



Smith ScholarWorks

Theses, Dissertations, and Projects

2007

Parental childhood sexual abuse : trauma-specific effects on therapists

Rebecca Elizabeth Randall

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Randall, Rebecca Elizabeth, "Parental childhood sexual abuse : trauma-specific effects on therapists" (2007). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/1281>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Rebecca Elizabeth Randall
Parental Childhood Sexual
Abuse: Trauma-Specific
Effects on Therapists

ABSTRACT

The purpose of this study was to explore how working with clients who have experienced the specific trauma of parental childhood sexual abuse impacts the therapist. Most of the literature on vicarious traumatization does not differentiate between trauma-specific affects of working with particular populations of trauma survivors. The sample for this qualitative study was comprised of twelve licensed clinicians who had worked with a minimum of five survivors of parental childhood sexual.

The major findings of the study were that there are trauma-specific risks for vicarious traumatization when working with survivors of parental childhood sexual abuse because of the degree of intensity of rapidly shifting emotions that are evoked when doing this work; and not the breath of emotions, except for the trauma-specific emotions connected to parental betrayal. These participants punctuated the need for consultation, supervision, and a range self care options as requisite supports to do the work. Recommendations include the need to benchmark minimum standards of support and self care for people doing this work that can be standardized throughout the industry. Participants remained positively connected and committed to the work despite the challenges, because of a sense of fulfillment from feeling that they are doing important and necessary work, and an affectionate attachment to their clients.

PARENTAL CHILDHOOD SEXUAL ABUSE:
TRAUMA-SPECIFIC EFFECTS ON THERAPISTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Rebecca Elizabeth Randall

Smith College School for Social Work
Northampton, Massachusetts 01063

2007

ACKNOWLEDGEMENTS

This thesis could not have been completed without the guidance and support of my thesis advisor Dr. Mary Hall. I would also like to say a special thank you to Dr. Jean LaTerz. Thanks also to all of the clinicians who shared their time and stories with me.

Thank you to all of my friends who endured this chaotic process with me. Most importantly I would like to thank my unbelievably supportive and loving parents for all of their encouragement and patience.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES	iv
CHAPTER	
I. INTRODUCTION	4
II. LITERATURE REVIEW	8
III. METHODOLOGY	35
IV. FINDINGS	39
V. DISCUSSION.....	70
REFERENCES	78
APPENDICES	
Appendix A: Human Subjects Review Approval Letter	83
Appendix B: Recruitment Letter	84
Appendix C: Informed Consent.....	85
Appendix D: Interview Guide	87

LIST OF TABLES

Table.....	Page
1. Table 1: Participant Demographics.....	40
2. Table 2: Participant Clinical Demographics.....	41
3. Table 3: Participant’s Clinical Experience	42
4. Table 4: Participant’s Clinical Experience with Specific Populations	43
5. Table 5: Case Gender Distribution	45
6. Table 6: Case Perpetrator Distribution	45
7. Table 7: Case Diagnoses.....	47
8. Table 8: How Participants Met the Challenges.....	54
9. Table 9: Difficulties of Specific Cases Discussed by Participants	61
10. Table 10: Difficulty of Working with Survivors of Parental Childhood Sexual Abuse as a Specific Population.....	64
11. Table 11: Suggestions for Other Therapists Working with Survivors of Parental Childhood Sexual Abuse.....	67

CHAPTER I

INTRODUCTION

A substantial body of literature has emerged in recent years concerning the potential risk for therapists to experience vicarious trauma when working with traumatized clients. For the most part, however, this literature has been generalized to include all types and populations of trauma survivors, regardless of the etiology or severity of the trauma. Thus, we know very little about whether there are trauma-specific effects on therapists working with particular populations of trauma survivors. The purpose of this study was to explore how working with clients who had experienced the specific trauma of parental childhood sexual abuse impacts the therapist.

Childhood sexual abuse is unequivocally taboo in this country; and yet, it is alarmingly prevalent and the numbers of reported cases continue to rise. Childhood sexual abuse is defined as the molestation of a minor, most often between the ages of 4 and 12, and includes exposure, fondling, verbal sexual assaults with or without physical contact, as well as intercourse (Kuyken, 1995). Currently there are 80,000 reported cases of child sexual abuse each year with an untold number of unreported cases (American Academy of Child & Adolescent Psychiatry, 2004). There are an estimated 39 million survivors of childhood sexual abuse in the United States, and an estimated thirty to forty percent of these survivors have been abused by a family member (Darkness to Light,

2005). The ramifications of childhood sexual abuse are numerous and can be extensive, as well as deeply disturbing victims and affecting their life choices.

From a clinical perspective, survivors of childhood sexual abuse may present with a multitude of issues that they do not necessarily associate with their sexual abuse e.g., eating disorders, depression, or generalized anxiety. Others may present with greater awareness that they are experiencing effects of their sexual abuse in the form of Posttraumatic Stress Disorder (PTSD). These symptoms may include: flashbacks, intentional reexposure to victimization, avoidance behaviors, withdrawal from sexual relationships, hypervigilance, numbing or dissociating, anhedonia, substance abuse, self-harm, or suicidal ideation or attempts (Dent-Brown, 1993; Kuyken, 1995). Furthermore, survivors may experience traumatic sexualization (problematic views or sexual dysfunctions), distrust in intimate relationships, feelings of powerlessness, or negative feelings turned inward (such as feeling dirty, bad, or shameful) (Cahill, Llewelyn, & Pearson, 1991; Finkelhor and Browne, 1985; Herman, 1981; Kuyken, 1995).

Perpetrators of childhood sexual abuse are diverse and may include: parents or caregivers; extended family members; or non family members, e.g. teachers, ministers/priests and other persons that are known to the victim; as well as strangers (Child Molestation Research & Prevention Institute, 2007; Etherington, 2000; Finkelhor & Brown, 1979; Kuyken, 1992; 1995). Childhood sexual abuse in any form is horrific for the individual. However the terror that accompanies childhood sexual abuse by a parent or guardian is considered among the most traumatic because it is accompanied by parental betrayal.

There is widespread acceptance in the literature that when the abuser is a parent, the impact on the victim is more pronounced than with any other type of abuser (Bagley & Ramsey, 1986; Finkelhor, 1979; Ketring, S. & Feinauer, L., 2000; Kuyken, 1992; Peters 1988). This is not hard to understand as the parent's role in a child's life is all-encompassing; the child is fully dependent on his or her parent for most everything (physical needs, emotional needs, and daily life). The role of the parent is to love and protect. The element of parental betrayal, in turn, intensifies the impact of the abuse (Ketring & Feinauer, 2000). With the exception of court intervention, there is usually no true replacement, avoidance, or escape from a parent. A parent who sexually abuses a child violates the innate trust inherent in the parent child relationship (Etherington, 2000). When the protector of the child becomes the perpetrator of sexual abuse, the victim must contend with powerful and conflicted emotions. These issues lend themselves to countertransference and put therapists at a greater risk for vicarious traumatization.

The phenomenon of countertransference in which the therapist has a personal reaction to the client and the content of the therapy is unavoidable and is considered, in most cases, to be a positive and important component of the treatment itself (Cunningham, 2003; Grabbard, 1999). In fact, Hafkenscheid, (1993; 2005) maintains that the fact that most therapists cite seriously traumatized patients as their most difficult cases is really a manifestation of a higher level of countertransference on the part of the therapist. Vicarious traumatization is a severe and potentially less beneficial reaction to the client and the content of a session on the part of the therapist when compared to countertransference. In the instance of parental childhood sexual abuse the material of severely traumatized clients may be so powerful as to traumatize the therapist him/herself

(Rasmussen, 2005). Vicarious traumatization refers to changes that a therapist experiences related to his or her sense of self or the world, as well as issues of safety and trust due to being indirectly exposed to a traumatic event. That is, therapists may experience some of the same symptoms experienced by childhood sexual abuse victims themselves (Pearlman & McIan, 1995).

While research on the impact of childhood sexual abuse on the victim is considerable, very little trauma-specific attention has been paid to the effects of the work on the professionals that provide treatment to the survivors of parental childhood sexual abuse. For the most part, this literature has been generalized to include all populations of trauma survivors, regardless of their cause. Thus, we know very little about whether there are trauma-specific effects on therapists associated with their work with particular populations of traumatized patients.

This qualitative study was designed to make a contribution to filling this gap by seeing what we can learn about the impact on the therapist of clinical work with survivors of childhood sexual abuse by a parent from the practice wisdom of experienced therapist that have treated this population.

CHAPTER II
LITERATURE REVIEW
Childhood Sexual Abuse

Statistics of Childhood Sexual Abuse

The statistics of childhood sexual abuse are sobering and just to give a sense of its magnitude, the following statistics are offered. There are 80,000 cases of reported childhood sexual abuse each year (American Academy of Child & Adolescent Psychiatry, 1998). One in four females and one in six males are sexually abused before age 18 (RAINN, 2006). Children under the age of 17 comprise 70% of reported sexual assault cases. Currently there are an estimated 39 million survivors of childhood sexual abuse in the United States, 30% to 40% of which were abused by family members (Darkness To Light, 2005). An additional 50% of victims of childhood sexual abuse are abused by non-family members that they know and trust, allowing strangers to account for only about 10% of the childhood sexual abuse perpetrators reported (Darkness To Light, 2005). It must be noted that these numbers comprise only reported cases. Because of the nature of the act, there are undoubtedly a significant number of unreported cases (Darkness to Light, 2005).

Twenty percent of reported childhood sexual abuse occurs before the age of eight, and the average age for reported childhood sexual abuse is nine years old (Darkness To Light, 2005). Since a child is unable to consent to sex or sexual behaviors, all sexual acts with a child are considered nonconsensual. In fact, sexual abuse usually comes to an end

when the child is 14 or 15 years old because at that age they child may threaten to report (Kuyken, 1995). Child sexual abuse in any form takes a serious toll on the child. For example the sexual abuse may cause serious physical injuries to the victim, however more alarming are the psychological ramifications that can endure for a lifetime and seriously impede one's personality development (Affeld-Niemeyer, 1995).

What is Childhood Sexual Abuse?

According to the American Psychiatric Association there is no universal definition of childhood sexual abuse; rather, childhood sexual abuse can be loosely characterized as forcing or coercing a child into any sexual activity (APA, 2001). While the sexual activities can be diverse, they generally fall into two categories in the literature: touching behaviors and non-touching behaviors. Touching behaviors may include: touching a child's genitals (vagina, breasts, penis, testicles or anus) for sexual pleasure; forcing a child to touch someone else's genitals; placing objects (body parts or others) into a child's mouth, vagina, or anus. Non-touching behaviors may include showing a child pornography, showing a child one's genitals, photographing a child in sexual acts, and invading a child's privacy, e.g., watching a child undress or go to the bathroom (Stop It Now!, 2005). Childhood sexual abuse can be characterized in a number of ways, including but not limited to, "fondling a child; talking dirty to a child; exposing a child to pornography; masturbating a child or forcing a child to masturbate an adult (or, other person); and oral, anal, or vaginal intercourse" (Vander Mey & Neff, 1986, p 2).

Perpetrators and Victims of Childhood Sexual Abuse

Childhood sexual abuse can be perpetrated by anyone. However in 90% of cases the victim knows and trusts the perpetrator (Stop It Now!, 2005). Perpetrators may

include parents, step-parents, siblings, other relatives, family friends, neighbors, child care persons, teachers, or strangers (American Academy of Child & Adolescent Psychiatry, 1998). Perpetrators of childhood sexual abuse span all age groups, genders, races, and socioeconomic backgrounds (APA, 2001; National Center for Victims of Crime, 1997). The stereotype of the loner male lurking around the playground is not only inaccurate, but can prohibit the protecting of children from the real perpetrators (Stop It Now!, 2005).

Similarly children are at risk for sexual abuse regardless of age, race, culture, gender, or socioeconomic status (APA, 2001; National Center for Victims of Crime, 1997). While there are really no children who are out of harms way, statistically females are abused more often than males (National Center for Victims of Crime, 1997). However, this could be due to the fact that males are less likely to report than females (RAINN, 2006). Both males and females are most likely to be sexually abused between the ages of seven and 13 (Finkelhor, 1994).

Effects of Childhood Sexual Abuse

The trauma of childhood sexual abuse may manifest itself in a variety of ways. Some survivors of childhood sexual abuse may experience short term effects of their trauma, such as: regressive behaviors, sleep disturbances, eating issues, behavior issues at school or at home, or lack of participation in normal activities (APA, 2001). Other survivors of childhood sexual abuse may encounter more long term symptoms, such as: depression, anxiety, self-destructive behaviors, or relationship or sexual issues (APA, 2001). Still other frequent effects may include feelings of fear or guilt, isolation, acting out, or nightmares (APA, 2001; National Center for Victims of Crime, 1997). Certain

survivors of childhood sexual abuse will not display any symptoms for extended periods of time lasting into adulthood, these are referred to as “sleeper effects” (APA, 2001).

Poor self-esteem, depression, anxiety and eating disorders are some of the most common effects of childhood sexual abuse and are just some of the diagnoses that are commonly found with survivors of childhood sexual abuse. Depression—and in some cases suicidal ideation—is the most commonly reported symptom by adult survivors of childhood sexual abuse, and in the case of female victims, depression and anxiety are both commonly experienced (Finkelhor, Araji, Baron, Browne, Peters, & Wyatt, 1986; Kuyken, 1995; O’Donahue & Geer, 1992). Eating disorders, especially purging (bulimia), are also commonly found in childhood sexual abuse survivors and are thought to be linked to poor self-esteem (Kuyken, 1995). As with many who experience emotional pain, an attempt is made to self-medicate to suppress intolerable memories or feelings, which often leads to substance abuse (Davies, 2004). Other effects of childhood sexual abuse may be recurring fears, sleeping and eating disorders, self-blame, feeling damaged; as well as acting out by being physically or sexually aggressive (O’Donahue & Geer, 1992). Childhood sexual abuse may also impact the individual socially. Many children experience difficulties in their relationships with peers in addition to having poor relationships with their parents (Kuyken, 1995).

Posttraumatic Stress Disorder.

Posttraumatic Stress Disorder (PTSD), which is often found in the aftermath of trauma, is one major consequence of childhood sexual abuse. PTSD symptoms may co-occur with many of the aforementioned symptoms, or they may present on their own. A host of symptoms regularly accompany PTSD when it occurs as a result of childhood

sexual abuse. These symptoms include flashbacks, repressed memories, reexposure to victimization, denial, avoidance behaviors, withdrawal from sexual or intimate relationships, hypervigilance, numbing, dissociating, anhedonia, substance abuse, self-harm, and suicidal ideation (Dent-Brown, 1993; Etherington, 2000; Kuyken, 1995). They may be temporary or last throughout one's life.

Other psychological symptoms experienced by survivors of childhood sexual abuse may manifest in one's behavior or in emotional states. For example, survivors of childhood sexual abuse may become hypervigilant, aggressive, withdrawn, unable to accurately test reality, or be developmentally delayed cognitively (Davies, 2004). These behaviors are caused by emotions brought about by the trauma. Survivors of childhood sexual abuse may experience "traumatic sexualization" (characterized by problematic outlooks on sex and sexual dysfunctions), a sense of betrayal (lack of trust or inexplicable anger in intimate relationships), stigmatization, or powerlessness (Cahill, Llewelyn, & Pearson, 1991a; Finkelhor & Browne, 1985; Kuyken, 1995). These symptoms may be temporary or long-lasting, depending on the individual's ability to process and make sense of his/her abuse.

Implications of childhood sexual abuse on development.

Childhood sexual abuse, as with many traumatic events, may hinder a child's ability to develop in a healthy manner, especially if the abuse is repeated (Davies, 2004). A number of developmental issues are raised, including the ability to trust (Walker, 2004). The overstimulation that a child experiences when sexually abused overwhelms their senses of fear, sexuality, and helplessness all at the same time, creating a delay, or in some cases, totally arresting the child's ability to develop into a well-adjusted adult

(Etherington, 2000). In short, childhood sexual abuse greatly impacts the way the child will function in the world.

Predictors of Trauma in Childhood Sexual Abuse Survivors

Although the trauma of childhood sexual abuse affects individuals differently, there are some factors that may best predict the level of trauma. These factors include the length of time that the child was abused, the child's relationship to the perpetrator, the severity of the abuse, the coercion involved in the abuse, whether the involvement of the child was active or passive, a child's reactions to disclosure, and the child's age when the abuse occurred (Kuyken, 1995). All of these factors shape the way in which the child is affected by the abuse, and some combinations lead to an exponential effect on the level of the trauma. Not surprisingly, the severity of the abuse is thought to be the biggest predictor of the level of trauma (Ketring & Feinauer, 2000; Kuyken, 1995). However, the severity of the abuse is not limited to the nature or content of the abuse, but also who is perpetrating the abuse.

Parental Childhood Sexual Abuse

The underreporting of childhood sexual abuse is particularly salient for parental childhood sexual abuse cases, since the victims of childhood sexual abuse by a parent are even less likely to report. When a child who has been sexually abused by someone they trust or care for, they often feel torn between affection, loyalty and the awareness that the sexual activities are wrong decreasing the likelihood of reporting (American Academy of Child & Adolescent Psychiatry, 1998). Survivors of childhood sexual abuse by a parent may experience feelings of guilt and shame, fear of physical punishment and/or loss of love, or that their disclosure will break up the family unit (American Academy of Child

& Adolescent Psychiatry, 1998). Thus children often do not disclose their abuse, even when asked.

The trauma of childhood sexual abuse is often turned inward, especially in cases of parental childhood sexual abuse. The phenomenon of blaming oneself for the abuse occurs because the victim often feels it's too dangerous to blame one's caregiver. Furthermore, the concept of one's parent—who is supposed to love and protect their child—violating that child clashes so completely that the victim may indeed be unable to believe that their parent is at fault. There are a number of ways in which survivors of childhood sexual abuse persecute themselves as a result of their abuse, which varies from individual to individual and the circumstances surrounding the trauma. Victims of childhood sexual abuse often create negative feelings about themselves, for example, feeling dirty, bad, or shameful (Herman, 1981; Kuyken, 1995). They may see themselves as bad or feel extremely guilty, which then may manifest in further negative feelings that are strongly linked to the individual's self-esteem and feelings of self worth (Violette, 1995).

Parental Betrayal

It is indicated that there is a profound impact on children sexual abused by a parent. As stated earlier many sexually abused children are victimized by a family member (Darkness To Light, 2005). As with any trauma, the victim experiences a fight-or-flight response; however, when the abuser is a parent, the victim can do neither (Davies, 2004). The child is essentially trapped with their trauma or his/her perpetrator, thus creating a sense of powerlessness that intensifies the trauma and the residual effects on the child. With regard to level of threat, the more threatening the person finds an

event, the more traumatic it will be (Beaton, Murphy, Johnson, Pike, & Corneil, 1998).

The sense of betrayal that accompanies parental childhood sexual abuse in itself elevates the trauma for the child (O'Donohu & Geer, 1992; Ketring & Feinauer, 2000), and when a parent is the perpetrator, the sense of betrayal is heightened.

Not surprisingly, parental childhood sexual abuse is the most powerfully traumatic form of childhood sexual abuse. Most researchers agree that survivors of childhood sexual abuse by a parent are more likely to experience more severe and longer-term effects than for any those abused by a nonparent (Finkelhor, 1979; Kuyken, 1995; Peters, 1988). Alternatively, there are some researchers who do not hold this view, but rather contend that the trauma is more impacted by the quality, nature, and proximity of the relation (Lucenko, Gold, & Cott, 2000). It has been pointed out, however, that children who are abused by their parents tend to be abused more frequently and for a longer period of time due to access (Lucenko et al., 2000).

Survivors of childhood sexual abuse at the hands of a parent must also grapple with the broken trust, misuse of power, and boundary violations, all of which would have less of an impact with sexual abuse by a nonfamily member (Etherington, 2000).

Children have no choice but to depend on their parents, and when a child is sexually abused by a parent, that child can no longer depend on that parent in the way in which they should, which is why parental childhood sexual abuse is particularly traumatic (Etherington, 2000). By removing the support of the parent (who would be the most likely confidant), parental childhood sexual abuse is less likely to be reported or even believed if it is reported. Just as children do not want to "tell on" their parents, people do not want to believe that parents are capable of abusing their own children. Without being

able to rely on their parents, victims of childhood sexual abuse are left with no support to report the abuse or to cope with the aftermath and stigma of reporting it. As a result, many survivors of parental childhood sexual abuse internalize, thus increasing the trauma (Ketring & Feinauer, 2000).

Researchers of sexual abuse have used strong language to describe the child's situation. Walker (2004) has characterized children who are sexually abused by a parent as stripped of any sense of safety; their home is turned into a "war zone," and every aspect of their lives is infected and affected. These individuals have suffered inescapable violence which has struck at the core of their sense of self. The confusion imparted upon them is both painful and destructive, leaving them essentially emotionally scarred for life.

Treatment of Childhood Sexual Abuse

Countertransference

A significant component in therapy is countertransference, which is currently characterized as the therapist's psychological reactions to the client and content of the therapy. These reactions are unavoidable and inevitable in clinical work, and they are especially relevant in trauma work and can provide invaluable information to the therapist (Cunningham, 2003; Hafkenscheid, 2005). Some theorists refer to countertransference as an emotional response to the transference presented by the client, and they, too, consider it an important tool to deciphering the client's unconscious (Grabard, 1999). Feelings that the client is unable to express verbally may be realized through transference and countertransference. "It [countertransference] has moved from a narrow conceptualization of the therapist's transference to the patient to a complex and

jointly created phenomenon that is pervasive in the treatment process” (Garabard, 1999, p. 6).

Countertransference affects therapists in a variety of ways. Some countertransference reactions of therapists are disbelief or fears that they are either being voyeuristic or that they themselves are acting abusive (Bartlett, 1996). These reactions are impacted by the way in which the client presents and thus evokes emotions from the therapist. It is important to the therapeutic process that the therapist recognize what role they are taking on for the client and the implications that this role has to the therapeutic process. Clients who have been abused often induce certain feelings from others (including their therapists), such as being abusive or abused, victimized, avoidant, or neglectful (Bartlett, 1996). These emotions experienced by the therapist can provide great insight into the client’s experience, and when acknowledged, can be a valuable and beneficial tool to the therapist. On the other hand, countertransference left unexplored has the potential to lead to more highly charged—and thus problematic—reactions on the part of the therapist.

Constructivist Self-Development Theory

People interpret events through their own realities. These realities are called schemas, and as one’s life experiences accumulate throughout adulthood, these schemas become more complex (McCann & Pearlman, 1990). Schemas are comprised of assumptions, beliefs, and expectations about others, oneself, and the world, and they are shaped through individuals absorbing information from other people and life experiences. Additionally when psychological core beliefs are disrupted it can prohibit a therapist from functioning to the best of their ability.

Trauma disrupts therapists schemas

Constructivist Self-Development Theory addresses the effects of trauma work on therapists and states that a therapist's schema may be disrupted when the therapist is indirectly exposed to trauma. This, in turn, may lead to vicarious traumatization. The principal beliefs impacted—and sometimes threatened—by exposure to trauma, on a personal level, are the sense of personal invulnerability, the positive view of oneself and belief in one's self-worth, and on a more general level, the belief that people are generally trustworthy and that we live in a meaningful, orderly, and benign world (Cunningham, 2003; McCann & Pearlman, 1990).

When one's personal beliefs and schemas clash with an event or experience, it creates a disturbance (Cunningham, 2003; McCann & Pearlman, 1990). For instance, if a therapist holds the belief that people are generally good but then is repeatedly exposed to stories and experiences that would suggest otherwise, it creates a disruption in the therapist's personal schemas. Thus, a primary indicator of the severity of vicarious trauma is the extent to which the traumatic material differs from the therapist's own schemas (McCann & Pearlman, 1990).

Psychological needs affected by trauma work

There are five primary psychological needs: safety, trust, power, esteem, and intimacy; these are all affected by trauma (McCann & Pearlman, 1990). According to Constructivist Self-Development Theory, these five needs are significantly impacted by trauma work, especially in cases of childhood sexual abuse, and may lead to vicarious traumatization (McCann & Pearlman, 1990). These psychological needs are the basis of one's emotional foundation, and when disrupted, one's ability to function at his/her full

capacity is compromised. When therapists work with childhood sexual abuse survivors, they are continuously hearing stories that contradict their own schemas and thus threaten their core beliefs around safety, trust, power, esteem, and intimacy. As a result, they may experience vicarious traumatization or compromised intentions.

Trust.

It is easy to believe that people are trustworthy and ultimately good when our lives revolve around a benign environment. However, when in a profession where one inevitably becomes repeatedly exposed to deceit, betrayal, and violations of trust, for instance when working with childhood sexual abuse survivors this inherent trust is broken (McCann & Pearlman, 1990). Repeatedly being exposed to people's sufferings due to the cruelty of others may result in the therapist becoming cynical or jaded. The therapist may potentially start to expect the worst of people so that his/her schemas are not continually disrupted. One's belief in an overall trustworthiness in humankind is invariably disturbed and put into question when being bombarded by stories of people who are not trustworthy.

Esteem.

Esteem is the way in which people view others as worthy of trust and respect (McCann & Pearlman, 1990). These psychological needs of trust and esteem, when contradicted, often lead to pessimistic views of people and the world as a whole. This can especially germane to clinical trauma work because therapists positive regard for people is constantly challenged when repeated listening to stories of abuse.

Safety.

The therapist's sense of safety and security may be challenged when being exposed to numerous accounts of dangerous situations (McCann & Pearlman, 1990). The therapist may experience fears or images similar to the traumatic experiences recounted by their clients. In the specific case of childhood sexual abuse, therapists may see images of children being raped or molested, and they may have a heightened sense of personal vulnerability. It is not uncommon for therapists who work with survivors of sexual abuse trauma to experience disruptions in their own sense of safety, and the greater the therapist's own need of a sense of safety, the greater the disruption (Cunningham, 2003).

Power.

According to Constructivist Self-Development Theory a client's feelings of helplessness may lead to the therapist questioning his/her own power and effectiveness (McCann & Pearlman, 1990). The greater the therapist's own need to feel in control and effective, the more vulnerable he/she will be. One example of how vicarious traumatization may manifest is when this feeling of powerlessness on the part of the therapist leads the therapist, in lieu of working to understand the client's situation, to erroneously advise the client to take action when the client may not be prepared to do so (McCann & Pearlman, 1990).

Intimacy.

Due to the professional requirements of confidentiality, therapists are particularly vulnerable to this need, because they cannot share their clients' stories with their colleagues or others, leading to isolation. Therapists who work with childhood sexual abuse may experience professional alienation from their peers. This is either attributable

to the assumptions by peers that the therapist is trying to work out some of his/her own unresolved issues or feelings around the taboo of sexual abuse, or simply that the work itself is repulsive (McCann & Pearlman, 1990).

Constructivist Self-Development Theory illustrates why vicarious traumatization can affect therapists working with trauma, including those working with survivors of childhood sexual abuse by a parent. The client's trauma can disrupt the therapists preexisting schemas or conflict with psychological needs, but ultimately can affect therapists competence. The following will discuss exactly what vicarious traumatization is and how to prevent it from impeding the therapeutic process.

Vicarious Traumatization

The term vicarious traumatization was coined by McCann and Pearlman in 1990, stemming out of the Constructivist Self-Development Theory. It is also sometimes referred to as secondary traumatization. Pearlman and McIan (1995) defined vicarious traumatization as a transformation or change experienced by a therapist in their sense of self and the world due to being indirectly and repeatedly exposed to trauma in a clinical setting. Vicarious traumatization supplies a framework for understanding the ways in which therapists are affected by trauma work (Cunningham, 1999).

Vicarious traumatization is an example of a highly charged reaction by the therapist, and although it is an exaggerated form of countertransference, it is not the same. That is, vicarious traumatization and countertransference cannot not be used interchangeably (Pearlman & Saakvitne, 1995). Unlike countertransference, which may occur in a single therapy session, vicarious traumatization is cumulative and occurs over an extended period of time (Cunningham, 1999). Vicarious traumatization is particularly

relevant to therapists working with survivors of parental childhood sexual abuse because of the elevated level of trauma addressed in therapy.

It is not surprising that most therapists cite seriously traumatized clients as their most difficult cases (Hafkenschied, 2005). It serves to reason that therapists are impacted more profoundly by their trauma work than by any other type of therapy. In fact, in a study of 558 mental health professionals and law enforcement professionals providing services to survivors of childhood sexual abuse, Follette and his colleagues (Follette, Polusney, & Milbeck, 1994) found unequivocally that exposure to trauma survivors leads to vicarious traumatization (see also, Cunningham, 2003; Nelson-Gardell & Harris, 2003; Rasmussen, 2005). Although vicarious traumatization should certainly draw a red flag, if identified and handled well, it can also have beneficial effects on the therapeutic process.

Vicarious traumatization occurs when the therapist connects to the client through empathy. However, while empathy is an essential element to the patient-therapist relationship (empathy requires the therapist to at least imagine what it would be like to have experienced what the client experienced), overidentification with the client impedes the therapy process and will inevitably lead to vicarious traumatization (Nelson-Gardell & Harris, 2003).

Predictors of Vicarious Traumatization

There are a number of predictors that put therapists at a higher risk for vicarious traumatization. Lerias and Byrne (2003) found that previous exposure to trauma, life stress, mental health status, level of social support, and coping styles all influence how therapists are impacted by trauma work. In addition, the age of the therapist and number

of years in the profession are predictors: younger therapists are at higher risk as are less-experienced therapists. Other demographic factors include gender, with female therapists at a higher risk than male therapists. Additionally therapists who are of higher socioeconomic status or education are more likely to utilize resources than other therapists, thus reducing their risk for vicarious traumatization (Hunter & Scholfield, 2006; Lerias & Byrne, 2003).

Other contributing factors that increase the likelihood of a therapist experiencing vicarious traumatization have to do with the therapist's personal exposure to trauma (Cunningham, 2003; Nelson-Gardell & Harris, 2003). For instance, there is a positive correlation between a personal history of sexual abuse and those therapists who work with sexual abuse survivors (Cunningham, 2003). Some researchers contend that the percentage of childhood sexual abuse cases on an individual therapist's caseload is a contributing factor, especially given the fact that cumulative exposure is a predictor of vicarious traumatization (Follette, Polusny, & Millbeck, 1994). Similarly, the potential for vicarious traumatization is commensurate with the level and length of the trauma experienced by the client, just as is the case with the client (Cunningham, 2003).

Impact of Vicarious Traumatization on the Therapist

Vicarious traumatization can impact the therapist in a multitude of ways. Recent studies show that human induced trauma has a greater impact on therapists than natural trauma (Cunningham, 2003). Thus, listening to the trauma of parental childhood sexual abuse impacts the therapist more than listening to the trauma of a terminal illness for example. This is why the effects of vicarious traumatization are so relevant to therapists working with survivors of parental sexual abuse. Vicarious traumatization is thought to

affect the therapist's sense of self, other, safety, trust, and esteem to such a great extent that therapists may experience symptoms similar to their clients (Cunningham, 2003; Rasmussen, 2005). Theorists suggest that vicarious traumatization can manifest in such ways as: therapists encountering some of the same symptomology as their clients; a diminished capacity for self-protective beliefs about safety, control, and predictability and attachment; and feelings of cynicism, despair and loss of hope (Pearlman & Saakvitne, 1995).

The symptoms of vicarious traumatization may come in the form of physical or emotional symptoms. Researchers have suggested that therapists experiencing vicarious traumatization may suffer from increased fatigue or illness, emotional numbing, social withdrawal, or reduced productivity (Nelson-Gardell & Harris, 2003). McCann and Pearlman (1990) suggested that therapists could experience the same PTSD symptoms as their clients who had been traumatized. Some of these symptoms include nightmares, intrusive thoughts, extreme vigilance, irritability, and suspicion of other people's motives (Hafkenschied, 2005). Grotesque and bizarre images, dreams, or fantasies are still other effects that may be experienced by therapists as a result of vicarious traumatization (Etherington, 2000). Additionally, therapists may encounter feelings of helplessness, incompetence, despair, and loss of faith in the power of the therapeutic relationship when experiencing vicarious traumatization (Etherington, 2000; Nelson-Gardell & Harris, 2003). As a result of the effects of vicarious traumatization therapists working with trauma survivors can become less emotionally available in their personal and professional lives (Trippany, Kress, & Wilcox, 2004). Therapists experiencing vicarious traumatization frequently also suffer from depression or anxiety (Cunningham, 2003).

Experiences of grief, alienation, as well as loss of esteem for self and others also often accompany repeated exposure to trauma in a therapeutic setting (McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996; Trippany et al, 2004). Symptoms of vicarious traumatization affect therapists on both a personal and profession level, thus impacting the therapeutic process.

Exasperating the symptoms of vicarious traumatization is the understandable and natural alienation experienced by therapists. Therapists, who work with survivors of childhood sexual abuse, often find that others regard their work as repulsive or horrifying. This may cause therapists to socially withdraw and/or increase their sense of isolation (Etherington, 2000). Vicarious tramatization is something that therapists experience in both their personal and professional lives, which ultimately increases the risk that there will not be the opportunity to process the extreme level of trauma that they are clinically exposed to.

Therapists that experience vicarious traumatization when working with survivors of childhood sexual abuse may find themselves adopting the role of one of individuals involved in the client's abuse. In this instance therapists are thought to identify with the victim, rescuer, or perpetrator, ect.; and experience the associated feeling of helplessness, rage, a need to 'champion' the client's cause, or even feelings responsible (Etherington, 2000). The therapist may feel the client's rage with the perpetrator or bystander, feelings of being unprotected or helpless. Similarly the therapist may also take on the role of the rescuer or hero, feeling that they are the only one who truly understands and can help the victim or client. On the other hand, the therapist may identify with the perpetrator by experiencing feelings of disbelief, judgment, or minimizing towards the client's

experience. This occurs due to the feelings of the helplessness experienced by the therapist; by taking the role of responsibility (or the perpetrator) the therapist can feel that they are powerful and in control (Etherington, 2000). Obviously, these feelings unacknowledged can be detrimental to the therapeutic process, but they can also be very insightful and beneficial if processed appropriately.

Impact of Vicarious Traumatization on the Therapeutic Process

As with any countertransference, it must be acknowledged and worked with. The result, even in the extreme form of vicarious traumatization, will inform and enhance the therapy and ensure its quality (Cunningham, 1999; 2003). Some researchers go so far as to view vicarious traumatization as a natural byproduct of working with trauma survivors (Figley, 1995). Of course, if the vicarious traumatization is not held in check, a number of situations detrimental to the therapy may occur. Vicarious traumatization has generally been regarded similarly to countertransference, in that it can be a useful tool to the therapist if it is monitored and used in an intentional way.

The establishment of proper boundaries between the therapist and the client is one of the most critical issues in the therapy. If these boundaries are compromised due to the therapist's vicarious traumatization, the therapy alliance may be ineffective (Hunter & Schofield, 2006; Pearlman & McCann, 1990; Trippany et al., 2004). This can be illustrated by the case in point when the client detects the therapist's discomfort and tries to protect the therapist from these unpleasant feelings by choosing not to bring the traumatic material into the room.

Another component of successful therapy is the establishment of a holding environment in which the client feels safe to disclose her emotions. In the case of

childhood sexual abuse victims, these emotions may range from being very intense to being completely muted. The therapist must be able to hold either extreme, and caution must be exercised when vicarious traumatization is in play that the therapist is able to be emotionally flexible. That is, the therapist should neither reflect back the client's emotions to them, nor should the therapist give the client the impression that he or she cannot sit comfortably with the client's material (Rasmussen, 2005).

Vicarious traumatization can lead to other clinical errors if unacknowledged (Trippany et al, 2004). In addition to avoiding traumatic content during sessions, the therapist might try to push their own personal agendas onto their clients (for example, pressuring a client to confront his or her perpetrator before the client is ready). It is critical for therapists to acknowledge and manage the effects of vicarious traumatization to protect themselves, as well as the therapeutic process.

Therapists' Role in Preventing Vicarious Traumatization

The therapist's main role in preventing vicarious traumatization is to recognize it and then seek assistance, either through supervision, individual psychotherapy, a social support network, further education, or spiritual or healing activities (Hunter & Schofield, 2006; Sexton, 1999). There are a number of other avenues therapists may use to counter the negative effects of vicarious traumatization. Within the clinical setting, they may practice intentionally detaching, adopt a positive outlook, and establish reasonable limits on their exposure to trauma. They may also choose to create their own personal rituals or become an advocate (Hunter & Schofield, 2006). On an individual level, the most effective combatant of vicarious traumatization is self-care; that is, attending to your own personal needs, which may range from seeking supervision or peer support to socializing,

creative expression, physical activity, and adequate rest. In addition to being a component of self-care, seeking supervision also addresses one's professional and ethical needs. From the personal to the ethical concerns, all the aforementioned activities can diminish the effects of vicarious traumatization (Hunter & Schofield, 2006; Trippany et al, 2004). It is also helpful and a good way to distance yourself from the trauma if you keep in mind that your client is a "survivor" of childhood sexual abuse—the trauma is in their past—and that you are helping work your client to work through the pain (Etherington, 2000).

Support systems and a general sense of connection also assist therapists who are working with trauma survivors and coping with vicarious traumatization. These support systems can also serve to counter the feelings of isolation experienced by many therapists working with trauma survivors. They may take the form of support or self-awareness groups, education courses, or spiritual settings (Nelson-Gardell & Harris (2003). Further, therapists who continue to be social and utilize their support systems experience fewer negative effects of vicarious traumatization.

One of these support systems, peer supervision, offers both social and professional support as well as normalizing the effects of working with trauma survivors (Trippany et al, 2004). Peer supervision provides therapists with a sense of community, support, and connection, and as such, alleviates feelings of isolation or alienation. In a 1993 study, Pearlman and Mac Ian found that 85% of trauma therapists reported peer supervision as their most frequent method of coping with vicarious traumatization.

The negative effects of vicarious traumatization can also be prevented by educating students in trauma theory and vicarious traumatization in the classroom

(Cunningham, 2003; 2004). Supervisors of therapists working with survivors of parental childhood sexual abuse, especially, should be educated and up-to-date on current research and practice surrounding vicarious traumatization (Walker, 2004). In short, education specifically addressing the issue of vicarious traumatization for both therapists and supervisors should be required as it is the only means for ensuring effective, safe, and healthy therapeutic interactions with this specialized population.

The most effective prevention against vicarious traumatization is simply to limit the number of cases in a therapist's caseload that deal with trauma and ensure a balance between trauma cases and other less-strenuous cases. This will invariably decrease the risk of vicarious traumatization both for those who have already experienced vicarious traumatization and for those who have not (Cunningham, 2003; Trippany et al, 2004; Walker, 2004).

These are all resources that will help the therapist either deal with or prevent vicarious traumatization. The first step, invariably, is that the therapist must be personally aware both of the vicarioustraumatization itself and of one's own personal reaction to it. As noted by McCann and Pearlman (1990), to prevent potentially damaging effects (such as becoming numb, emotionally distant, or unempathetic to one's client) to their work, the therapist "must be able to acknowledge, express, and work through these painful experiences in a supportive environment." (McCann & Pearlman, 1990, p. 144) Being personally aware has great benefits for the therapist working with trauma. Critical to coping with trauma survivors is the ability to identify the areas of need that are particularly relevant for the therapist, as well as understanding how his or her schemas have been disrupted or altered. This may preclude the negative symptoms of vicarious

traumatization (McCann & Pearlman, 1990). As noted earlier, seeking out support is also essential to thwarting the effects of vicarious traumatization; support groups can provide emotional and professional reprieve from vicarious traumatization.

It is never safe to assume that a therapist's unresolved issues are at play when that therapist experiences vicarious traumatization from his/her work with trauma survivors (McCann & Pearlman, 1990). Nonetheless, it is important for individual therapists and their supervisors to carefully look at how therapists are being affected by trauma work. It is possible for therapists to be more susceptible to and more impacted by vicarious traumatization due to their own unresolved issues, especially since there is a positive correlation between a personal history of sexual abuse and those who work with sexual abuse survivors (Cunningham, 2003).

Pearlman and McCann (1990) make a number of suggestions for reducing the risks of working with trauma survivors. These include (a) balancing personal and professional self-care, (b) respecting personal and professional boundaries (i.e., limiting weekly caseload), (c) balancing trauma cases with other cases, (d) providing oneself with realistic expectations, (e) acknowledging and giving oneself permission to have emotions, and finally, (f) focusing on hope and optimism. It is always important, throughout a therapist's career, to be conscious of personal conflict areas or personal triggers as these may change with exposure to new experiences (Pearlman & McCann, 1990).

Lastly and poignantly, it is imperative to remember the positive aspects of working with trauma survivors, especially survivors of parental childhood sexual abuse. Simply reminding oneself of why you chose to work with this particular population and its unique rewards can in itself reduce the effects of vicarious traumatization (Sexton,

1999). Working with this deeply troubled population gives the therapist a tremendous sense of personal meaning and personal reward. It also brings with it a deeper connection with others, a more realistic view of the world, and a heightened sense of empathy that can be utilized in both their personal and professional lives (Cunningham, 1999; Pearlman & McCann, 1990). In short, it is vital to our society.

Impact of Vicarious Traumatization on Agencies and Organizations

Agencies and organizations as a whole may also be impacted by the phenomenon of vicarious traumatization. That is, the quality and effectiveness of an organization may be compromised if a number of its therapists are suffering from vicarious traumatization and are not receiving proper or effective supervision (Sexton, 1999). In addition, an organization may become somewhat unstable if it experiences a high turnover of therapists (Sexton, 1999). This is especially true for organizations that specialize in serving traumatized populations. It is critical that these agencies take responsibility for combating the effects of vicarious traumatization as a result of working with trauma survivors (Trippany et al., 2004).

Supervisors play a considerable role in preventing vicarious traumatization. It is their job to assist therapists in identifying and dealing with the effects of vicarious traumatization. Supervisors need to be particularly conscious of how their supervisees are being affected by heavy caseloads of trauma victims. Supervisors should always be on the lookout for any behavior or attitude changes of therapists towards their clients, any signs of alienation or boundary issues, and any sense that the therapist is feeling overwhelmed or on the brink of burnout (Etherington, 2000). Supervisors should probe for these signs in an attempt to detect vicarious traumatization early on. One way is to

note how the therapist is using supervision. Therapists may exhibit feelings of mistrust or general fearfulness, or they may repeatedly focus on certain aspects of their cases in supervision that creates a pattern indicative of vicarious traumatization (Etherington, 2000). Supervisors also need to be aware of therapists who appear to be reluctant to discuss certain cases in their caseload (Walker, 2004). Avoidance on the part of the therapist is one of the primary indicators to supervisors that the therapeutic work may be compromised by vicarious traumatization (Walker, 2004).

The Role of Agencies and Supervisors in Preventing Vicarious Traumatization

The responsibility of fighting the negative effects of vicarious traumatization does not fall solely on the shoulders of the therapists working with trauma survivors.

Organizations and agencies that concern themselves with trauma victims should and can combat the negative effects of vicarious traumatization in a number of proactive ways.

The first step is to treat work-related stress as legitimate and foster an approach in which vicarious traumatization is seen as an organizational issue rather than an individual therapist's issue. In short, organizations should not pathologize these natural and human responses to the bleak realities of traumatized clients, nor should they blame the individual therapists for not coping well. Rather, agencies should seek out those therapists who are struggling with their case material and offer support, tolerance, and effectiveness supervision to combat the effects of vicarious traumatization (Sexton, 1999). Agencies can also be proactive by balancing their clinicians' workloads so that individual therapists are not doing only trauma work (Hunter & Schofield, 2006).

In addition to offering supervision and consultation for individual therapists, there are a number of other resources that can be made available to therapists to assist them in

processing difficult clinical material, thus diminishing the negative effects of vicarious traumatization on the organization. These resources include peer process groups, trauma therapy training, as well as personal psychotherapy (Cunningham, 1999; Figely, 1995; Hunter & Schofield, 2006; Sexton, 1999). Agencies can also support their clinicians in working with trauma survivors by providing professional development, continuing education opportunities, paid vacations, and limiting the number of trauma cases that any one therapist has at one time (Trippany et al, 2004).

It is the fundamental task of the supervisor to ensure that the therapist's reactions to traumatic material are used in a therapeutic way and not allowed to damage the therapist, the client, or the therapy (Walker, 2004). For example, being able to dissociate can be a powerful tool and thus very beneficial to the therapist when listening to cases of severe trauma, such as parental childhood sexual abuse (Etherington, 2000). The supervisor can assist the therapist in recognizing transference and countertransference issues that might otherwise blur the therapeutic relationship and process (Etherington, 2000). It is also the job of the supervisor to assist their supervisees by addressing any negative feelings brought about by vicarious traumatization. Left unattended, these feelings can lead to exhaustion and stress (Etherington, 2000). Conversely, if a supervisor allows the therapist to deny his/her feelings, the therapist may become unavailable to his/her clients and essentially a less effective therapist. One of the supervisor's most useful tool is his/her objectivity, which can be used to help the therapist to recognize how they are being affected by working with survivors of parental childhood sexual abuse. As a caveat, it must be noted that supervisors should be sensitive to their supervisee's

personal histories of sexual abuse when working with survivors of childhood sexual abuse (Walker, 2004).

CHAPTER III
METHODOLOGY

Formulation

The purpose of this study is to explore how working with clients who have experienced the specific trauma of childhood sexual abuse by a parent impacts the therapist. A considerable literature has emerged in recent years concerning the potential risk for therapists to experience vicarious trauma and/or countertransference reactions when working with clients that have been traumatized. For the most part, this literature tends to assume a philosophic stance of being generic, i.e., there is the implicit or explicit assumption that what is learned from studying the effects on therapists of working with a specific population of trauma survivors (e.g., vicarious trauma) can be generalized to the effects on therapists of working with all populations of trauma survivors. Thus we know very little about whether there are trauma-specific effects on therapists associated with their work within particular population of traumatized clients, e.g., childhood sexual abuse by a parent versus a non family member. This study seeks to discern what we can learn from the practice wisdom of experienced therapists who have worked with survivors of childhood sexual abuse by a parent about the potential for trauma-specific effects on the therapist working with this population.

Sample

To participate in this study therapists had to be licensed in their discipline (MSW, MFT, PsyD, or PhD), have experience (minimum of five cases) in working with clients

who have been sexual abused as children by a parent(s) and agree to meet in a face-to-face interview to discuss the effects of their clinical experience(s) with the target population on them as clinicians.

Recruitment

Participants for this study were obtained using a snowball sampling strategy. The names of potential candidates for the study were initially solicited from colleagues and other professional contacts in the Bay Area of Northern California. Once a potential candidate was identified, they were sent an email or letter to introduce the study and invite their participation (See Appendix B). This was followed up by a telephone call to ascertain if the potential candidate was willing to participate and, if so, to arrange a convenient time and place to meet for the face-to-face interview. Although this was a sample of convenience, every effort was made to recruit as diverse a sample as possible in terms of demographic backgrounds and professional treatment experiences with trauma survivors.

Data Collection

As indicated, the initial contact with potential candidates is a letter or email describing the study and inviting participation that is followed up with a telephone call. Those that agreed to participate were seen in a face-to-face interview scheduled at a time and place that is mutually convenient. The interview took up to an hour. The subjects were required to sign two copies of the informed consent (keeping one for their records) before the research interview began. The researcher also reminded the participants not to use the names or any identifying information about any clients or cases that you discuss during the interview. The interview used a predetermined list of

questions for the interview (See Appendix D). The interview schedule began with demographic background questions and proceeded to more open ended questions designed to probe the effects on the subject of working with clients that have experienced childhood sexual abuse by a parent in their role as therapist. All interviews were taped and the researcher took some brief notes during the interview. The tapes were subsequently transcribed by the researcher in preparation for the analysis of content. All materials were coded and kept in a locked file cabinet.

Informed Consent

The written informed consent was sent to all potential candidates prior to the initial telephone contact (See Appendix C). This document described the design and purpose of the study, the nature of participation being requested, confidentiality procedures and risks. The informed consent also made clear the rights of the participants; i.e., that their participation is voluntary, they have the right to refuse to answer any particular question(s) without penalty as well as the right to withdraw at any time prior to the study being written up. Both the informed consent form and recruitment letter provided the subject with the researchers contact information in the case that they do want to withdraw.

Confidentiality

The researcher took precautions to protect the participants. Once the interviews were completed all identifying information about the participant was be removed from the study materials and replaced by a numeric code. Findings of the study were presented in exaggerated form only. Any illustrations or brief quotations were sufficiently disguised so that it cannot be identified with a particular participant. Consistent with federal

regulations, all study materials will be kept in a secured location by the researcher for a period of three years. After that time, the material will be destroyed or continue to be kept secured until it is no longer needed.

CHAPTER IV

FINDINGS

Demographics

Participants in this study consisted of 12 mature seasoned clinicians. There were 11 females and one male interviewed about their clinical experience with survivors of childhood sexual abuse by a parent. The ages of the participants ranged from 30 to 63 years old for a mean average of 51.3 years. However, all of the participants were over the age of 43 with the exception of the one participant who was 30 years old. All of the participants save one identified themselves as Caucasian, who self identified as Chinese American. In terms of marital status, six of the participants were married, three were single, two were divorced, and one was partnered. Five of the 12 participants had children. (See Table 1)

All of the participants had master degrees in either social work (5=41.7%) or marriage and family therapy (7=58.3%). The participants years licensed ranged from two to 38 years, with a mean average of 16.6 years and a total of 200 years. When asked about the total number of cases of parental childhood sexual abuse they had treated the participants responses ranged from six to 500 for a mean average of 156.3 for the group. The total number of cases treated was 1,876. (See Tables 2)

In summary, the participants had masters degrees and were mostly women. Their mean average of yeas licensed was16.6 years, and the mean average of parental childhood sexual abuse cases was 156.3 years.

Table 1

Participant Demographics

Participant	Age	Gender	Race	Marital Status	Children
1	30	Female	Chinese American	Single	No
2	43	Female	Caucasian	Married	Yes
3	43	Female	Caucasian	Single	No
4	46	Female	Caucasian	Married	No
5	48	Female	Caucasian	Married	Yes
6	52	Female	Caucasian	Divorced	Yes
7	54	Male	Caucasian	Single	No
8	56	Female	Caucasian	Partnered	No
9	59	Female	Caucasian	Married	No
10	60	Female	Caucasian	Married	No
11	62	Female	Caucasian	Married	Yes
12	63	Female	Caucasian	Divorced	Yes

Table 2

Participant Clinical Demographics

Participant	Clinical Degrees	Years Licensed	Number of Parental Childhood Sexual Abuse Cases
1	MSW	2	6
2	MSW	5	20
3	MFT	6	20
4	MFT	16	30
5	MFT	14	20
6	MFT	12	300
7	MFT	21	150
8	MSW	21	200
9	MSW	23	500
10	MFT	21	300
11	MFT	21	30
12	MSW	38	300
		M=16.6	M=156.3
		Total=200	Total=1,876

Note. MSW=Masters in Social Work; MFT=Masters in Marriage & Family Therapy;

M=Mean.

Table 3

Participants Clinical Experience

Participants	1	2	3	4	5	6	7	8	9	10	11	12
<u>Settings</u>												
Private Practice				X		X	X	X	X	X	X	X
Mental Health/Social Services			X	X					X	X		
Family Services						X				X		X
Hospital	X							X				X
Child/School Counselor	X			X								
Child Protective Services						X						
<u>Treatment Modalities</u>												
Family Therapy		X			X							X
Group Therapy		X			X							
Couples Therapy					X					X		
Individual Therapy		X										
Community Based							X					
Day Treatment								X				
Residential	X											

Table 4

Participants Clinical Experience with Specific Populations

Participants	1	2	3	4	5	6	7	8	9	10	11	12
Trauma/Crisis		X				X	X	X	X	X	X	
Survivors				X					X		X	
Childhood Sexual Abuse				X		X						
HIV/AIDS							X				X	
Suicide Prevention					X					X		
Emotionally Disturbed	X	X										
Runaways				X								
Chronic Mentally Ill										X		
Eating Disorders					X							

When asked about the types of settings and populations with which they had worked, the participants generated a list of six settings, eleven populations, and seven treatment modalities (See Tables 3 & 4). The settings included: private practice, mental health/social services, hospitals, Child Protective Services, and school based settings. The ten populations included: trauma/crisis, abuse survivors, childhood sexual abuse, substance abuse, HIV/AIDS, suicide prevention, emotionally disturbed, runaways, chronic mentally ill, and eating disorders. And the seven treatment modalities included: family therapy, groups, couples counseling, individual, community based, day treatment, and residential.

Overview of the Most Challenging Cases

Following the demographic questions discussed above the participants were asked to consider all of the parental childhood sexual abuse cases with which they had worked and select one of the most challenging to discuss. Eleven of the 12 cases generated had female clients and only was a male client. (See Table 5) Ten of the cases were adults and the remaining two were adolescents. The majority of the clients were in their thirties (7=58.3%). Two clients in their forties (2=16.6%). Two clients in their adolescents (2=16.6%). The final one client was in her sixties (1=8.3%). The primary perpetrator in eight of the cases was the father. In three of the remaining four cases the perpetrator was the mother, and in one case both the mother and father were described as equal perpetrators. (See Table 6) It should be noted that in four of the cases there were multiple perpetrators in addition to the parents (e.g. siblings, strangers, and parent's partners or friends).

Table 5

Case Gender Distribution

Participants	1	2	3	4	5	6	7	8	9	10	11	12
Female	X	X	X	X	X	X	X	X		X	X	X
Male									X			

Table 6

Case Perpetrator Distribution

Participants	1	2	3	4	5	6	7	8	9	10	11	12
Father		X	X		X		X	X		X	X	X
Mother	X			X					X			
Both Parents						X						

Most of the cases had more than one diagnosis. Collectively there were seven different diagnoses generated by these cases. In almost all (11=91.7%) of the cases one of the diagnoses was PTSD. In the remaining case when the client was not diagnosed with PTSD, there was a diagnosis of depression and Dissociative Identity Disorder (DID). Seven (7=58.3%) of the clients discussed had been diagnosed with some sort of dissociative disorder, including: DID or Dissociative Disorder Not Otherwise Specified (DDNOS). Five (5=41.7%) of the clients were diagnosed with depression. There were two clients who had been diagnosed with anxiety disorders, and two clients who had been diagnosed with substance abuse. Finally, there was one client who was developmentally delayed, and one client who had been diagnosed with an eating disorder. In summary, there were seven different diagnoses, most frequently noted was PTSD followed by DID and depression. (See Table 7)

Table 7

Case Diagnoses

Participant	1	2	3	4	5	6	7	8	9	10	11	12
Posttraumatic Stress Disorder	X	X	X	X	X		X	X	X	X	X	X
Dissociative Disorders (DID or DDNOS)					X	X	X	X	X	X	X	
Depression					X	X	X	X				X
Generalized Anxiety Disorder					X		X					
Substance Abuse							X	X				
Eating Disorder					X							
Developmentally Delayed		X										

Nature of Parental Childhood Sexual Abuse in Cases Described

Collectively the cases that the participants described also had a wide array of sexual abuse perpetrated by parents against their children. Most frequently cited (8=66.7%) was rape/penetration as the central type of abuse. This was followed by five (5=41.7%) of the cases having ritual abuse intertwined with the sexual abuse.

Participant 1

She was sexually abused by multiple people in her family system, primarily by her biological mother, as well as many partners and friends of her mother. She was prostituted out at a very young age, and so was engaging in sexual acts from the age of 1 and up. Our reports indicated that there was penetration on countless occasions.

Participant 6

Her father would rape her on a regular basis, and her mother would be there and join in. One particular gruesome thing that she described was when her father decided to have the [family] dog rape her.

Participant 8

It came out that she had been raped by her father memories back to toddler age until about mid adolescents.

Participant 5

About seven years old the actual intercourse started. It had always been happening [referring to penetration prior to the age of seven]. He would take her out to the tool shed and stick things in her. She just went through surgery, and they took all sorts of things out of her. Splinters that had been there for 20 years.

Participant 10

Her father sexual abused all of the children in a ritual way. He would do things like hang them and then burry them alive.

Participant 5

He would threaten her. He would kill animals, and her pets, in front of her. He would wash her out with and make her gargle with chemicals after he would sexually abuse her. Very ritualistic, but it was just him. He wanted to purify her. He would tie her down and things like that, make her watch videos, take her out of school, and keep her up all night stuff like that. Never fed her ever...her whole life. This went on for 18 years and then again in her twenties. The worst of the worst. She feels very lucky to be alive.

She was tortured for 18 years or more. There was never a moment when she could take a breath. There was no reprieve. Nobody in her family helped her, and they all knew about it. Her father starved her to death; he would feed her brother but not her. He would make her stand in the hallway while he would feed her brother. It's the worst case I have ever worked with.

Participant 6

Ah, well one sticks out in my mind because it was satanic ritual abuse, with both parents.

This person, and I know it sounds outrageous, but was forced to participate in the rituals...and I have no doubt that everything she said was true or her truth. She was forced to...and this is how they controlled children, is to have them murder a baby, and then they say (to the child) you killed a baby no one is ever going to believe you (about going outside of the cult).

Participant 3

I have worked with other clients, who have had childhood sexual abuse histories, but many of them do not go into such great detail about what happened, and hers was rape and torture. I mean her father would tie her up and rape her...ritualistic abuse.

Two of the participants discussed cases in which the parent had sexual abused the child via touching behaviors but had not penetrated the victim. In these two cases the parents had fondled the victim in an inappropriate way. There were a variety of other behaviors presented in the cases, including: voyeuristic behaviors; being prostituted out to strangers, family members, and family friends; and bestiality.

Case Specific Challenges

The participants were asked what made these cases of parental childhood sexual abuse that they described as the most challenging so demanding. Most frequently noted six (6=50%) of the participants cited listening to the abuse or witnessing the client's stories about the abuse as the most challenging aspect of the case.

Participant 6

Her recalling the memories. The horror. The horror that she endured, and it was many many many memories, because she fragmented time after time after time. The horror of what she was put through, I would say that it was traumatic for me

also...I would really have to, before she came in do a mediation to protect myself from this horror so that I would not lose my objectivity.

Participant 2

I guess just the horrific stories, because she was so young and the way that the father used his daughters as sex objects and hurt them forever and he only had to serve a year in jail.

Participant 3

Hearing about what she went through. I have worked with other clients, who have had childhood sexual abuse, but many of them do not go into such great detail about what happened, and hers was rape and torture. I mean her father would tie her up and rape her. So that was really difficult to listen to, other people that I have worked with will mention it and not want to go into such detail as she did. Its difficult hearing her tell about things that happened in her childhood.

Participant 7

Sometimes utterly flabbergasted by things she would say. I went from believing her story, to not knowing how it would be possible and not believing it, to believing it again, and then realizing that it didn't matter what I believed. To listen to that level of human behavior is very hard. It is a very dark underside of humanity, which I do think exists. But it is hard to think that it exists and get perpetrated on people.

Five (5=41.7%) of the participants cited the associated dysfunction in the client's current lives with which the therapists felt helpless to intervene as what made this cases among the most challenging. There was a sense of feeling powerlessness or helplessness when it came to protecting the clients. Lastly two of the participants stated that their feelings of countertransference were what made the case one of the most challenging.

Participant 7

The reason I am describing her is because of my countertransference, which was varied, changing, and extensive. This woman had a very chaotic life style and history, and some very self destructive behavior. I found myself vacillating, in a similar dissociated way that she would present, that different parts of myself would come out with her. I would be a sensitive listener, empathic, a stern father, and a finger wagging father.

Some of them [responses] were...a lot compassion, anger, sadness, incomprehension, feeling very much a container, very connected, and sometimes feeling like I wanted to throw her out the window.

Participant 10

I would say being an abuse survivor myself, really increases my identification with the client. Even if their abuse is not exactly like my own there are still similarities for all abuse survivors, and that then impacted my countertransference.

[Probed about her countertransference by the researcher]

Well, I guess it would say...compassion. I feel a great deal of compassion for this woman. And I guess that I feel that way with a number of my abuse survivors.

Meeting the Case Specific Challenges

The participants were subsequently asked how they were able to meet the challenges that were presented to them in these specific cases of parental childhood sexual abuse. This generated five major trends: consultation, personal therapy, supervision, meditation/spiritual practice, and allowing for emotional reactions. Specifically nine (9=75%) participants reported using consultation. Five (5=41.7%) participants commented on utilizing their own personal therapy. Three (3=25%) participants emphasized the importance of supervision. Finally two (2=16.7%) participants remarked on their use of meditation and spiritual practice, and two participants stressed the importance of allowing room for their emotional reactions. Additionally the participants generated two more lists of less frequently noted strategies addressing personal supports and treatment strategies. (See Table 8)

Meet the challenges with consultation:

Participant 6

I meet with her at least once a month to talk about transference, countertransference, what is going on, and why it hurts so much. I am confused by things that are coming, and she used to be my supervisor at Family Services so I have known her for a very very long time. And I recommend that to anyone working in this field to work with someone else who has a real good understanding of trauma and abuse.

Participant 8

I got consultation, although I had seen a lot of trauma survivors, I had not seen someone who had unwrapped quite the way she had. And I felt that it was really important for me to have a container so that I could contain her. And if you don't have that you lose your boundaries, and that is the worst thing that you can do with a trauma survivor. So that really helped.

Participant 10

I used a lot of consultation. I relied on my peers to discuss the case and get advice.

Participant 5

Consultation. Experts. Lots of consultation. I didn't try to take it on myself. This was the first DID case that I had ever worked with. So I was rather shocked. Then we decided that it would be best for me to keep working with her due to the relationship. I got consultation every week. And I'm still working with someone.

Meet the challenges by utilizing personal therapy:

Participant 10

I also have done and continue to do a lot of work on myself, to make sure that I am keeping myself neutral and not letting my own stuff into the room. I think that is really important.

Participant 6

It was a fascinating case. So in order to maintain my sanity I see a therapist, I have done over 18 years of therapy.

Participant 3

I had to make space on my own for being able to carry that stuff, and be effective. To take it outside of the therapy in consultation and in my own therapy. To work with this. It had a huge impact on me, so I had to look at really using my resources.

Participant 5

Well, I actually enjoyed the case. I found it challenging, and I learned a lot. But I also had to get outside help, like my own therapy.

Meet the challenges through supervision:

Participant 1

I really used group supervision. Um, really utilized my professional support systems.

Participant 6

I went and got a different supervisor, because my supervisor at the time said this case was beyond me. So I contacted a lot of people, and Survivorship, is a place located out of Oakland that does a lot of work with survivors of childhood sexual abuse. And I got someone to supervise me. She [the client] was paying \$5 an hour and I was paying about \$80 an hour to be supervised.

Lastly participants commented on their use of medication and spiritual practice as a ways to combat the difficulties they encountered with regards to this case, as well as making room for their emotions and not judging them.

The remaining participant's responses were varied but each was only mentioned by one of the participants. The lists generated fell into two categories: strategies that were individual to the therapist and treatment related strategies. The personal ways which helped the participants to cope with the challenges when working with parental childhood sexual abuse were: self care, social supports, venting, and exercise. The techniques that were reported by participants that were more treatment related were: remembering previous clients who got better, being flexibility in treatment, research, relying on the therapeutic relationship, medication for the client, and maintaining strong boundaries.

Table 8

How Participants Met the Challenges

Participant	1	2	3	4	5	6	7	8	9	10	11	12
Consultation	X	X	X	X	X	X		X	X	X		
Personal Therapy			X		X	X			X	X		
Supervision	X					X						X
Meditation/Spiritual Practice								X	X			
Allowing for Emotional Reactions	X			X								
Self Care		X										
Social Supports	X											
Venting	X											
Exercising		X										
Remembering Success Cases												X
Flexibility in Treatment Approaches		X										
Research												X
Utilizing the Therapeutic Relationship												X
Medication for the Client					X							
Maintaining Strong Boundaries											X	

Participants Satisfaction with the Outcomes of the Cases

The participants were asked about the outcome of the case and if they were satisfied with it or not. This question addressed the overall outcome of the case and not specific interventions, challenges, or treatment modalities. Nine (9=75%) of the participants were pleased or satisfied with the outcome of the cases, and felt that they had done good work. Only three (3=25%) were dissatisfied.

Participant 3

Yes, I was. I felt like it was a success for her to be in a relationship that was working. Because her past relationships were reenacting her trauma and this one was much better so I felt like she was improving and healing. Yes, I was pleased with the way that it turned out.

Participant 10

I worked with her for about three years. We had talked about her sexual abuse, and how she could deal with it and go on with her life. I was very pleased [with where she was at when] she moved on, because she relocated. Overall I was very happy with the work that we had done.

Participant 7

That outcome of the case was an unfortunate one. It's a little bit funny, but unfortunate. I had seen her one day in the clinic, and there were two entrances to the clinic, the front and the elevator entrance. And at the elevator entrance there were a few things stored. And after one session after the client had left a secretary came in and said did you authorize your client to take the loading dolly down the street. And I said "What?" So I did some investigation, and talked to the case manager where she was living and confronted her later that afternoon and it was quite clear that she had stolen it. And that is a fairly blatant breaking of clinic policy. And we had to discharge her. And that was a situation that I didn't really have any control over. As far as the outcome I would have to say no, I was not satisfied.

Participant 4

I was dissatisfied. She decided to go back to using, and she didn't use meth but used other things. And I am not seeing her anymore.

Additional Comments about the Cases

Finally, the participants were asked if they had any additional comments about how they were affected by the case they had just described. Once more the participants have a variety of answers. Seven of the participants recalled being struck by how many different emotions were evoked by the cases and how intense these emotions were. Most frequently noted (7=58.3%) by the participants was how many different emotions were evoked by the cases and how intense these emotions were.

Participant 1

I think that even now, so it has been maybe a year almost, since she has left and I definitely do think that it has impacted my life, if nothing else not on a day to day basis but when I think about her or talking about her in depth it does trigger some sort of response. When I think about her and when I think about her mother's death and what that experience was like having to tell her that her mother had been kill, and even saying goodbye and having to terminate our work there is a lot of...I did have an emotional reaction an emotional response to this client, and I did definitely have countertransference so I feel like it is something that I am still working through and holding onto and trying to figure out what to do with all of that residual emotion I guess.

Participant 4

Well, it affected me a lot. I felt a lot of empathy. I felt that I was a positive maternal object for a while and then a negative maternal object. And I was inadequate and not able to help her resolve issues. I do feel like I let her down; like that there were things that I could have done differently. The complexities of her case, and regressing to her old habits was natural, it made it very hard for her to relate to other kids. I was angry at times; I would put her down the way that she would put herself down. What was happening between us was played out a lot and that affected me

Participant 7

There was a lot compassion, anger, sadness, incomprehension, feeling very much a container, very connected, and sometimes feeling like I wanted to throw her out the window.

Participant 12

The sense of helplessness and powerlessness and pain that you walk away with-it was almost unbearable at times. And having to try to create, for myself, a more

hopeful feeling about the world when all you have lived with every day was the way that grownups could hurt children. And dealing with tremendous rage.

Four (33.3%) of the participants commented that they felt that they had learned something from their work with the case, which they would be able to take with them and apply to future work.

Participant 11

I think that it deepened understanding in some profound ways. Like some of the stories or situations that she would reveal were so astonishing. Once she was saying how her nighty back on her, but it was inside out, you know after he had raped her, and the label sticking out. And as a little child feeling that texture the wrong way, just little details like that that were pretty stunning to me that deepened my understanding. And softened and expanded the work that I was able to do.

Participant 8

I think that really informed me how really careful with working with trauma you need to be. I really let me know that people can get disabled as a result of working with or being with their trauma. It was a very demanding case. It taught me a lot about trauma, and setting boundaries for yourself and the client about what you can do for someone. It's like CPR all of the time.

Trauma-Specific Effects of Working with Survivors

Of Parental Childhood Sexual Abuse

The participants were then asked if they had found any express effects on themselves as a result of working with the specific population of survivors of parental childhood sexual abuse. The participants listed ways in which their personal and professional selves had been affected by their work with this population. Eight of the participants also mentioned feeling significant negative effects of working with the specific population of parental childhood sexual abuse survivors over an extended period of time. Working with survivors of parental childhood sexual abuse has affected the participants personal sense of themselves and the way in which they live in the world.

Participant 5

I would think about it a lot and I would talk with colleagues and therapist. There were a few pictures that stuck in my mind. I would sometimes get a little teary, because I am working with the child not the adult sitting in my office. It's so sad to see this seven year old sitting there asking if she is a good little girl and if she is loved.

Participant 6

I listen to sad stores 35 hours a week. I can't watch the news anymore, I start getting to depressed. I tell friends to tell me if there is anything really important going on, but otherwise I don't need to hear how much the Bush administration is screwing up. I do avoid more negative things. I find that I do not have the capacity to take on world problems as well as each individual's problems. I think that it has made me more over protective of my daughter. I know that there a lot of dangers out there in the world. It's made me a more serious person I think I used to laugh more as I get older and do more of the work I laugh less.

Participant 12

I used the word at the time, before any one wrote about, which was vicarious traumatization. I guess in my own mind—a parent who can hurt a child is unfathomable. You fathom it because it is there, but I don't know—the betrayal is of such incredible magnitude. Its just horror, you can barely breath, the pain of going into that place of what the child went through. It's hard to stay there, it feels bad. I would leave my office completely numb...I would feel as though I had been through the Hundred Year War. Just beaten up. I tell ya I couldn't do it again if my life depended on it. Been there, done that, have that T-shirt.

Participant 3

It was traumatizing to hear what she had went through, to be sitting with someone like that. It had a traumatizing effect on me. Sitting with someone and feeling that experience as she is talking about what happened to her, and because it wasn't just talking about it in some ways I think that she was experiencing it in the room. That was very difficult.

Participant 2

It takes me about an hour to get home, and that is really good for me to separate the work from home. But then when I get home I am exhausted, and I don't have a lot to give to my own family. And if I have had really hard day I will withdraw.

These participants described situations where they were affected beyond the treatment and into their personal lives.

Six participants described feeling a heightened sensitivity or awareness toward the world and parental childhood sexual abuse.

Participant 1

I think that, before I started working at this particular place, where this client was housed and before I started working with this particular client. In your every day like you aren't, or at least I wasn't, aware that these types of things happened to the extent that they do. And so it really does open up your eyes to so much of others lives. Horrific lives. I think that something that I have been mulling over since time has passed and this particular client has moved on it's a really, I have a very specific glimpse of a very small subsection of the world, but that it is in such intensity and the frequency within my case load can make it hard to remember that. But that is something that I try to hold onto...the whole world is not like this one case.

Well, I guess...with a lot of my parental childhood sexual abuse survivors the idea is that there is a heightened sense.

Participant 11

And so I think that there is a heightened awareness and also sort of suspiciousness. I think that there were times that I would start to suspect every friend or every friend's parent just wondering what happened to them. A heightened sensitivity to it.

Participant 10

Well, nothing compares to the break of trust that comes with a parent being the perpetrator. I think that it is even worse when the perpetrator is the mother. I think that working with this population I have a heightened sense or just being more sensitive. That betrayal of trust, especially if both parents are involved, is so hard to listen to. It can be really hard.

Participant 5

It makes me more vigilant. Even more so than I was. I think about...I realize it can hide anywhere. Just because someone presents themselves as high functioning, prominent, and with money does not mean a damn thing. And I know how these kids can hide it because they are so fearful. Especially with a parent I really keep my eyes open. I mean I have kids...I don't have girls, but that doesn't mean anything as we know. I talk to my kids about it. I am very vigilant. I don't talk to my partner about this obviously; I talk to my consultant about it, but it's calmer now than it used to be for me. I don't take a lot of cases like this.

Participant 6

It has altered the way that I look at the world.

Four of the participants cited specific emotions that were evoked by their work with survivors of parental childhood sexual abuse, including: disbelief, compassion, sadness, rage, hopelessness, and feeling overwhelmed. Two of the participants commented on their own personal histories of sexual abuse being triggered by working with survivors of parental childhood sexual abuse. Two more participants discussed noticing an increased need for boundaries with this population. And two participants remarked on how this specific population seemed to consume more of their energy than other populations.

Level of Challenge in Working with Survivors of Parental Childhood Sexual Abuse

Difficulties of the Specific Case

The participants were asked how they would rank the case that they had described in terms of: least challenging, below average level of challenging, average, above average level of challenging, and most challenging. The case was compared to all other cases that the participants had seen in their professional careers. Eleven (11=91.7%) of the participants said that they found the case of parental childhood sexual abuse that they described to be among the most difficult cases that they had worked with. One participant said that they felt that the case was above average level of challenging. Overwhelmingly the participants stated that the case of parental childhood sexual abuse that they had discussed was in the category of most challenging. (See table 9)

Table 9

Difficulty of Specific Cases Discussed by Participants

Participant	Most Challenging	Above Average	Average	Below Average	Least Challenging
1	X				
2	X				
3	X				
4	X				
5	X				
6	X				
7		X			
8	X				
9	X				
10	X				
11	X				
12	X				

Parental Childhood Sexual Abuse as a Population

The participants were asked how they would rank parental childhood sexual abuse as a general population in comparison to all of the other cases and populations that they had worked with. (See Table 10) Eight (8=66.7%) of the participants identified parental childhood sexual abuse as the most difficult type of work they did. The majority of clinicians found parental childhood sexual abuse to be above average, if not the most challenging working that they had done in their extensive careers. This was followed by three (3=25%) participants who considered it to be above average, and one participant that considered work with this population to be below average for his case load.

Participant 2

Most, because of the relationship that you are supposed to have with your child. You're not supposed to harm your child. That's just unacceptable. If you can't keep them safe give them up.

Participant 5

Most challenging. Because when it's the parents there is nothing to go home to. When your parents betray you it's the worst. I think that it is all bad...everyone is affected by childhood sexual abuse by a parent.

Participant 6

I have very few other ones. It is always more challenging. I just have very few cases where that was not the case, and little for comparison.

Participant 8

Most challenging. It includes so many aspects of the self that it is absolutely the most challenging.

Participant 12

The most challenging. Unequivocally the most. Anything else feels like nothing in comparison. Even physical abuse does not feel—does not have the same emotional resonance that the childhood sexual abuse does. Its (physical abuse) horrific and I don't condone it—I remember a training that I took when it was referred to “soul murder” and I thought to myself that's what childhood sexual abuse is. So I think that the thing is that the child's developmental trajectory has

been derailed. And then there is resilience. I think I still have as many questions as I have answers.

In addition, three (3=25%) participants said that parental childhood sexual abuse was above average level of challenging when compared with other cases. These participants noted that they felt parental childhood sexual abuse was on par with other forms of childhood sexual abuse by a family member.

Participant 1

Above average, with a kind of specifier that I feel like family sexual abuse whether that is a parent or uncle or non relative who has been incorporated into the family and I feel like all of those things are more powerful than things like stranger danger. Definitely above and more challenging. (Meaning family more than strangers) Does that make sense?

Participant 11

My sense is that they are similar to severe abuse by uncles or siblings or whatever. It is hard to say, because when you are in the room you feel that it as hard as it is with a parent or non parent. My head seems to want to say that it is worse with a parent but I think that they are pretty similar especially when it comes to the impact. I guess above average.

Only one participant found parental childhood sexual abuse to be below average level of challenging, and stated that this was because the wrong doing was more clear than in other cases of sexual abuse.

Participant 7

Below average, because there is a clear line of attachment. There are clear lines of attachment and role bound behavior, which abuse would stem out of. Expected behavior, overt behavior verses covert behavior. Expected verses unexpected—I think that it is easier for me to frame that for the clients.

Table 10

Difficulty of Working with Survivors of Parental Childhood Sexual Abuse as a Specific Population

Participant	Most Challenging	Above Average	Average	Below Average	Least Challenging
1		X			
2	X				
3	X				
4	X				
5	X				
6	X				
7				X	
8	X				
9	X				
10		X			
11		X			
12	X				

Additional Comments & Suggestions for Therapists

Finally the participants were asked if they had any additional thoughts about the effects of working with survivors of childhood sexual abuse on therapists that had not been covered in the interview. The participants commented on other effects of their work, but also made suggests for other therapist in or entering the field.

Suggestions for Other Therapists

All of the participants with the exception of one made suggestions for other therapists working with survivors of parental childhood sexual abuse. (See Table 11) Five (5=41.7%) of the participants suggested consultation to help combat the negative effects of working with this specific population.

Participant 10

I think getting consultation also really helps.

Participant 5

Get lots of consultation. You need to be able to talk about it.

Participant 11

Get lots of consultation and support from trusted elders, and really attend to yourself. These kinds of things, in my early days, I would be very haunted and upset and distressed and fortunately I had a lot of colleagues to hold my hand through it.

Participant 3

I would suggest people get a lot of consultation.

Five participants recommended self care when working with survivors of parental childhood sexual abuse to help cope with the negative effects. Self care was thought to be important to maintain effectiveness in treatment and a healthy state of mind.

Participant 2

And to take care of yourself when doing this type of work is also important. Take vacations, mental health days, supervision all that stuff.

Participant 5

If you work with this population you have to be really diligent about taking care of yourself.

Participant 10

Taking care of yourself as a therapist is key.

Participant 11

And I would say that you need to go carefully with yourself because the vicarious traumatization is real.

Three participants commented on their perceived need for personal and professional support systems. Supervision was mentioned by three participants as a useful tool when working with this population. Three participants expressed a need for to invest in training and continuing education. Two participants discussed an intense demand for boundaries when working with survivors of parental childhood sexual abuse. Two participants emphasized knowing oneself and ones limitations to ensure professionalism and competent care. One participant advocated for limiting the number of parental childhood sexual abuse cases that any therapist has on their caseload at any one time.

Table 11

Suggestions for Other Therapists Working with Survivors of Parental Childhood Sexual Abuse

Participants	1	2	3	4	5	6	7	8	9	10	11	12
Consultation	X		X		X					X	X	
Self Care		X			X					X	X	X
Supervision	X	X									X	
Additional Training						X		X	X			
Support Systems			X								X	X
Boundaries					X					X		
Personal Therapy			X							X		
Know Yourself & Your Limitations							X	X				
Limit the Number of Parental Childhood Sexual Abuse Cases					X							

In connection to the suggestions that the participants made for other therapists they also addressed the positive attitudes or mantras that they found helpful. Three participants discussed ways in which they were able to remind themselves why they were doing this work that is so challenging, by focusing on positives and a sense of hope. Two participants said that remembering the extreme need for this work with this population. Two participants remarked that they found it helpful to focus on cases that they felt were successful, and the people that they had helped. Another participant said that finding good in the world helped her to cope with the seemingly overwhelming amount of abuse and evil in the world.

Additional Personal Comments

Not all of the comments regarding working with survivors of parental childhood sexual abuse were negative. Six of the participants made comments to the effect that they loved the work that they were doing or that they were very fond of the clients they worked with.

Participant 6

But I also love what I do...I absolutely love what I do.

Participant 2

My husband keeps trying to get me to switch jobs, but I love the kids.

Participant 10

Just that I liked working on it, and felt that she was a client who really needed the therapy which helped me deal with any difficulties. I loved her as a client.

Participant 5

It's amazing. I mean I love her. She is doing so well; she is going to be fine.

Participant 12

I mean, I'm glad that I did when I look at the people that I have helped and how far some of them have come—I know that it was a job well done, and there is a lot of satisfaction with that.

These participants felt that although the work was challenging at times that they felt that the work was need, that they enjoyed it, and their clients.

Other participants commented on ways in which they had been affected by working with this population over an extended period of time. Three participants discussed alternative reactions to their work with this specific population, including: profound sadness, a lower tolerance in their personal life for trauma or drama, and a desire for social justice. Two of the participants felt that they could no longer work specifically with trauma survivors after their intensive work with parental childhood sexual abuse. It is also worth mentioning that one participant said that they found that certain clients refused to work with him because he was male, and that this was something he felt was to be expected in the field.

CHAPTER V

DISCUSSION

The purpose of this study was to explore how working with clients who have experienced the specific trauma of parental childhood sexual abuse impacts the therapist. A substantial literature has emerged in recent years concerning the potential risk for therapists to experience vicarious trauma when working with clients who have been traumatized. For the most part, this literature tends to assume a philosophic stance of being generic; e.g., there is the implicit or explicit assumption that what is learned from studying a specific population of trauma survivors can be generalized to all populations of trauma survivors and their clinicians. Thus, we know very little about whether there are trauma-specific effects on therapists associated with their work within a particular population of traumatized survivors. This study sought to fill this gap by addressing what we could learn from the practice wisdom of experienced therapists about the personal and professional effects of their work with survivors of parental childhood sexual abuse.

Limitations

This is a qualitative study and a sample of convenience and thus cannot be generalized beyond the current sample. It should be noted that this sample mirrors what we know about the general age distribution and gender, but is skewed in terms of race.

Findings

The major findings of this study were:

1. All of the participants identified trauma-specific effects on themselves that resulted from working with this population that were either personal and/or professional. Effects ranged from managing their own powerful rapidly shifting emotions evoked by the material in sessions to feeling exhausted and having a lower tolerance for engaging with the problems of daily living outside of sessions to experiencing symptoms of vicarious traumatization that warranted personal therapy.
2. The vast majority of participants said that parental childhood sexual abuse cases ranged from being above average to the most challenging cases that they have treated. The prototype for the most challenging case was a female client who had been sexually abused by her father; penetration/ritual abuse were major features of this case. The most frequent diagnosis was Posttraumatic Stress Disorder followed by Dissociative Disorders for the cases that the participants described.
3. The vast majority of participants could identify at least one strategy that they had adopted to meet the challenges of working with these cases. Most frequently noted were consultation, followed by supervision and personal therapy.
4. When asked for additional comments that they would like to add, almost all (11=91.7%) of the participants stressed the need for self care and expanded on their lists of strategies.
5. Despite the challenges, most of the participants (10=83.3%) remain positively cathected to the work with this population and note positive attachments to the

clients and satisfaction knowing that they are making a difference as mediating factors.

The participants unanimously reported trauma-specific effects of working with survivors of childhood sexual abuse. The most frequently cited effect was intense and rapidly shifting emotions. These poignant emotions were varied but consistently intense and included anger, rage, sadness, frustration, hopelessness, helpless, desensitization, and feeling generally overwhelmed. Managing such intense emotions is what makes working with this population so challenging. In fact, these participants suggested that what was trauma-specific was the degree of intensity of the rapidly emotions evoked and not necessarily any additional breath of emotions other than the trauma-specific effects of parental childhood sexual abuse.

The effects of the work on the participants was consistent with the literature. The participants' description of the feelings they experienced further supports the research on the effects of vicarious traumatization of therapists but also focuses the research by specifying the population of survivors of parental childhood sexual abuse beyond the general population of trauma survivors (Etherington, 2000; Nelson-Gardell & Harris, 2003; Pearlman & Saakvitne, 1995).

The participants identified a series of ways that the work affected them personally. These varied from a heightened sense of hypervigilance around the issue of parental childhood sexual abuse in their lives beyond therapy to feeling generally taxed emotionally in their personal lives and having little energy for their personal relationships. Several of the participants specifically identified themselves as having been vicariously traumatized by their work, a trend which is consistent with the literature.

There is a heightened risk to experience vicarious traumatization when working with parental childhood sexual abuse population due to the intensity of and rapidly shifting emotions evoked by the cases.

When asked to rate how challenging their work with survivors of parental childhood sexual abuse was compared to other populations, all but one of the participants stated that they found it to be at least above average and usually the most challenging work that they have done. These results are consistent with previous literature asserting that seriously traumatized clients account for clinicians' most challenging cases (Hafkenschied, 2005). Again, this study takes the research one step further by specifying the population of parental childhood sexual abuse survivors as a subgroup of seriously traumatized clients. While there is literature to suggest that human induced trauma has a greater impact on therapists than natural trauma, little differentiation has been made in the literature between types of human trauma (Cunningham, 2003). This high level of difficulty experienced by therapists working with this specific population is emphasized by the dual trauma mentioned above. These difficulties require the therapists working with this population to enlist certain strategies to keep these challenges from infringing on their personal and professional lives.

Virtually all of the participants identified at least one, if not more, strategies that they use to assist them in meeting the challenges of working with survivors of parental childhood sexual abuse. Most of the participants reported utilizing consultation and/or supervision, followed by the use of personal therapy. Participants recognized the difficulties which accompany treating this population and were forthcoming about the tactics that they implored to continue their work while maintaining the personal and

professional boundaries. This finding was also consistent with previous literature which recognizes the need and effectiveness of therapists utilizing supervision to meet the challenges that accompany working with survivors of parental childhood sexual abuse (Pearlman & McIan, 1993; Trippany et al, 2004). The literature also notes that the practice of limiting the number of trauma cases reduces one's risk of experiencing the negative effects of vicarious traumatization (Cunningham, 2003; Trippany et al, 2004; Walker, 2004). A few participants in this study echoed this notion of fewer cases equaling lower risks. While the findings of this study supported much of the literature already in existence, it also honed the general theme of "self care" to the more specific strategies of consultation, supervision, personal therapy, and boundary maintenance to be especially effective when working with survivors of parental childhood sexual abuse.

In addition to identifying strategies that they personally used, the majority of the participants really punctuated the need for self care for persons considering this work. They generated a list of strategies, but emphasized the connection between self care and minimizing the risk for vicarious traumatization. The participants recommended implementing consultation, self care, supervision, education/training, boundary maintenance, paying attention to one's reactions to the therapy, and limiting the number of cases of parental childhood sexual abuse. The participants felt strongly that making use of these strategies reduces the risk of the negative effects of vicarious traumatization that therapists working with survivors of parental childhood sexual abuse may encounter.

It is notable that therapists are not solely responsible for combating the negative effects of vicarious traumatization when working with survivors of parental childhood sexual abuse. Agencies working with this population are equally responsible for

encouraging and providing strategies to support their clinicians. In addition to providing peer process groups and/or consultation, they can encourage their staff to seek personal therapy to assist them with the high level of trauma associated with survivors of parental childhood sexual abuse. Furthermore, education and training around trauma victims and specific populations are all ways in which agencies can help to combat the risks connected with working with this population (Cunningham, 1999; Figely, 1995, as cited in Sexton, 1999; Hunter & Schofield, 2006). Agencies can also support their staff by promoting self-care with paid vacations and limiting the number of trauma cases that any one therapist has (Trippany et al, 2004). There is such an essential need for this work, and it is imperative that agencies are attentive and conscientious with regards to supporting their staff.

The participants suggested that the greatest challenge in working with this population is also the greatest reward. Most of the participants remained positively connected and committed to the work despite the challenges, difficulties, and need for self care. The participants noted a feeling for a need for the work and a satisfaction from doing it but also a great deal of affection towards their clients. Even with all of the challenges that these cases presented to the therapists, almost all of the participants said that they were still pleased with the outcome of the cases. Therefore, despite the challenges that working with survivors of parental childhood sexual abuse present, the majority of the participants in this study still felt a strong need for the work, a commitment to the work, a sense of fulfillment from the work, and an affectionate attachment to their clients within this population. Again, this is consistent with previous literature. Cunningham (1999) stated that a myriad of therapists found working with

survivors of parental childhood sexual abuse to be rewarding. It is also imperative to remember the societal need for this type of work and all of the positive ramifications it has on both society and the therapists conducting it (Cunningham, 1999; Pearlman & McCann, 1990; Sexton, 1999). Only two of the participants felt that they had reached a point where they could no longer work with this population. Overall, in spite of the challenges and difficulties the participants were positively cathected to their work with this specific population.

In summary, the findings of this study confirmed that there is a greater risk for therapists working with survivors of parental childhood sexual abuse. It also confirms the existing findings that therapists are in need of self care, and that human induced trauma has a greater impact than other trauma. Unfortunately the research has not examined what other factors put therapists at risk when working with population. What has not receive as much emphasis is that what puts therapists at greater risk is the intensity of the rapidly shifting emotions that are evoked when doing this work, and not the breath of emotions except for the issues of parental betrayal.

Recommendations

The participants punctuated the need for self care at the end of the interview by unanimously discussing ways to combat the risks of vicarious traumatization via self care strategies. This was said in such a way as to suggest that although it is mentioned in the previous literature, the participants felt that these self care strategies could not be strongly advocated for enough. Suggesting that there is a need for standardization of self care, and at a minimum a standard of what is available, within agencies, to people doing this work to implement their own personal self care strategies.

The findings of this study suggest that there is a need for additional exploration into the trauma-specific effects of working with parental childhood sexual abuse to see if the findings of this study are supported and whether there are other risk factors other than the intense and rapidly shifting emotions that can be identified.

References

- Affeld-Niemeyer, P. (1995). Trauma and symbol: Instinct and reality perception in therapeutic work with victims of incest. *Journal of Analytical Psychology*. Vol 40(1), 23-39.
- American Academy of Child & Adolescent Psychiatry (1998 & 2004), Retrieved on March 12, 2007, from <http://www.aacap.org/>
- Anastas, J. W. (1999). *Research design for social work and the human services: Second edition*. New York: Columbia University Press.
- American Psychological Association (2001). Retrieved on March 12, 2007, from <http://www.apa.org/releases/sexabuse/>
- Barlett, A. (1996). Clinical assessment of sexual trauma: Interviewing adult survivors of childhood abuse. *Bulletin of the Menninger Clinic*, Vol 60(2), 147-160.
- Beaton, R., Murphy, S., Johnson, C., Pike, K., & Corneil, W. (1998). Exposure to duty related incident stressors in urban fire fighters and paramedics. *Journal of Traumatic Stress*, Vol 11, 821-827.
- Berzoff, J., Flanagan, L. M., & Hertz, P. (2002). *Inside out and outside in*. New York: A Jason Aronson Book.
- Cahill, C; Llewelyn, S. P.; & Pearson, C. (1991a). Long-term effects of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology*, Vol 30(2), May, pp. 117-130.
- Cahill, C; Llewelyn, S. P.; Pearson, C. (1991b). Treatment of sexual abuse that occurred in childhood: A review. *British Journal of Clinical Psychology*, Vol 30(1), Feb., pp. 1-12.
- Child Molestation Research & Prevention Institute (2007). Retrieved on May 25, 2007, from http://www.childmolestationprevention.org/pages/prevention_plan.html#tellothers
- Child Sexual Abuse: Stop It Now!, (2005). Retrieved on May 25, 2007, from <http://www.stopitnow.com/comquest.html#Q1>
- Cook-Cottone, C. (2004). Childhood Posttraumatic Stress Disorder: Diagnosis, treatment, and school reintegration. *School Psychology Review*, Vol 33(1), pp. 127-139.

- Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Work Education*, Vol 40(2), Spring, 305-317.
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *National Association of Social Workers*, Vol 48(4), Oct., 451-459.
- Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal*, Vol 16(4), Aug., pp. 227-290.
- Dent-Brown, K. (1993). Child sexual abuse: Problems for adult survivors. *Journal of Mental Health*. Vol 2(4), 329-339.
- Davies, D. (2004). *Child development: A practitioners guide*. New York: The Guilford Press.
- Diagnostic and statistical manual of mental disorders* (4th ed.). (2000). Arlington, VA: American Psychiatric Association.
- Diamond, M., J. (1997). The unbearable agony of being: Interpreting tormented states of mind in the psychoanalysis of sexually traumatized patients. *Bulletin of the Menninger Clinic*, Vol 61(4), Fall, 495-519.
- Etherington, K. (2000). Supervising counselors who work with survivors of childhood sexual abuse. *Counselling Psychology Quarterly*, Vol 13(4), 377-389.
- Figley, C. (1995). *Compassion fatigue*. New York: Brunner/Mazel.
- Finkelhor, D. (1994a). Current information on the scope and nature of child sexual abuse. *The Future of Children*, Vol 4(2), 31-53.
- Finkelhor, D. (1994b). The international epidemiology of child sexual abuse. *Child Abuse & Neglect*, Vol 18(5), May, 409-417.
- Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An Update. *Professional Psychology: Research and Practice*. Vol. 21 (5), pp. 325-330.
- Finkelhor, D., Araji, S., Baron, L., Browne, A., Peters, S., Doyle, W., & Gail, E. (1986). *A sourcebook on child sexual abuse*. Thousand Oaks, CA: Sage Publications, Inc.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, Vol 55(4), Oct., pp. 530-541.

- Finkelhor, D., & Dzuiba-Leatherman, J. (1994c). Victimization of children. *American Psychologist*, Vol 49(3), 173-183.
- Follette, V., Polusny, M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, Vol 25(3), Aug., pp. 275-282.
- Freyd, J., J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behavior*, Vol 4(4), pp. 307-329.
- Freyd, J., J. (1996). *Betrayal trauma*. Cambridge, Massachusetts: Harvard University Press.
- Gabbard, G. (1999). Countertransference issues in psychiatric treatment. *Review of Psychiatry*, Vol 18, 1-25.
- Hafkenschied, A., (2005). Event countertransference and vicarious traumatization: Theoretically valid and clinically useful concepts? *European Journal of Psychotherapy*, Vol 7(3), Sept., 159-168.
- Herman, J. (1981). Father-daughter incest. *Professional Psychology*, Vol 12(1), Feb., pp. 76-80.
- Hunter, S., & Schofield, M. (2006). How counselors cope with traumatized clients: Personal, professional and organizational strategies. *International Journal for the Advancement of Counselling*, Vol 28(2), June, 121-138.
- Kendall-Tackett, K., A.; Williams, L., M.; Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, Vol 113(1), Jan 1993. pp. 164-180.
- Ketring, S., Feinauer, L. (2000). Perpetrator-victim relationship: Long-term effects of sexual abuse for men and women. *The American Journal of Family Therapy*, Vol 27, 109-120.
- Kuyken, W. (1995). The psychological sequelae of childhood sexual abuse: A review of the literature and implications for treatment. *Clinical Psychology and Psychotherapy*. Vol. 2 (2), 108-121.
- Lerias, D., & Bryne, M. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health*, Vol 19, 129-138.

- Little, L., & Hamby, S. (1996). *Impact of a clinician's sexual abuse history, gender, and theoretical orientation on treatment issues related to childhood sexual abuse. Professional Psychology: Research and Practice*, Vol 27(6), Dec., pp. 617-625.
- Lucenko, B., Gold, S., & Cott, M. (2000). Relationship to perpetrator and posttraumatic symptomatology among sexual abuse survivors. *Journal of Family Violence*, Vol 15(2), 169-179.
- McCann, L. I., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, Vol 3(1), Jan., pp. 131-149.
- Merriam-Webster's collegiate dictionary* (11th ed.). (2005). Springfield, MA: Merriam-Webster.
- Childhood Sexual Abuse: National Center for Victims of Crime (1997). Retrieved on May 25, 2007, from <http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentAction=ViewProperties&DocumentID=32315&UrlToReturn=http%3a%2f%2fwww.ncvc.org%2fncvc%2fmain.aspx%3fdbName%3dAdvancedSearch>
- Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare League of America*, Vol 82(1), Jan., 5-26.
- O'Donohue, W. & Geer, J., H. (1992). *The sexual abuse of children: Theory and research volume 1*. New Jersey: Lawrence Erlbaum Associates, Publishers.
- O'Donohue, W. & Geer, J., H. (1992). *The sexual abuse of children: Clinical issues volume 2*. New Jersey: Lawrence Erlbaum Associates, Publishers.
- Pearlman, L., & Mac Ian, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, Vol 26(6), Dec., pp. 558-565.
- Pearlman, L., & Mac Ian, P. (1993). Vicarious traumatization among trauma therapists: Empirical findings on self care. *Traumatic Stress News for the International Society for Traumatic Stress Studies*, Vol 7(3), 5.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W. W. Norton.

- Peters, S. (1988). Child sexual abuse and later psychological problems. *In*, Lasting effects of child sexual abuse (pp. 101-117). Wyatt, Gail Elizabeth; Powell, Gloria Johnson; Thousand Oaks, CA: Sage Publications, Inc.,.
- Statistics & Key Facts: Rape Abuse & Incest National Network (2006). Retrieved March 12, 2007, from <http://www.rainn.org/statistics/index.html?gclid=CMCJzqrj6YwCFsQWgQodxB7bzA>
- Rasmussen, B. (2005). An intersubjective perspective on vicarious trauma and its impact on the clinical process. *Journal of Social Work Practice*. Vol. 19 (1), March, pp. 19-30.
- Saakvitne, K., & Pearlman, L. (1996). *Transforming the pain: A workbook on vicarious traumatization*. Traumatic Stress Inst, Ctr for Adult & Adolescent Psychotherapy, New York, NY: W W Norton & Co.
- Sexton, L. (1999). Vicarious traumatization of counsellors and effects on their workplaces. *British Journal of Guidance & Counselling*, Vol 27(3), Aug.. pp. 393-403.
- Statistics Surrounding Child Sexual Abuse: Darkness To Light (2005). Retrieved March 12, 2007 from http://www.darkness2light.org/KnowAbout/statistics_2.asp
- Trippany, R., Kress, V. W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development*, Vol 82, Winter, 31-37.
- Vander Mey, B., J. & Neff, R., L. (1986). *Incest as a child abuse: Research and applications*. New York: Praeger.
- Violette, B., L. (1995). "Betrayal and repetition" revisited: A relational perspective on sexual abuse. *Clinical Social Work Journal*, Vol. 23 (4), Winter, pp. 465-470.
- Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: counter transference; secondary traumatization and terror. *Psychodynamic Practice*, Vol 10(2), May, pp. 173-193.

APPENDIX A

Human Subjects Review Approval Letter

February 5, 2007

Rebecca Randall
668 Hillgirt Circle
Oakland, CA 94610

Dear Rebecca,

Your amended materials have been reviewed and you have completed all of the requested revisions. All is now in order and we are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. I hope participants will come forward. It is a tough and painful subject and I'm sure working with these issues takes its toll. It is an important thing to explore.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

Cc: Mary Hall, Research Advisor

APPENDIX B

Recruitment Letter

Dear (participant's name):

My name is Rebecca Randall, and I am a graduate student at Smith College School for Social Work. For my thesis I am conducting a qualitative study which will be exploring the effect(s) on therapists of clinical work with survivors of childhood sexual abuse (CSA) by a parent.

Participants in this study must be licensed clinical practitioners in their discipline, have clinical experience (minimum of five cases over the course of their career) treating CSA by a parent and be willing to meet for an interview. You have been identified as someone that meets the criteria and may be interested in participating in this study.

You will find enclosed a copy of the informed consent for the study that describes the study in greater detail and what would be required of you should you agree to participate. I will be following up this letter with a phone call to answer any additional questions you may have.

I hope you will consider participating in this study and thank you in advance for the attention you have given this matter.

Sincerely,

Rebecca Randall
710 S. Broadway, Suite 300
Walnut Creek, CA 94596

(925)295-4901
rrandall@email.smith.edu

APPENDIX C

Informed Consent Form

Dear Potential Participant:

My name is Rebecca Randall. I am conducting an exploratory investigation into how clinical work with clients that have been victims of childhood sexual abuse (CSA) by a parent(s) impact the therapist. In recent years there has been widespread acceptance in the clinical literature that clinical work with trauma survivors can have an independent effect(s) on the therapist. However most of this literature has tended to assume that any identified effects of the work on therapists were generic to the genre and could be generalized to most if not all populations of trauma survivors. Thus very little is known about effects on therapists that may be population-specific and integral to clinical work with distinct populations of trauma survivors, such as survivors of CSA by a parent. This study intends to make a contribution to filling this gap by exploring what we can learn from the practice wisdom of seasoned clinical therapists about effects on the therapist that are population-specific to clinical work with survivors of CSA by a parent. The data collected will be used in a Smith College School for Social Work thesis and for future presentation and publication.

To participate in this study you must be a licensed clinical practitioner (MSW, MFT, PsyD, or PhD), that has engaged in clinical practice with at least five cases of CSA by a parent(s) over the course of their career. You must also agree to meet with the researcher in a face-to-face interview to discuss these clinical experiences. The interview should take no more than 60 minutes to complete. At the time of the interview, you must sign this informed consent before the interview can begin. You will be given a copy of the signed consent form for your records. The interview will begin with more structured demographic background questions and will be followed by more open ended questions that explore your practice experiences with this population. Interviews will be tape recorded and this researcher may take a few notes during the session. The researcher will be transcribing the interviews at a later date.

Consistent with the mandates of the social work profession, strict standards of confidentiality will be maintained. Your name and any other identifying information will be removed from all tapes and transcripts and a code will be developed to identify data. Please remember not to use the names or any identifying information about any clients or cases that you discuss during the interview. The only people reading the raw data will be the researcher and thesis advisor. In any presentations and future publications, the findings of the study will be presented in aggregate form only. Any illustrations or brief quotations used will be sufficiently disguised so that it cannot be identified with individual study participants. All materials will be kept in a secured location for a period

of three years consistent with federal regulations. After that time the material will remain secured until it is no longer needed and will then be destroyed.

In terms of risks and benefits, there are few risks anticipated with participation in this study. You have the right to refuse to answer any particular question(s) and to withdraw from the study at any time before the findings have been written up. However in any experience of self reflections, strong feelings may emerge which you may feel warrant additional exploration.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to our professional knowledge base on this important topic about how clinical work with CSA by a parent case can affect the therapist. You may also benefit from having this opportunity to reflect on your views and clinical experiences.

This study is completely voluntary. You are free to refuse to answer a specific question(s) and/or to withdraw from the study at any time until April 1, 2007 when the findings will be written up. If you decide to withdraw, all data describing you will be immediately destroyed.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION: THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

DATE

DATE

Please make sure to keep a copy of this document for your records. If you have any questions or wish to withdraw your consent, please feel free to contact me.

Thank you,
Rebecca Randall
710 S. Broadway, Suite 300
Walnut Creek, CA 94596

(925)295-4901
rrandall@email.smith.edu

APPENDIX D

Interview Guide

For Rebecca Randall's Smith School for Social Work Master's Thesis:
Personal and Professional Implications for Therapists that Work with Clients Who Have
Been Sexually Abused by Parents or Guardians

(Please remember not to use the names or any identifying information about any clients or cases that you discuss during the interview.)

I. Demographic Background Questions

1. How old are you? (Or which age range do you fall in? 25-30, 31-40, 41-50, 51-60 or 60+ and over)
2. Gender: Male, female, other?
3. How would you identify yourself racially or ethnically?
4. What is the highest level of education you have completed?
5. What is your clinical degree? When and where did you receive it?
6. What is your clinical license? When and where did you first receive it? (Listen for: licensure & practice in multiple states)

II. Interview Questions re Practice Experience

1. Could you briefly describe the types of settings where you have worked, the position(s) you held and length of service in each in setting. (Overview of clinical experience)
2. What other populations/types of trauma survivors have you treated in addition to survivors of CSA by a parent? (Identify population(s) and estimate number of cases- goal to have some idea of most-least work experience with specific populations of trauma survivors).

Population	# of Cases Treated
------------	--------------------

3. Now I am going to ask you to consider the CSA survivor cases you have treated and select the case you found most challenging.

- a. Could you give me a brief summary/overview of your work on this case? (Listening for: presenting problem, how it was understood, treatment focus/interventions, formal diagnosis, and outcome)
 - b. What made this the most challenging CSA by a parent(s) case with which you have worked?
 - c. How did you meet the challenge(s) at the time and what was required of you to do this? (Listening for: What demand did it make on the therapists, and how did they deal/meet it? Did they have to change or grow in any way? Etc.)
 - d. What was the outcome of the case (if not already answered)? How satisfied were you with this outcome?
 - e. Is there anything else that you would like to say about how you were affected by this case (Listen for domain, e.g., personal or professional effects; additional information/insights...)
4. When you think of all the trauma survivor cases that you have treated, can you identify any effects on you in your role as therapist that you consider to be unique to your work with survivors of CSA by a parent as a specific population of survivors?
5. When you think of the total cases you have treated which of the following would best describe the case you just shared with me?
- Least Challenging
 - Below Average Level of Challenging
 - Average Level of Challenging
 - Above Average Level of Challenging
 - Most Challenging
6. When you think of the total cases you have treated where would you rank cases of parental childhood sexual abuse against other cases?
- Least Challenging
 - Below Average Level of Challenging
 - Average Level of Challenging
 - Above Average Level of Challenging
 - Most Challenging

7. Do you have any more thoughts you would like to share about effects on the therapist that you consider unique to work with survivors of CSA by a parent(s)?