of *individual factors*, *family factors*, and *sociocultural factors* were identified.

*Individual factors*—Individual characteristics affecting survivors’ responses to sexual abuse were noted as “resilience,” “degree of resources,” “self-esteem,” “level of safety,” and “knowledge of sexual abuse and its effects.”

*Family factors*—Factors relating to family that were considered salient included whether the abuse was the result of incest; whether the family was dysfunctional; the degree of care, protection, and support; and whether the child was deemed credible in relation to the disclosure of sexual abuse.

*Sociocultural factors*—From a sociocultural perspective, it was perceived that beliefs helped shape attitudes towards sexual abuse and people who have been sexually abused. For example, one respondent stated that “experiencing sexual abuse remains covertly the responsibility of the sufferer.” Other respondents believed that society often denies the reality of sexual abuse and, as one person noted, sexual abuse is “a social issue that is linked to how society excuses violence.” The terms “disconnection,” “whakamā,” and “shame” were frequently used when describing the social environment of people who had been sexually abused. One respondent advised that the behavioural responses by people around the individual could have greater traumatic effect than the actual abuse or could vastly increase devastation.

Key themes emerging from respondents’ understandings about the meanings and effects of sexual abuse suggested that sexual abuse can result in damaging and often long-term consequences that have the potential to affect all areas of an individual’s life. These understandings were articulated in terms of “development,” “identity,” and “social functioning.” Other factors, particularly those related to family, were considered significant in mitigating or exacerbating the effects of the abuse.

### **Treatment/therapy**

Practitioners’ information about therapeutic practice was identified through three open-ended questions: (a) Question 18: “When people present for therapy or counselling following sexual abuse, they bring with them unique histories, stories, concerns, issues, or problems. How do you think about and strategise how to help each client? What do you need to know to decide how to help them?” (b) Question 19: “When working with clients who have been sexually abused, different people recommend different types of therapeutic interventions. What interventions have

you found to be useful?” and (c) Question 20: “Various aspects of counselling/therapy are necessary for addressing particular issues faced by someone who has been sexually abused. What in your opinion are the essential components that need to be operating for counselling/therapy to be successful?”

Thematic analysis articulated *initial stages*, and *techniques and essential components of therapy*. The terms “treatment” and “therapy” are used here interchangeably, reflecting practitioner terminology.

### *Initial stages*

Information was sought to determine how practitioners strategised their work when clients presented for therapy. A thematic analysis of written responses indicated that they considered a wide range of issues. Four sub-themes emerged: *therapeutic relationship*, *safety*, *general assessment*, and *goal setting*.

### *Therapeutic relationship*

There was consensus across respondents that if a good therapeutic relationship was not developed, the therapeutic process would be undermined. Therapists expressed these ideas in terms of promoting healing, and providing a base from which clients could feel safe and free to talk about their experiences. The perceived importance of the relationship was exemplified by statements such as “the building of the therapeutic relationship is crucial,” and “feel listened to—validated—normalised—understood.” Other respondents expanded on the theme, articulating specific reasons for its importance: “within the safety of the container provided by the therapeutic relationship, the client can face their experience and be supported to let go of the shame and terror associated with the trauma,” and “time and time again I find that the factor that the client felt was the most helpful in her healing was that someone really heard her, believed her, and knew that she could make progress. It wasn’t the clever methods I thought I was pulling out of my learning—it was the relationship that mattered—it is almost a heart to heart connection and I know from experience that when this is really happening, the client’s progress is much faster.”

### *Safety*

Safety issues covered the client’s current safety, safety from further sexual abuse, risk of self-harm, and suicidal ideation.

### *General assessment*

This sub-theme addressed areas of general functioning; symptoms, with particular focus on trauma symptoms and degree of dissociation; personal history; attachment

patterns; a client's goals; contextual issues; and observation of how the client responded in the interview. Specific assessment techniques are beyond the scope of this article.

### *Goal setting*

Goal setting evoked differing responses. Some practitioners were inclined to follow the client's lead, while others developed goals with their client. A few mentioned specific goals such as "develop self-acceptance," "set up systems to manage issues," "empowerment," and "work with the client to rebuild and develop mastery over their life."

### *Techniques and essential components of therapy*

As noted above, a range of techniques and modalities were listed, with some therapists noting more than one approach. The following describes what respondents considered were essential components of therapy, accompanied by illustrative quotes. Qualitative analysis of the content of each of the practitioner's responses indicated that these components embraced the following sub-themes: *therapeutic relationship*, *therapeutic environment*, *therapist characteristics*, *client characteristics*, *tasks of therapy*, and *structure and process issues*.

#### *Therapeutic relationship*

Once again, this theme emerged strongly, with its frequent occurrence suggesting that it was considered a principal element of the therapeutic process.

#### *Therapeutic environment*

People advised that the room in which therapy is conducted should be "comfortable," "warm," "friendly," "a confidential venue," and that clients should feel welcome and safe.

#### *Therapist characteristics*

Many responses were written that identified the qualities and abilities of a competent therapist, yielding embedded sub-themes of *ways of being* and *competencies*.

*Ways of being*—The competent therapist was considered to have personal qualities of "acceptance," "awareness," "clear and sound mind," "belief in client," "grounded," "sensitivity," "gentleness," "engendering hope," "down to earth," "respectful," "congruent," "approachable," and being "supportive." Many abilities were noted that would derive not only from training, but also from experience with sexual abuse counselling. The following generic abilities were considered relevant to any counselling practitioner: "pacing," "clear communication," "ability to hold transference and work with them to create powerful healing," "attend to the countertransference and process

it,” “quick thinking,” “challenging,” “coaching,” “empowering,” “reflexive,” “provide structure and boundaries,” “eye contact,” “working within client’s frame of reference,” “modelling,” and “ability to be clear and directive.” However, the following quotes, while also relevant to other clients, do reflect the importance of issues specifically related to clients who have experienced sexual abuse: “belief in the client’s story however bizarre,” “ability to be with/hear the hard stuff,” “not shocked,” and “not to be afraid or avoid difficult material.”

*Competencies*—The competencies sub-theme relates to training, education, and supervision. Respondents expected a high level of competence among their colleagues that suggests appropriate and adequate training, as well as ongoing professional development. They expected colleagues to have a good understanding of cultural values and developmental issues; possess a thorough understanding of sexual abuse and its effects; understand trauma and trauma theory; have a sound theoretical base; have the ability to recognise mental health problems and be able to refer on if necessary; be competent in their assessment, formulation, and treatment planning; and possess a wide range of intervention skills and strategies. When working with this specific client population, it was expected that therapists would allow and facilitate clients’ expressions of grief and suffering. It was considered helpful for the therapist to share a little personal history.

Some respondents reported their particular *expectations* of therapists in this field. A practitioner should be well informed. Therefore, as well as ongoing training, there should be ongoing reading, regular supervision, networking with other professionals, and having a professional support system. Inherent in these ideas is the conviction that practitioners should not be isolated. They need to be able to share ideas and receive support from colleagues and supervisors within the stressful and potentially traumatising climate of sexual abuse work. Further, it was stated that therapists should go through their own therapy, and address any of their own sexual abuse issues.

### *Client characteristics*

Several client-related characteristics were believed to be factors in effective therapy. The issue of a client’s readiness for therapy was mentioned, as well as a commitment to attending therapy, and being prepared and motivated to do therapeutic work to make changes. To some extent, this issue links to the importance of pacing. The concept of belief was raised and expressed in terms of the client believing in the therapist and believing they could heal and change. Stability in the life of the client was illustrated by the following comments: “not filled with chaos and drama,” “no longer in abusive

relationship,” “availability of support for client outside of therapy,” “no addictions, no psychotic disorders.”

### *Tasks of therapy*

Although practitioners responding to this survey were multi-disciplinary, the list of issues that emerged was considered important across practitioners working with sexual abuse clients. Tasks of therapy included teaching clients specific techniques and “building capacities and skills.” These covered “anger management,” “breathing/relaxation,” “affect work,” “self-soothing thoughts and behaviour,” “safety building,” “teaching client to ground self,” “reconnecting to life and self,” and “methods to deal with trauma-related effects.” Other tasks of therapy not specifically related to teaching clients included “identification of the effects of the abuse,” “consolidation,” “address mental health issues,” “encourage grief process,” and “review progress and needs.” As noted earlier, responses such as “safety building,” “identification of the trauma symptoms,” and “empowering clients by teaching skills” were also given in the initial tasks of therapy.

### *Structure and process*

Factors relating to timing and pacing were given attention, for example: “regular appointments,” “consistent appointment days and times,” “uninterrupted sessions,” “ensuring the provision of sufficient time for the client,” and “working at the client’s pace and not trying to hurry the work.” Providing structure and boundaries was noted. Several individuals stated it was important to let the clients tell their stories, and this narrative thread was evident in some of the responses.

## **Discussion**

The survey yielded information about the therapeutic approaches of practitioners working with sexual abuse survivors in Aotearoa/New Zealand. Respondents comprised a range of people with differing backgrounds, training, and client groups. Most were counsellors or psychotherapists, reflecting the predominance of these disciplines among practitioners registered with ACC to work with sexual abuse survivors (ACC, 2009). Although practitioners used a variety of therapeutic approaches when working with sexual abuse survivors, issues that emerged were considered important across disciplines. In recognition of the diversity of therapeutic techniques, no one specific approach has been focused on in the present article. Respondents demonstrated insight into relevant issues surrounding their practice, reflecting wide-ranging experiences, compassion for their clients, and commitment to their work. Some individuals devoted much time to answering the questions, as shown by quite lengthy responses.

### *Sexual abuse—meanings and effects*

Practitioners considered that sexual abuse had the potential to damage all areas of a person's life and could result in lifelong problems. Development could be impaired, leading to a variety of losses. Practitioners' reporting was consistent with the literature outlining impaired development of secure attachment, resulting in lifelong difficulties in negotiating stable interpersonal relationships and decreasing feelings of connection with others (Cook et al., 2005; van der Kolk, 2007), impaired sexual functioning (Lemieux & Byers, 2008), and impaired ability to regulate internal experiences and to self-soothe (Cook et al., 2005). In an effort to manage negative emotional states, poor self-esteem, and poor social and sexual functioning, survivors were described by practitioners as engaging in potentially harmful behaviours, self-harm, and drug and alcohol use. High rates of risk-taking sexual practices (Lemieux & Byers, 2008), substance abuse/dependence (Duncan et al., 2008; Fergusson et al., 2008), as well as suicidal ideation and suicide attempts (Fergusson et al., 2008) are found among survivors of sexual abuse.

It was noted by practitioners that the severity of the consequences could be affected by personal factors, the family's response to the abuse, family support, and whether the perpetrator was a family member, as well as sociocultural characteristics. These differential factors have been well-documented in the literature (Heflin & Deblinger, 2007). Factors increasing resilience to the trauma include others' beliefs about disclosure, support, and the ability to place responsibility on the perpetrator (Hunter, 2006). Coping self-efficacy can also mediate the effects of negative cognitions caused by trauma (Cieslak, Benight, & Lehman, 2008).

### *Treatment/therapy*

In the initial stages of therapy, the therapeutic relationship emerged as the key component. The importance of the therapeutic relationship has been emphasised in the literature (Antoniou & Blom, 2006; Dattilio & Freeman, 2007; Pollack & Brezina, 2007). Practitioner qualities identified by participants reflected those needed to engender a sound therapeutic relationship. Arguably, these qualities and abilities are able to be taught and then grounded in the experience of counselling practice. The importance of safety issues, general assessment, and goal setting was emphasised. Many essential components of therapy were identified which covered the therapeutic environment, the therapist, the client, and the therapy itself. While many of the issues raised would be relevant to most client populations, it was important to elucidate what practitioners considered pertinent to their work with survivors of sexual abuse.

The complexity of working with this client group was illustrated by the degree of overlap in responses regarding tasks of therapy. In some cases practitioners considered the main tasks of therapy, such as safety building, identifying trauma symptoms, and empowering clients, as important to consider during the initial stages. Overall, many of the respondents expressed an awareness of the complex nature of the issues surrounding sexual abuse and therefore the importance of supporting well-trained, experienced practitioners to work in this field.

### **Conclusion**

The survey was the first stage of a multi-faceted research project undertaken to inform the development of best-practice guidelines for practitioners working with survivors of sexual abuse (Rāranga Whatumanawa, 2008). Other methods included reviewing the national and international literature, conducting archival file and meta-analyses, and holding focus groups and key informant interviews with practitioners and consumers. Triangulating data from several sources enabled the information gathered from the survey to be validated and extended.

While the survey response rate of 24% is somewhat less than reported in some health practitioner surveys, where the response rate was between 33% and 83% (Bor, Mallandain, & Vetere, 1998; Cull, O'Connor, Sharp, & Tang, 2005; Cummings, Savitz, & Konrad, 2001; Puleo *et al.*, 2002), it is similar to the 26% reported in a study of mental health practice in the United Kingdom (Skidmore, Warne, & Stark, 2004). The present survey was time-consuming for respondents to complete, which is likely to have reduced the response rate (Dillman, 2000). However, an open-ended question format allowed respondents to provide comprehensive information, resulting in a depth and richness of data, which was analysed qualitatively. Responses were provided by a range of people experienced and knowledgeable in providing therapy for survivors of sexual abuse.

The data elicited through the survey could provide a baseline for follow-up studies to determine how New Zealand-based practitioners evolve their practice methods in response to the emergence of the latest evidence-based guidelines. Furthermore, information provided by practitioners allows specific issues to be identified, which can be studied in more depth as practices evolve over time.

### Acknowledgements

Rāranga Whatumanawa (The Weaving of Heart Patterns) is a research project undertaken by the Psychology Clinic at Massey University (Cheryl Woolley, Principal Investigator, and Ian Evans, Senior Research Consultant) to investigate the assessment, diagnosis, treatment, and outcomes for people experiencing mental injury arising from sexual abuse. The research was funded by the Accident Compensation Corporation of New Zealand (ACC). The project was conducted in conjunction with the Psychology Centre in Hamilton, and involved a large team of researchers as well as an Advisory Committee representing distinguished researchers, practitioners, consumers, and tangata whenua. No official endorsement of this paper by ACC should be inferred, nor does it necessarily reflect the policy and opinions of ACC.

The Rāranga Whatumanawa research team was impressed by the overall response to and interest in the survey, and is grateful for the input of this dedicated group of practitioners.

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