CLINICAL WORK WITH ADULT FEMALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE FROM A CHRISTIAN PERSPECTIVE

by

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ABSTRACT

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The purpose of this study is to research, compare, and integrate treatment modalities used by mental health professionals in the United States who counsel adult female survivors of childhood sexual abuse from a Christian perspective. It is a qualitative study designed to gather information about available treatment modalities. The 3 major topics covered in the research include:

1. Healing is a stage process;
2. Healing requires relationship work with self, others, and God;
3. The therapeutic relationship and grief and loss work are significant therapeutic interventions that can facilitate healing for adult female survivors of childhood sexual abuse.

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> "Are you far away from home this dark and lonely night?
> Tell me what best would help to ease your mind.
> Someone to give direction to this unfamiliar road
> Or one who says follow me and I will lead you home?
>
> How beautiful, how precious the Savior of Old
> Who loves so completely the loneliest soul.
> How gently, how tenderly he says to one and all,
> Trust me and follow me and I will lead you home" (Grant & Eaton, l999).

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CHAPTER ONE

Introduction

There have been many studies (Finkelhor, l987; Finkelhor, Hotaling, Lewis, & Smith, l989; Russell, l983) that have surveyed the general population for prevalence of childhood sexual abuse (CSA). The variation of the results (Stein, Golding, Siegel, Burnam, & Sorenson, l988; Peters, l988) may be attributed to differences in the definition of abuse, sampling techniques, sample size, and/or methods of obtaining retrospective data (Donaldson & Cordes-Green, l994).

It has been estimated that 1 in 4 women and 1 in 7 men have been victims of childhood sexual abuse (Russell, l986). Russell (l983) found that 16% of adult American women experienced incest before age l8. Vought & Heitritter (l989) claim that, "Some sources indicate that every two minutes in the United States a child is sexually abused but that less than 2% of molestations are ever reported" (Heitritter & Vought, l989, p 13; Russell, l986).

The estimation for all adult women seeking therapy who have issues related to childhood sexual abuse being in some way, is 85% (Russell, l986). Mental health professionals have become increasingly aware that their outpatient caseloads are between 25% to 44% survivors of childhood sexual abuse (Briere, l984; Westermeyer, l978). The studies show that 43% of inpatients are victims of physical and/or sexual abuse (Carmen, Rieker, & Mills, l984).

It is not without surprise then, that Christian therapistsalso experience a large percentage of clientele who have been victimized as children by sexual abuse. Carolyn Holderread Heggen, in her book Sexual Abuse in Christian Homes and Churches, describes her surprise that her practice in psychotherapy of

over 20 years consists mostly of adult survivors of sexual abuse (Heggen, l993).

Even more surprising and disturbing are the accounts of incest by family members who seem to be "very religious," "Christian," "devout," and "godly" people (Heggen, l993, p.13). Murray, in her work, believes that sexual abuse is worse in religious families than in the population as a whole (Murray, l991). She says that children from ministry families (clergy and missionaries) keep her clinic, with several therapists, busy (Murray, Personal Communication, January, l999). This is not to say that all her clients are victims of childhood sexual abuse or that all fathers involved with the church are sexually abusing their children, but it is to say that some are and it is a greater problem than many realize or are willing to admit.

Christian Scripture does not deny sexual violence and abuse. Phyllis Trible in Texts of Terror (l984), reminds us of some of the most painful stories that exist are in the Bible, e.g., the stories of Tamar and the Unnamed Concubine.

Denial in the church, though, has fostered a long and painful history of silence. It has become the "unmentionable" sin (Fortune, l983). Patriarchy (still endorsed by many and therefore a commonly held tradition of the church) and patriarchal oppression of women and children contributes to the denial of the problem of sexual violence. Patriarchy continues to view women and children as property of men with the consequence often being the abuse of power (Fortune, cited in Heggen, l993). No wonder sexual abuse continues to abound in the church.

Men have more power than women in every measurable social, economic, and political category (Eisler, l987). This makes women and girls vulnerable to the power and control of men and especially the men closest to them. Sexual

abuse is not about sex, in many cases. It is about power and control. "In such abuse the misuse of power to control and dominate is inextricably tied to the reinforcement of erotic stimulation for the offender. This creates a complex web of power and eroticism difficult to untangle" (Fortune, cited in Heggen, l993, p. 10).

Unfortunately, sexual abuse of women and children by men has been an extension of male privilege, and the church, both in the past and the present, has accepted and promoted a patriarchal agenda which has fostered this pathology.

Scripture, though, commands the church to stand with those who are harmed and exploited, "to protect the little ones, to offer hospitality to the vulnerable, to set free those imprisoned by social convention" (Fortune, cited in Heggen, l993, p. 11). Jesus taught intentionally about the worth of all people and condemned the misuse of power.

Finally the church is waking up. Centuries of denial of incest, rape, and sexual harassment are no longer being ignored. Exposure of sexual abuse by clergy in ministerial relationships is forcing the issue (Fortune, cited in Heggen). It seems that this is beginning to open the door so that the voices of victims and survivors can be heard. Mental health professionals, both secular and those counseling from a Christian perspective, are being confronted with a need for a clear theoretical perspective and

treatment modality when working with people who have been sexually abused.

Statement of the Problem

The purpose of this study is to research, compare, and integrate treatment modalities used by mental health professionals in the United States who counsel adult female survivors of childhood sexual abuse (AFSCSA) from a

Christian perspective. The researcher proposes to do this by studying available literature (books, journal articles and theses) and by interviewing counselors who have developed these modalities and/or are using them.

Mental health professionals who have a Christian counseling perspective that have written literature, a sample of counselors who belong to The American Association of Christian Counselors and The Americ an Association of Pastoral Counselors, and therapists counseling from a Christian perspective known by the researcher will be interviewed in person, by phone, or by mail. Each counselor will be asked a series of questions or asked to fill out a questionnaire if a personal or phone interview cannot be arranged.

Research Questions

Each interview will be evaluated by a series of questions. The questions are as follows:

1. Are you a mental health professional who counsels from a Christian philosophical perspective?

2. Do you treat adult female survivors of childhood sexual abuse (AFSCSA)?

3. What is the theory or theories on which your treatment for AFSCSA is based?

4. What is your method for treating the effects of childhood sexual abuse (CSA) on adult female survivors?

5. What in your theory and treatment is specifically from a Christian perspective?

6. What in your theory and treatment has been specifically developed by you?

7. What do you borrow from other Christian treatment modalities for AFSCSA?

8. What do you borrow from secular treatment modalities for AFSCSA?

9. How long have you been treating AFSCSA with this method of treatment?

10. On what are you able to base the effectiveness of your treatment?

Definition of Terms

For clarity of understanding, the following terms need to be defined.

Mental health professionals who counsel from a Christian perspective bring Christian values and stories into their therapy. They blend modern psychotherapy and Bible-based Christianity that results in a critical healing edge from faith. They unite their mortal efforts and the divine agency of the "Wonderful Counselor" of Scripture. They are a mix of the "warm spirit of personal compassion, spiritual integrity and the determination to love, rather than judge" (Wylie, 2000). Christian psychologist David Brenner says, "It is important for us not to be just counselors, but to be agents of God's grace...Our challenge is to look behind the symptoms and see [the client] first and foremost through God's eyes of love" (Benner, cited in Wylie, 2000).

Secular theories and treatment modalities for AFSCSA refers to theories and treatment modalities that do not specify in some way that they are from a Christian perspective.

Mental Health Professional is being used synonymously with the terms "counselor" and "therapist." For the purposes of this paper, a mental health professional is one who has at least a Master's level degree in a mental health field.

Childhood sexual abuse (CSA) refers to when "a child is sexually exploited by an older person for the satisfaction of the abuser's needs" (Langberg, l997, p. 61). The sexual exploitation may consist of verbal, visual, physical, or psychological activity. For the purposes of this paper, childhood sexual abuse is defined as occurring prior to age 18.

"Verbal sexual abuse can include sexual threats, sexual comments about the child's body, lewd remarks, harassment, or suggestive comments. Visual sexual abuse includes the viewing of pornographic material, exhibitionism, and voyeurism. Physical sexual abuse includes intercourse, cunnilingus, fellatio, sodomy, digital penetration, masturbation in front of the child or masturbation of the child, fondling of the breasts and genitals, and exposure of the child's body to others. These may be performed on the child, or the child may be forced to perform any or all of the above" (Langberg, l997, p. 62).

Psychological abuse "occurs when a parent behaves in ways which blur the appropriate emotional boundary between a parent an child" (Heggen, l993, p. 23), i.e., surrogate "spouse" or confidante.

Incest refers to sexual abuse by a family member.

Adult female survivor of childhood sexual abuse (AFSCSA) refers to a woman (age l8 or older) who has been a victim of childhood sexual abuse and who is in the process of healing from the effects of the abuse.

Assumptions

There are several assumptions which are apparent in this research.

1. There are different modalities used by mental health professionals for treatment of AFSCSA.

2. There are specific treatment modalities for AFSCSA that are derived from a Christian philosophical perspective.

3. There are specific secular treatment modalities for AFSCSA.

4. There are differences between traditionally Christian treatment modalities, secular treatment modalities and treatment modalities used by mental health professionals treating AFSCSA from a Christian perspective.

5. There is a need to research treatment modalities for AFSCSA from a Christian perspective.

6. Some counselors belonging to The American Association of Christian Counselors are Christian/Pastoral Counselors.

7. There are long-term effects from childhood sexual abuse.

8. AFSCSA can heal from the effects of childhood sexual abuse.

Limitations

Several limitations have been identified by the researcher.

1. It may be difficult to locate all available literature on or by mental health professionals from a Christian perspective that have treatment modalities for AFSCSA.

2. It may be difficult to differentiate between mental health professionals that counsel from a Christian perspective and specific Christian treatment modalities for AFSCSA.

3. It may be difficult to sample a portion of counselors in The American Association of Christian Counselors and get an accurate representation of mental health professionals that counsel from a Christian perspective.

4. To do an exhaustive study of all mental health professionals who counsel from a Christian perspective, Christian, and secular treatment modalities for AFSCSA would be beyond the scope of this research.

CHAPTER TWO

Literature Review

The review of literature for this paper is divided into three major themes that emerged while examining resources related to theories of clinical treatment of adult female survivors of childhood sexual abuse (AFSCSA) from a Christian perspective. The themes are as follows:

1. Healing is a stage process.
2. Healing requires relationship work in three areas:
   a. With self
   b. With others
   c. With God.
3. There are therapeutic interventions that facilitate healing for AFSCSA. These include:
   a. Use of a therapeutic relationship
   b. Grief and loss work

Included in grief and loss work are what grief work entails, development and core belief work, and spiritual development.

Healing is a Stage Process

There are numerous therapists who write on the subject of healing for AFSCSA (Bass & Davis, l988; Harvey, l996, Herman, l992; Heitritter & Vought, l989; Langberg, l997; Murray, l991; Smith, l997). Each one identifies stages of healing that survivors go through on the journey to recovery and restoration.

The authors are specific in saying that these "stages" do not have to be in any specific order. They are a natural rhythm of the process of healing. They are maps to make sense of that rhythm for both therapist and client. The concept of stages gives understanding and a sense of direction to the

therapist. "It is crucial that therapists have a clear picture of what that treatment includes; otherwise it is very easy to shortchange a client" (Langberg, l997, p. 89). They give encouragement and hope to the client.

The following is a discussion of several examples of prominent stage theories:

Harvey's Seven Elements of Recovery

The researcher will begin by addressing Harvey's seven essential elements of recovery (l996) that provide elements of progress that allow both clients and therapists to know healing is in process. Effective interventions seek the following as goals:

1. Authority over the remembering process (To recall or not to recall and what is done with the memory becomes a choice rather than an intrusion.);

2. Integration of memory and affect; (etc.)

3. Affect tolerance (Feelings associated with the trauma can be felt, named, endured without overwhelming arousal, defensive numbing and/or dissociation.);

4. Symptom mastery (Persistent symptoms are abated or become more manageable.);

5. Self-esteem and self-cohesion (Healthful, self-caring routines, consistent experiences of self, and more realistic positive views of self are developed.);

6. Safe attachment (Relational capacities are repaired or developed so there can be healthy attachment and support.);

7. Meaning-making (New meanings of the trauma are developed. Some are able to see that their life has new strength and compassion. A survivor mission may emerge.) (Harvey, l996).

In essence, Harvey states that recovery is occurring whenever there is a change from a poor outcome to a desired one in any area affected by trauma.

Herman's Three-Stage Model for Recovery

A commonly used 3-stage model of recovery was developed by Judith Herman (Herman, l992). Her first stage of recovery is to establish safety. The therapist and client must work to form safety as their first goal and no other work should be attempted until it is secure. Safety starts with control of the body and moves to control of the environment. Control of the body includes "attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, and the control of self-destructive behaviors and the symptoms of posttraumatic stress disorder" (Lebowitz, Harvey & Herman, l993, p. 379). A safe environment includes a safe living situation, adequate finances, and adequate plans for self-protection.

This first stage may take quite a while to secure if the AFSCSA has become a danger to herself. "Self-harm (suicidal behavior, self-injury, substance abuse), passive failures of self-protection, and/or repetitive involvement in exploitative or dangerous relationships... may be symbolic or literal reenactments of the initial abuse" (Lebowitz, Harvey, & Herman, l993, p. 380). They function to regulate intolerable feeling states. The survivor has to develop abilities to soothe and care for herself in ways she may never have learned in her abusive childhood environment.

The second stage of recovery is the active and in-depth exploration of the traumatic experience(s). It is important to be alert to pacing and timing so as not to overload. Small steps with the client in control is the goal. The purpose is not just catharsis but also the integration of the traumatic experiences. Careful attention to previously dissociated or repressed parts of memory, cognition, and affect are involved with the exploratory work. If the

client's tolerance is not attended to, the result will not be mastery of the situation, but instead, a reenactment of not being in control. As losses become fully apparent, a period of intense grief and mourning is inevitable. It is possible for a major depressive episode to be triggered at this point. The therapeutic alliance, peer support, the hope of restoring or building new relationships, and the creating of new meaning from the trauma sustains the client.

The third and last stage of recovery developed by Judith Herman is the stage of reconnecting with others. The client will often reassess and renegotiate long-standing relationships as part of establishing new, mutual, and nonexploitative peer relationships. Boundaries, limits, and secrets may be addressed in formerly abusive relationships. The survivor may wish to confront her abuser and disclose the abuse to her family of origin if that has not happened. Often this stage includes a different level of meaning-making and transformation of the trauma, such as in a survivor mission.

The therapeutic relationship affects the work of the survivor in all three stages. It is shaped by the therapist's deeply held belief in the reality of the trauma and the understanding of how the trauma affects the client in all aspects of her daily life and relationships, including the therapeutic relationship. It is important for the therapist to work diligently to create "a genuinely respectful and collaborative relationship that can accept, legitimize, and contain traumatic affect, provide nurturance without infantilization, and address trauma-shaped perceptions and behaviors without shaming or disempowering the survivor" (Lebowitz, Harvey, & Herman, l993, p. 382). As educator, ally, and witness, the therapist can provide information about trauma that normalizes its effect. This, in turn, helps the victim make sense of her response and helps contain the process for her. The information

also provides a cognitive structure for her work which can empower her to work on her related issues.

The 11-Stage Process by Bass & Davis

Once a woman recognizes the effects of sexual abuse in her life, in order for deep healing to occur, she must make a commitment to heal. The ll-stage process for healing described by Laura Davis and Ellen Bass in their book, The Courage to Heal (l994), includes the very important decision to heal. The following is a brief outline of these stages to heal.

1. The Emergency Stage: The emergence of memories and suppressed feelings. This is the stage of great turmoil.

2. Remembering: Integrating memory and feeling.

3. Believing It Happened: It happened and it really hurt.

4. Breaking Silence: Breaking the shame.

5. Understanding It Wasn't Your Fault: Placing the blame where it belongs, on the abuser.

6. Making Contact with The Child Within: Getting in touch with vulnerability. The child within can help you feel compassion for yourself, more anger towards your abuser and more intimacy with others.

7. Trusting yourself: Your own perceptions, feelings, and intuitions are a good guide.

8. Grieving and Mourning: Feeling your losses.

9. Anger - The Backbone of Healing: directing anger away from yourself and onto your abuser and those who did not protect you.

10. Disclosure and Confirmation: Deciding on the appropriateness of confronting your abuser and disclosing to your family.

11. Forgiveness: Not about forgetting. This is about leaving the responsibility of the abuse with the abuser (Bass and Davis; l994).

The Murray Method

Murray (l985) identified a formula by which behavior is determined. This especially pertains to adult female survivors of childhood sexual abuse. She states that behavior is determined by the past 3 generations + your parents + you + the trauma + your external positive influences. After taking an oral history, her stages of healing include the following:

1. Connect with Original Feeling Child - Guided Imagery, drawing;
2. Connect with Sobbing Hurting Child - Guided Imagery, drawing Trauma Egg, drawing image of SHC, psychodrama, anger work;
3. Connect with Controlling Child - Drawing;
4. Internal & External Positive Influences;
5. Determine if and where victimizing self and others (Angry Rebellious Child - ARC, Selfish Stubborn Child - SSC);
6. Educate Feeling Adult to balance inner children, to tell inner children the truth, to deal with today's feelings as only today's feelings and to do it today;
7. Deal with automatic thoughts and core beliefs;
8. Examine and adjust Circles of Intimacy, Responsibility, and Impact;
9. Establishing Boundaries: Five Ways to Say "Yes" or "NO!" (Murray, l985).

Smith's TheoPhostic 3-Stage Theory

Smith, in his TheoPhostic Counseling Theory (l997), has a 3-stage recovery model. The three stages, all of which must be present for the model to work, include the historical emotional echo, the memory picture and the embedded original lie.

The first component, the historical emotional echo, is the feeling the AFSCSA experiences each time she accesses the painful memory of the original trauma. This emotion comes from the false message believed at the time the trauma occurred. The message about the victim (e.g., that it was her fault) is a false interpretation, a lie, but it feels true. The present emotion is actually a reflection of the previously felt event triggered by something remotely similar in the present. It is appropriate to one's perceived state of being and the belief assumed when the original lie was embraced at the time of the historical event.

The next step is to locate the memory picture which feels the same way or matches the emotions the client is currently feeling. The principle behind this is that the client's present life is being affected by the active lie surfacing from the original memory. The client needs to see the connection between the unresolved historical pain and the current "trigger."

Memory can be visual, emotional, or physical. Many abuse victims cannot access a visual picture of the event because of how it was stored in the brain during the trauma in order to protect themselves. Healing can occur even without a visual memory. Sometimes even in repressed memories, bits and pieces may surface with enough reality in the picture to give evidence that the event actually occurred.

Emotional memory is the most common form of memory people experience. It only takes someone saying something or acting in a similar way to the original event to trigger the emotional aspect of the memory. "When people access a memory at an emotional level, they actually feel the emotions which were experienced at the time of the event" (Smith, l997, p.12). They thus become a window back to the original wound.

Memories experienced on a physical level are felt in bodily sensations, sounds and smells. It is very possible for survivors to feel in their body the awful details of the abuse.

Once the historical echo has been identified and matched with the memory picture of the trauma, the third stage is to identify the original lie. This is the belief statement which was planted in the victim's mind during the time of the trauma. It may not seem logical but it definitely feels true. That is how the therapist and client can know that they really have the lie.

When these three components are in place, the focus moves to intensifying the feeling and asking God to speak the truth into the memory. Smith (Personal Communication, 12/23/99) claims that in his five years of treating AFSCSA, God has always spoken, either verbally or in images and brought recovery. The recovery is such that when the memory is now accessed, no painful emotions surface.

Langberg's Three Phases to Recovery

Langberg's (l997) initial phase of treatment of AFSCSA focuses on establishing a safe relationship with the therapist, symptom relief, and memory work.

When an AFSCSA enters therapy, it is often because of other presenting symptoms, not the sexual abuse. They come seeking treatment and her first need is a climate of safety with the therapist. It is not unusual for the survivor's life to become chaotic as the truth of her history unfolds. A safe therapeutic relationship is essential. Trust has to be established over and over because trust has been so abused historically for the client.

The therapist must be a safe person. "Therapy means *being* the truths we teach...God also *became* what he taught...If we follow his example, therapy will be not simply about telling others what is true but also

about living out what is true in relationship with them" (Langberg, l997, p.91). Safe therapy is governed by love. "The relationship that is established in the course of therapy is healing only as long as it is governed by love" (Langberg, l997, p. 95). Love and kindness is what makes the relationship safe and healing. It is what helps the client trust the therapist's patience with her.

A safe therapist has integrity the client can trust. A safe therapist cannot promise that the client will always feel safe with him/her but promises to continually work at being safe. The safe therapist invites questions and discussion whenever anything in the relationship feels unsafe.

The safe therapist does safe things. He/she is ethical, carefully keeps confidences, is careful to be governed by the needs of the client, not those of the therapist. When these are not adhered to, the client, who is especially vulnerable to wounding, can be in position to be abused again.

The second focus of Langberg's initial treatment phase is symptom relief. Normalizing the client's symptoms as natural responses to trauma can provide almost immediate relief. Educating clients about the common responses survivors have, experiencing through reading or groups of survivors that they are normal is often surprising and helpful to them.

Often survivors have coped with their trauma by developing destructive addictions. At this point, dealing with these addictions will begin to be addressed and dealt with.

The last focus of the initial phase is memory retrieval. It must be governed by a search for truth and a demonstration of love. Langberg encourages clients to ask God to make clear to them what is true. She suggests to clients who are unsure of their history to investigate the accuracy of their memories. Sometimes returning to the scene of the memory is helpful.

Often visual, emotional, and body memories have to be pieced together with commonalities held by other AFSCSA's to reach the truth.

The restoration of voice and power to the AFSCSA is the guiding principle in dealing with traumatic memories. Too often, "the abuse was suffered in silence, was handled in isolation, and occurred with no thought to the needs or desires of the victim" (Langberg, l997, p.107). The restoration of voice begins when the truth can be spoken in a context where power is not abused, where the pace is good for the client. The restoration continues when the lies embedded in the traumatic experience are exposed and have a chance to be replaced with what is true.

The major parts of Phase Two begin with grief work. This includes facing the losses of the past and present. "Such grieving as this is a passing through the valley of the shadow of death. Many clients fear there is no end to this valley. They often ask how long they must endure such pain. The answer is most unhelpful: As long as it takes" (Langberg, l997, p.154-155). The steady presence of the therapist through this long, painful, dark process is necessary.

The second and third parts of Phase Two are the desire and need to confront and forgive. Both need to be initiated by the client, not the therapist. The following list are the principles governing any confrontation and process of forgiveness:

1. Confrontation and forgiveness should be governed by a purpose;
2. Confrontation and forgiveness should be done with care;
3. Confrontation and forgiveness requires maturity;
4. Confrontation and forgiveness must be governed by truth.

Phase Three, Langberg's final phase, includes four major areas needing attention. The first focus is ongoing work in the area of relationships.

Survivors see relationships as either abusive or wonderful. They do not know how to love, trust, speak the truth, and handle conflict during the normal ups and downs all relationships go through. Survivors tend to fall back into the silence, isolation, and helplessness that characterized their life in the past. They need continued practice in the truths of their voice, connection, and choice. They need help and encouragement to develop a strong support network. If they are married, often intensive marital counseling is necessary. Finally, to deal with their relational needs, the survivor often needs further nurturing and strengthening in their relationship with God.

The second focus of Phase Three is reclaiming the body. AFSCSA need help finding positive ways of thinking and feeling about their bodies. This is hard because they often have spent a lifetime hating their bodies and wanting to separate from them.

The third focus of Phase Three is re-creating life. This part grows naturally from all that has preceded it. Because of the safe relationship with her therapist, the survivor has discovered her voice and has found she can have an impact on her world. Because of that relationship, she has been able to start having improved and meaningful relationships with God and others. Her focus has started to move to ordinary life tasks instead of being focused only on recovery. Her life and relationships have begun to take on new joy. The natural outflow is "an increasing desire to give to others what has been given to her" (Langberg, l997, p.l97).

Finally, the focus in Langberg's Phase Three is termination. This can be a frightening thought. Clients must know that this is their choice, not the therapist's. There must be room for safe discussion and exploration of the idea. It is important

that clients can move ahead slowly and back up, if necessary. It is important that clients be able to return down the road to touch base and that that is discussed as not being a failure.

A 9-Step Group Approach by Heitritter & Vought

Heitritter & Vought (l989) have proposed a 9-step group approach to the treatment of AFSCSA. The approach is part of the BECOMERS program which was started at the New Life Family Services, a Christian social service agency licensed by the state of Minnesota and located in Minneapolis, Minnesota. The following are the 9 steps to recovery included in the BECOMERS program:

1. Realizing Powerlessness;
2. Acknowledging Victory in Christ;
3. Experiencing Freedom From Shame and Guilt;
4. Discovering Self-Identity;
5. Sharing Feelings;
6. Accepting Responsibility;
7. Forgiving;
8. Maturing in Relationship with God and Others;
9. Ministering to Others.

The Twelve Steps
A Working Guide for Adult Children
from Addictive and Other Dysfunctional Families

The Twelve Steps of Alcoholics Anonymous (l990) has been adapted to provide steps to recovery for Adult Children from addictive and other dysfunctional families. It is easily adaptable to treatment of AFSCSA. The following is a list of the twelve steps:

"1. We admitted we were powerless over the effects of childhood sexual abuse - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to other survivors of childhood sexual abuse, and to practice these principles in all our affairs" (Recovery Publications, l990).

In summary the researcher has tried to give examples of several of the prominent stage theories pertaining to Christian-based therapy with AFSCSA.

All literature reviewed reveals that therapists view optimal treatment and recovery from childhood sexual abuse as happening in a stage process.

Healing Requires Relationship Work in Three Areas

In order to heal, an AFSCSA needs to take responsibility for changes needed for recovery and restoration (Bass & Davis, l994). Unfortunately no one can do that for her. There may be many, though, who are willing and able to walk along side her to assist her in this journey. According to Murray (l985), the first relationship that requires work is the survivor's relationship with herself. "You can be intimate with someone else, even God, only to the degree with which you are intimate with and know yourself" (Murray, l985, p. 11). The second relationship that needs strengthening and nurturing is the survivor's relationship to God. The third relationship that needs attending is the survivor's relationship to others. This involves relationships with family, past and present, peers, and often, it includes a healing, therapeutic relationship.

A healing relationship with oneself involves several things among which are learning to know, value, and love oneself, including one's body, needs, thoughts, desires, feelings, concerns, competencies, dreams. This involves taking care of oneself, setting boundaries, journeying with feelings to original wounds, grieving losses and reaching out to others in healthy ways.

Often AFSCSA enter therapy with their life in huge turmoil. Langberg would describe it that, because of the abuse, they have lost their voice, they are in isolation, they are powerless (Langberg, l997). By entering therapy, they are beginning to take some of the first steps to regaining aspects of how they are created in God's image, to have "voice, relationship, and power" (Langberg, l997, p. 23-29).

Murray (l999) would describe it as being out of balance in several of the following areas:

1. The survivor's Sobbing Hurting Child (SHC) is gushing out her pain so she cannot function. The wound has festered long enough to create such a pool of pain to have a "volcanic" eruption.

2. The survivor's Controlling Child (CC) is holding down the SHC's pool of pain in such a destructive way that addiction is damaging the survivor's life.

3. The CC is tired of holding down the SHC and so has joined forces with her as an Angry Rebellious Child (ARC) or a Stubborn Selfish Child (SSC).

4. The Original Feeling Child (OFC) is being buried below the other "children."

5. The Feeling Adult (FA) is submitting her control to one of the children and not bringing them into balance and unity (Murray, l999).

Smith would say that the turmoil in an AFSCSA entering therapy is the result of current events in the survivor's life triggering emotional "echoes" from the original wounds (Smith, l997).

Herman would normalize the symptoms involved in the turmoil the client is presenting as normal responses to traumatic events. "When survivors recognize the origins of their psychological difficulties in an abusive childhood environment, they no longer need attribute them to an inherent defect in the self. Thus the way is opened to the creation of new meaning in experience and a new, unstigmatized identity" (Herman, l997, p. 127).

"Many survivors fear that they are going insane" (Herman, l997, p. ll4). Davis (l990) would assure the client that she is not going crazy. Turmoil and feeling overwhelmed is normal in dysfunctional situations and situations where

feeling, remembering, and receiving images from the past are occurring (Davis, l990, p.7)

The first place of healing has to be to decide to take care of oneself (Davis, l990). It may be that the gift of the turmoil is to force a decision to do something about it. Sometimes entering therapy is a sign that someone suffering has made that decision. Initially people have to decide that they have a problem, that they are powerless over it, that their lives have become unmanageable (Recovery Publications, l990). They have to break the silence (Andrews, l998, p.94). Then there is a place from which to start.

In order to recognize that there is a problem, an AFSCSA needs to connect with her feelings, thoughts, concerns, and desires (Guerney, Nordling, & Scula, l998, p. l2). "Many professionals say the first step toward change is awareness. The second step is acceptance" (Rogers, l961). This may be very hard since the AFSCSA often has spent a lifetime repressing or avoiding her feelings about the traumatic event(s) in her life. They have been secrets she dare not tell (Bradshaw, l995). Whether the abuse was repressed or is just being avoided, the effects are similar. Cutting off from feeling anything in one's life results in continued cut-off of feelings in other areas of one's life (Bowen, cited in Nichols & Schwartz, l99l). Many times, an AFSCSA needs work in therapy that centers around just identifying what she is feeling in the events in her life. Often, victims have a limited vocabulary for feeling words and may benefit by lists of feeling possibilities (Wurtz, Personal Communication, 10/98).

Once an AFSCSA has decided to pay attention to her feelings and search for what to do about them, she has begun to take care of herself. She has taken a huge step toward learning who she is, valuing and loving herself. She has begin to deal with codependency issues.

Codependency

Melody Beattie, in Codependent No More (l987), writes specifically for people who need and want help with understanding, coping with and healing from the effects of codependency. She begins her book with a quote from Agnes Repplier. "It is not easy to find happiness in ourselves, and it is not possible to find it elsewhere" (Repplier, cited in Beattie, l987).

Dealing with codependency is an issue most AFSCSA have to deal with in order to start taking care of themselves (Beattie, l987, p. 38). In a study by Vought (l99l) with AFSCSA in group work, one informant wrote in her evaluation about how helpful the teaching on codependency was to her.

> I learned more about what it was and the description of what co-dependent people are like. I remember one speaker that gave 25 different characteristics of a co-dependent person. This was especially helpful to me. I think to have a handle on what shame and co-dependency means has helped me to learn how to be free of these things. I feel that if I can identify these behaviors in myself, I can do something about it (Vought, l991).

Beattie defines a codependent person as "one who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior" (Beattie, l987, p. 31). Codependent people tend to have trouble taking care of themselves. They have trouble seeing that their needs are just as important as the other people's in their lives. Their habitual way of thinking, feeling and behaving toward themselves and others tends to cause them pain, tends to be self-destructive, and tends to rob them from finding peace and happiness with the most important person in their lives - themselves. It is understandable that survivors who struggle with codependency would want to blame others for these problems in their lives (they are not to

blame for the abuse) but they must come to grips with the fact that they themselves are responsible for dealing with the effects of the abuse. According to Beattie, they are the only ones that can make the necessary changes they need to resolve the turmoil they are experiencing (Beattie, l987).

The following is a list of some characteristics of codependency (Beattie, l987). The list was originally developed for codependents in general, but has numerous similarities to characteristics and literature specifically addressing treatment of AFSCSA. These characteristics of codependency provide a useful overview of what an AFSCSA may need to be aware of and deal with in order to have a healthy relationship with herself, God, and others. Following each statement related to codependency (Beattie, l987), the researcher will present related literature and discuss its application to AFSCSA.

Caretaking

Codependents may:

1. "think and feel responsible for other people - for other people's feelings, thoughts, actions, choices, wants, needs , well-being, lack of well-being, and ultimate destiny;

"anticipate other people's needs." (Beattie, l987, p. 37).

There are numerous times in the life of an AFSCSA that this applies. The first and foremost is the need to think about, attend to, and feel responsible for the needs and actions of her abuser. It could save her life. It requires constant alertness. "Children in an abusive environment develop extraordinary abilities to scan for warning signs of attack. They become minutely attuned to their abusers' inner states. They learn to recognize subtle changes in facial

expression, voice, and body language as signals of anger, sexual arousal, intoxication, or dissociation. This nonverbal communication becomes highly automatic and occurs for the most part outside of conscious awareness. Child victims learn to respond without being able to name or identify the danger signals that evoked their alarm" (Herman, l997, p. 99).

Practiced in this, the survivor can become overfocused on others as a way to survive. To heal, she must begin to think about, attend to, and feel responsible for her needs and actions.

Herman, in her study with 40 AFSCSA (l98l), found several women who felt that they had extraordinary powers over others, especially sexual and destructive. This came from the incestuous situation in childhood. Partly it was a defense against the feeling of being dominated and overwhelmed by their fathers. Partly it came from a sense of specialness and privilege at being the father's favorite. Partly it came from the potential power these women as girls had to destroy their family if they revealed their secret (Herman, l981).

2. "feel anxiety, pity, and guilt when other people have a problem" (Beattie, l987, p. 37).

"By developing a contaminated, stigmatized identity, the child victim takes the evil of the abuser into herself and thereby preserves her primary attachments to her parents. Because the inner sense of badness preserves a relationship, it is not readily given up even after the abuse has stopped; rather, it becomes a stable part of the child's personality structure"(Herman, l997, p. 105).

3."feel compelled - almost forced - to help that person solve the problem, such as offering unwanted advice, giving a rapid-fire series of suggestions, or fixing feelings" (Beattie, l987, p. 37).

The AFSCSA struggles with having to fix others feelings because she feels she can't her own and being present with overwhelming, unfixable problems reminds her, even subconsciously, of her own. When others' problems are fixed, she can feel better inwardly (Smith, l997).

4. "feel angry when their help isn't effective" (Beattie, l987, p. 37).

They may be angry that they can't meet their own needs and if they can't meet the needs of others, it touches those inward anger messages towards themselves (Heitritter & Vought, l989)

5. Wonder why others don't anticipate their needs as they do for others (Beattie, l987).

Child victims see that they were invisible in their homes, for what they truly needed was for protection from the abuse and no matter what they did, they or no one else could make it stop (Langberg, l997). The invisibility of the inner needs continue into adult life. It seems to them that no one really sees nor attends to what they really need.

6. "find themselves saying yes when they mean no, doing things they don't really want to be doing, doing more than their fair share of the work, and doing things other people are capable of doing for themselves" (Beattie, l987, p. 37).

The AFSCSA is practiced in doing what she does not want to do. The abuse taught her to disregard her own voice, self, and power to do what others are demanding (Langberg, l997).

7. "not know what they want or need or, if they do, tell themselves what they want and need is not important."

If the AFSCSA wakes up to her own wants and needs and recognizes their importance, it could make her wake up to the truth of what went on in the abuse. Not only might this cause more abandonment in her life, something of

which she is deathly afraid, it could bring back all the pain, terror, and rage inherent in the original event. Traumatized people do all they can do to avoid this intensely difficult situation (Herman, l997, p. 41 & 46).

8. "try to please others instead of themselves" (Beattie, l987, p. 37).

Again the AFSCSA is practiced in pleasing her abuser and it generalizes to others. One reason she does this is because of the belief that she is bad and worthless (Herman, l997). She concludes that this is why the abuse happened in the first place. It helps her construct meaning to justify it, give her a sense of hope and power. It enables her to attribute goodness to her parents. Possibly she can change it if she has brought the abuse upon herself. If she tries hard enough, she may secure their forgiveness and protection and care she so desperately needs.

9. "find it easier to feel and express anger about injustices done to others, rather than injustices done to themselves" (Beattie, l987, p. 37).

The AFSCSA often feels an attachment to her abuser and therefore takes the blame for the abuse (Herman, l997, p. 103-105, 107). Healing involves putting the blame where it belongs, on the abuser, and allowing the AFSCSA to experience the appropriate anger (Bass & Davis, l994; Murray, l985).

10. "feel safest when giving" (Beattie, l987, p.37)

It is very important for AFSCSA to feel safe and in control (Murray, l999). It is much harder to be in control when receiving. AFSCSA have major trouble with trusting that what someone is giving is really a giving situation. The abuser often appears as giving but is actually taking to meet personal needs (Zakich, l997).

11. "feel insecure and guilty when somebody gives to them" (Beattie, l987, p. 37).

The AFSCSA often feels she does not deserve being genuinely given to. The message from her abuse was she is bad (Murray, l985).

According to Herman (l997), there are several things that sustain and contribute to the ongoing "bad" message in the AFSCSA. The first is that because of a lack of verbal and social skills for problem solving, she approaches problems with hostility. Every act of hostility convinces her that she really is a bad person.

The second ongoing contributor to her current-day feeling that she is bad is that she may have had even the smallest gratification from something in the abusive relationship. This convinces her of her innate wickedness.

Finally, if she was forced to participate in abuse against others, her inner badness is compounded (Herman, l997).

12. "feel sad because they spend their whole lives giving to other people and nobody gives to them" (Beattie, l987, p.37).

The AFSCSA tends to be externally oriented where she depends on others to meet her needs (Murray, l999).

13. "Find themselves attracted to needy people" (Beattie, p. l987, p. 37).

The AFSCSA needs people who need her. She wants intensely to connect with people and to feel close. If her abuser was a close family member or someone she had a close relationship with, her closeness tends to be enmeshed and abusive because of her relationship with the abuser (Bowen, cited in Nichols and Schwartz, l99l; Herman, l997).

14. "Find needy people attracted to them" (Beattie, l987, p. 37).

They understand neediness, have compassion for them, but also are willing to put aside their own boundaries to attend to them (Cloud & Townsend, l992).

15. "feel bored, empty, and worthless if they don't have a crisis in their lives, a problem to solve, or someone to help."

"overcommit themselves; feel harried and pressured" (Beattie, l987, p. 37).

If an AFSCSA can keep herself busy with other people's agendas, even to the point of an activity addiction, she is too busy to think about herself (Prissel, Personal Conversation, l998).

Also AFSCSA may need more external support than others because they have little internal support. There have been few experiences of trustworthy and dependable caretakers to form supportive, soothing images to sustain them at times of distress. They therefore have to build their safety and self-worth by acts of giving to others. Even though it may be genuine giving, there is always hope for gaining anything lost from the abuse (Herman, l997).

16. "believe deep inside other people are somehow responsible for them" (Beattie, l987, p. 37).

AFSCSA tend to be stuck emotionally at the developmental stage that they were at when the abuse occurred (Murray, l997). Because they were children and still at the appropriate place of needing others to be responsible for their care, they many times have felt stuck continuing to need others to take care of them. As an adult, though, the AFSCSA must take responsibility for her own recovery and do what is necessary to make changes that heal (Cloud, l992; Norwood, l985).

17. "find other people become impatient or angry with them for all the preceding characteristics" (Beattie, l987, p. 38).

AFSCSA may be very sensitive to what others are feeling about them and work hard at being as perfect as possible in order to be loved. Healing begins

to come in relationships where someone loves them unconditionally and is patient with them no matter what. Often this is a therapeutic relationship where the therapist knows how to unconditionally love yet have boundaries that are safe for both therapist and client (Langberg, l997).

Low Self-Worth

Codependents tend to

1. "come from troubled, repressed, or dysfunctional families but deny it" (Beattie, l987, p. 38).

Studies show that many families-of-origin of AFSCSA tend to have a high incident of marital discord and sexual estrangement between the parents (Herman, l981, p.43). One study by Herbert Maisch (l972) examined 72 court cases pertaining to incest. The study found that 88% of the couples had a "disturbed or disorganized" marriage prior to the onset of incest, and 41% had a disturbed sexual relationship. The fathers accused the wives of being rigid, cold, and driving them into the incest. The study actually concluded that the "negative influence of the husband" was the major disruptive factor in the marital relationship (Maisch, l972, p.139).

Popular men's magazines, such as Penthouse, attribute father-daughter incest to the worthlessness of the mother as a sex partner and companion (Noble, l977). Even some professional authors, such as psychiatrist Bruno Cormier (Cormier, Kennedy, & Sangowicz, l962), and authority on child abuse, David Walters (Walters, l975), make inappropriate innuendoes about wives whose husbands are in incestuous relationships with their daughters.

It is inappropriate to blame wives for what husbands are doing unless one believes husbands are entitled to female services within their families, without regard to circumstances (Herman, l981, p.49). Often men who are "having sexual relations with their sons or daughters are doing so in addition

to, rather than instead of, their wives. Those offenders who confined their sexual activity to children did so through choice" (Groth & Birnbaum, l979, p.140)

"Mothers do have a role in the genesis of incest...The theme of maternal absence, in one form or another, is always found in the background of the incest romance" (Herman, l981, p. 44). Strong, healthy, and competent mothers do not tolerate incest. Mothers who are rendered powerless in their families, for any reason, often tolerate abuse in many forms, including sexual abuse (Herman, l981, p. 47). Finkelhor (l979) found in his studies that girls with a strong relationship with a present and a healthy mother had the best protection from sexual abuse.

An AFSCSA tends to deny her family's dysfunction because of the shame and guilt she generally feels. Children need to accept the blame because their life depends on their parents.

2. "blame themselves for everything" (Beattie, l987, p.38).

The AFSCSA struggles often with the blame for the sexual abuse. Children have sexual feelings, and do seek out affection and attention from adults. However,"it is the adult, not the child, who determines the sexual nature of the encounter, and who bears the responsibility for it" (Herman, l981, p. 42). Abusers often tell the child that she is to blame and that she is bad but it is not true. This message creates in them a hard to change belief. Whenever something goes wrong, then, it is easy for them to accept the blame since it goes with what they were told about themselves and embrace.

3. "feel different than the rest of the world; feel a lot of shame and guilt" (Beattie, l987, p. 38).

The most common complaint among the patients in therapy that Herman interviewed in preparation for writing her book, Father-Daughter Incest

(l981), was the feeling that they were different from other people and the feeling that they could never be normal, even though they appear to be so to others. They felt set apart by a feeling of their own "evilness...The incest secret formed the core of their identity" (Herman, l981, p. 97).

AFSCSA have trouble being good enough to be loved, unconditional love is a hard concept for them (Langberg, l997).

4. "feel guilty about spending money on themselves or doing unnecessary or fun things for themselves" (Beattie, l987, p. 38).

According to Murray, the Original Feeling Child (OFC) was buried after the abuse in order to tolerate the pain of the trauma. The Controlling Child (CC) is the only child functioning in an AFSCSA. Doing something fun is a function of the OFC and it's the job of the CC to keep her out of existence (Murray, l985).

5. "fear rejection" (Beattie, l987, p. 38).

Rejection of who she is and what she feels and needs is well-known to the survivor from the original trauma. She wants to avoid rejection now at all costs since it reminds her of the agonizing pain of the original trauma (Smith, l997).

6. "feel like victims; have been victims of emotional, physical, and sexual abuse" (Beattie, l987, p. 38).

The AFSCSA is exploited by the misuse of power through "force or threats of physical power and/or the manipulation or intimidation of abusive emotional power" (Heitritter & Vought, l989, p.23). Many times this abuse of power is sexual in nature.

Sexual abuse always victimizes children. They cannot withstand premature introduction of sexuality by an adult because of a lack of emotional and intellectual maturity. They not only are victimized by the betrayal of their

vulnerability, they are also victimized by having no resource or reference on how to evaluate and understand what is happening to them. Abuse has an impact on every corner of their being (Heitritter & Vought, l989).

7. "tell themselves they can't do anything right" (Beattie, l987, p.38).

AFSCSA may tend to be very careful to do everything right. The thing they wanted the most to do right is to not cause the abuse and they failed at that in their own mind. It colors everything else (Herman, l98l). It has demolished their confidence in making good decisions (Herman, l997).

8. "get strong feelings of low self-worth - embarrassment, failure, etc.-from other people's failures and problems (Beattie, p. 39, p. 39).

AFSCSA take on the responsibility for the problems and failures of the people they associate with, a habit learned from doing that with their abuser (Herman, l997).

9. "settle for being needed" (Beattie, l987, p. 39).

AFSCSA long to be needed, to be close and cared for and so may pay the cost by being open to an unhealthy relationship, their need is so desperate (Herman, l981).

Repression

Many Codependents:

1. "push their thoughts and feelings out of their awareness because of fear and guilt" (Beattie, l987, p. 39).

Physiological arousal, emotion, cognition, and memory are a complex system of self-protection that normally functions together (Herman, l997, p. 34). A century ago Janet believed that "the severing of the normal connections of memory, knowledge, and emotion resulted from intense emotional reactions to traumatic events" (Janet, cited by Herman, l997, p. 35). Damage to this system produces profound and lasting changes (Herman, l997, p. 34).

2. "become afraid to let themselves be who they are" (Beattie, l987, p. 39).

AFSCSA have many fears. As children and then as adults, they may fear they have been damaged. They may fear someone finding out their secret and that others can tell by looking at them that they are bad. With incest, they may fear that if they tell it will break up the family. They may feel totally trapped by fear of rejection by both the offender and the non-abusing parent. There may be fear of personal harm especially if the abuser has threatened (Heitritter & Vought, l989)

Controlling

Many codependents:

1. "have lived through events and with people that were out of control, causing the codependents sorrow and disappointment" (Beattie, l987, p. 40).

The AFSCSA has been rendered helpless by overwhelming force. "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman, l992, p. 33). Anything reminiscent of that feeling of relating to someone out of control can trigger generalization of feelings from the trauma to the present situation (Smith, l997) and alert the AFSCSA to danger. "Each component of the ordinary response to danger...tends to persist in an altered and exaggerated state long after the actual danger is over" (Herman, l992, p. 34).

Each situation is seen as a new, and dangerous surprise but felt with the intensity of the original event (Shalev, cited in Herman, l997, p. 36). Even if there is no cognitive memory of the original event, it is relived as though it is continually happening in the present (Herman, l997, p. 37). It intrudes repeatedly.

2. "become afraid to let other people be who they are and allow events to happen naturally" (Beattie, l987, p. 40).

An AFSCSA is on constant alert, expecting danger to return at any moment (Herman, l997, p. 35). It is too scary for her to not be in control in order that she might do what she can to prevent the inevitable trauma from reoccurring in some shape or form.

3. "think they know best how things should turn out and how people should behave" (Beattie. l987, p. 40)

The AFSCSA, especially in the case of incest, is used to being an adult and directing life from that position. She develops adult capacities, outwardly, quickly, because of the adult role she has been handed as care-giver and surrogate spouse (Heitritter & Vought, l989).

4. "try to control events and people through helplessness, guilt, coercion, threats, advice-giving, manipulation, or domination" (Beattie, l987, p. 40).

AFSCSA have been faced with the "extremities of helplessness and terror" (Herman, l992, p.33) The common response to psychological trauma is a feeling of intense fear, helplessness, loss of control, and threat of annihilation (Andreasen, l985, 918-24).

Potentially, no place or person really feels safe for the AFSCSA because even insignificant reminders can evoke memories with all the vividness and emotional force of the original event (Herman, l997, p. 37; Smith, l997)

5. "feel controlled by events and people" (Beattie, l987, p. 40).

AFSCSA have faced extreme control by others that overwhelms the ordinary systems of care that give people a sense of control, connection, and meaning. The severity of the trauma, which cannot be judged on any one determinate, is maximized when the abused is surprised, trapped, exposed to

the point of exhaustion, annihilation threatened (an intrinsic fear), experiences physical violation or injury, exposure to extreme violence, or witnesses grotesque death (Grace, Green, & Lindy, l990; Grace, Green, & Lindy, l985).

Denial

Codependents tend to:

1. "ignore problems or pretend they aren't happening" (Beattie, l987, p. 40).

The AFSCSA tends to see any problems as a threat to them as it perhaps subconsciously reminds them of their original threat. They are able to deny and ignore problems because threat tends to alter ordinary perceptions: "people in danger are often able to disregard hunger, fatigue, or pain" (Herman, l992, p.34).

2. "pretend circumstances aren't as bad as they are" (Beattie, l987, p. 40).

In order to keep her primary attachment to her parents, a child survivor represses the memory of the abuse or minimizes, rationalizes, or excuses to the point that it no longer is seen as abuse (Herman, l997).

3. "get confused" (Beattie, l987, p. 40).

"Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized" (Herman, l992, p. 34).

4. "get depressed and sick" (Beattie, l987, p.40).

Even though a child rationalizes or represses the abuse, its effects are still registered in the body (Herman, l997). If the abuse is held internally and not spoken out, the body will over time speak out the abuse through pain, sickness and depression (Murray, l999).

5. "develop addictions: work, relationship, sex, food, substance, activity, exercise, etc." (Beattie, l987, p. 40).

Murray uses the concept of the Controlling Child using addictions to try to cover the pain of the abuse (Murray, l991).

6. "believe lies" (Beattie, l987, p. 40).

The pain an AFSCSA feels every time the memory of the abuse is triggered is not from the abuse but from the false interpretation, the message, the lie given to her about her (Smith, l997).

7. "lie to themselves" (Beattie, l987, p. 40).

It is important for AFSCSA to keep the truth from themselves because it brings a torrent of feelings and destruction to recognize the truth of what has happened to them. In the long run, it is the only way they can begin to heal but it is very scary (Herman, l997).

8. "wonder why they feel like they're going crazy" (Beattie, l987, p.40).

AFSCSA have not been able to develop ways of self-soothing that comfort at times of distress and so it is common for them to feel like they are loosing their minds when times are difficult (Herman, l997).

Dependency

Many codependents:

1. "don't love themselves; don't feel happy, content, or peaceful with themselves; look for happiness outside themselves; latch onto whoever or whatever they think can provide happiness; feel terribly threatened by the loss of any thing or person they think provides their happiness" (Beattie, l987, 41).

Many AFSCSA feel that the only way to feel loved and be happy is for someone else to give it to them. They give up many areas of personal

responsibility and want others to take care of them. "This is a disguise for protection (not consciously perceived by the individual)" which gives the message, "I am helpless; I am weak; I can't make it without you because I'm not OK in myself" (Heitritter & Vought, l989, p.46). Fear of abandonment is a central fear because they know well the intense loneliness they have experienced from adults who should have been there for them. Until they build adequate loving images in their mind in order to be able to self-soothe, they are very dependent on external support for comfort. That is why they are desperate for someone to depend upon (Herman, l997).

2. "try to prove they're good enough to be loved" (Beattie, l987, p. 41).

Many AFSCSA struggle with perfectionism, hoping to be good enough to be loved (Heitritter & Vought, l989).

3. "don't take time to see if other people are good for them; often seek love from people incapable of loving" (Beattie, l987, p. 41).

Traumatized people "often feel impelled to re-create the moment of terror, either in literal or in disguised form" (Herman, l997, p.39), without realizing what they are doing. Therefore they often set themselves up for even further harm.

If they are able to form lasting relationships, they are often tormented and stormy. Because they have not learned to protect themselves, they tend to draw and pick men who at best are aloof and unreliable, and exploitive at the worst. They expect that their men will mistreat them and that they will have to put up with it since that is what was modeled for them by their mothers. At the time Herman interviewed her patients, 63% of the women had been married and 14% were still married. They had a common complaint that their husbands did not really value or respect them (Herman, l981).

Poor Communication

Codependents frequently

1. "gauge their words carefully to achieve a desired effect" (Beattie, l987, p. 42).

The AFSCSA is very concerned about being protective and so will try to choose her words carefully to assure safety and get what she wants.

2. "talk too much" (Beattie, l987, p. 42).

AFSCSA are trying to let people know about what they have had to keep secret, even to themselves. Their hope is that if they talk, it will come out.(Sometimes the motive is to distract as well.) They are often trying, many times without knowing it, to re-create some aspect of the trauma so that there can be integration and resolution. Reenactments, even when they are not dangerous, have a drive, a compulsion about them (Harvey, l997, p.41). Many times this compulsion is seen in talking a lot.

Lack of Trust

Codependents:

1. "don't trust themselves, their feelings, their decisions, or other people" (Beattie, l987, p.43).

Trauma destroys a person's assumptions that they are safe in the world, that they have positive value, and that there is a meaningful order to life (Herman, l997). It is the destruction of basic trust that is formed early in life with the first caretaker. If this trust is betrayed, a survivor will have trouble forming trusting relationships which will in turn, compound her feeling of isolation. She feels betrayal by both parents (If they weren't the perpetrators, they should have known; if father was the perpetrator, mother should have known and protected her) which results in expecting abuse and disappointment in all intimate relationships. Continued abuse increases her

mistrust of people and further increases her isolation. It is a vicious cycle that makes her even more desperate for closeness and understanding, for the nurturance and care she missed as a child. Therefore she tends to "make desperate attempts to capture even a fleeting feeling of closeness and warmth" (Herman, l981, p.100).

The AFSCSA's relationship with her father taught her that sex will get her attention. The lie she accepted from the abuse was that she was good for little else and so in her pursuit of intimacy, she settles for superficial sexual intimacy as she overvalues and idealizes men. The hope is to recapture

the specialness felt in the relationship with her father. That is the only intimacy that feels right, yet it is based on what is unhealthy. She is caught in a merry-go-round with powerful longings, a faulty barometer of what meets those needs, the ability to draw unhealthy people toward her, and a difficult time trusting people who could help her. Her submitting to lovers is often her attempt to fulfill her "unsatisfied childhood longings for protection and care" (Herman, l981, p.103).

As a child, her "loss of trust in authority figures is one of most devastating effects of incest" (Mayer, l985, p.54). The incest is a betrayal of the first adults children learn to trust. Since this generalizes to other adults, children may tell peers before telling other adults. If the abuse happens by someone other than the family, parents may be blamed for not protecting them even though they didn't know. Many children assume parents know or should know. "The erosion of trust is often tragically progressive in the life of the victim" (Heitritter & Vought, l989, p.27).

2. "think God has abandoned them; lose faith and trust in God" (Beattie, l987, p. 43).

Because parents are the first teachers about God by word and/or by action, children view God as being like their parents.
When incest occurs by a parent, it often damages a victim's ability to trust God.(Langberg, l997).

Even so, some survivors despair of human understanding and seek comfort in a personal relationship with God, like several women Herman interviewed in her study, others feel rejected by the church or feel so sinful that they could never enter a church (Herman, l981).

Anger

Many codependents:

1. "feel very scared, hurt, and angry" (Beattie, l987, p. 43).

Herman found that many AFSCSA do not express overt anger about how they have been mistreated. With those that do, it is most commonly directed at women rather than men. Except for those who become feminists, most view women with contempt. Because of their favored position with their father, many exempt themselves from that condemnation, at least on a surface level. Their only possible source of self-esteem depends upon continued identification with their powerful fathers and yet on a deeper level, they identify with their despised and worthless mothers.

This hostility towards women hampers the development of supportive female friendships. They view other women as competition to them. This hostility also hides a deep longing for a relationship with a caring woman which could add in the healing of many of the effects of the abuse (Herman, l981).

As children in an abusive situation, they rarely have an outlet to express the intrinsic anger that accompanies such atrocities. They feel angry about what was done to them, possibly at themselves for not trying to stop the abuse, or for enjoying parts of the abusive relationship. Outwardly they may appear compliant and passive yet be seething with resentment and hostility inwardly (Heitritter & Vought, l989).

2. "are frightened of other people's anger" (Beattie, l987, p. 43).

Many AFSCSA see anger as the warning sign that abuse is impending and so are very frightened when they experience it (Heitritter & Vought, l989).

3. "repress angry feelings" (Beattie, l987, p. 43).

Many of the women studied by Herman did not express overt anger about the ways they were mistreated (Herman, l981)

4. "wonder if they'll ever not be angry" (Beattie, l987, p. 44).

Because of the "permanent alert" tendency, an AFSCSA tends to "startle easily, react irritably to small provocations, and sleep poorly" (Herman, l997, p. 35) This adds to the "always angry" tendency.

Kardiner, from his observation of World War I combat veterans, interpreted the irritability and explosively aggressive behavior of traumatized men as disorganized fragments of a shattered 'fight or flight' response to overwhelming danger" (Kardiner & Spiegel, cited in Herman, l997, p. 36). This researcher wonders if this also applies to AFSCSA.

Sex Problems

Some codependents:

1. "are caretakers in the bedroom" (Beattie, l987, p.44).

Survivors have been taught that their needs don't count and so that pattern continues into adulthood. (Langberg, l997) A survivor may feel intense shame if she experienced any pleasure during the abuse. "She may try to shut down those feelings and only try to comply with her husband to meet his needs"(Heitritter & Vought, l989, p.47).

2. "have sex when they don't want to; have sex when they'd rather be held, nurtured, and loved" (Beattie, l987, p.44).

Many AFSCSA believe that the only way they can get what they need is to be sexual. They learned that they were good only for sex and to be used by others. Thirty-five percent of the women studied by Herman had periods of sexual promiscuity. Many alternated between times of compulsive sexual activity and times of asceticism and abstinence (Herman, l981).

3. "try to have sex when they're angry or hurt" (Beattie, l987, p. 44).

This may because of what was modeled for the AFSCSA. Many times abusers abuse to deal with their own anger and to avenge their own hurt (Herman, l981).

4. "are afraid of losing control" (Beattie, l987, p. 44).

The AFSCSA often "associates sex with the feeling of being dominated and controlled" (Herman, l981, p.105). Relinquishing control and responding sexually to a loving spouse may be hard since she was stimulated against her will as a child (Heitritter & Vought, l989). She may react negatively whenever he initiates arousal. It is often hard for her to relax, trust, and enjoy since anything like this would trigger a memory.

5. "feel sexual revulsion toward their partner" (Beattie, l987, p.44).

Often things a partner does triggers a memory or emotional response connected to the original trauma. Often this is not because of the current situation but because of its connection to the past abuse (Smith, l997; Heitritter & Vought, l989).

6. "force themselves to have sex, anyway" (Beattie, l987, p.44).

Sometimes AFSCSA are caught in two extremes, complete aversion to sex or compulsive sexual behavior. Compulsive sexual activity is not about enjoying or desiring sex. It is about escaping pain: medicating pain, reducing isolation, seeking attention (Heitritter & Vought, l989).

Miscellaneous

Codependents tend to:

1. "be extremely responsible or irresponsible" (Beattie, l987, p.44).

Because of the caretaker role and difficulties imposed on them as children, many AFSCSA have developed impressive strengths and many times contributed great achievements to their world (Herman, l981 p.l06).

2. "become martyrs, sacrificing their happiness and that of others for causes that don't require sacrifice" (Beattie, l987, p. 44).

Herman found that a great many of the survivors she interviewed continued the caretaker role as adults that was imposed them as children (Herman, l981, p. 106).

3. "not seek help because they tell themselves the problem isn't big enough, or they aren't important enough" (Beattie, l987, p.45).

AFSCSA may minimize the problems in their life now because their feelings were minimized or neglected in the abuse (Herman, l997).

Progressive

In the later stages of codependency, codependents may:

1. "feel lethargic" (Beattie, l987, p. 45).

Lethargy occurs for an AFSCSA when she is feeling powerless and any form of resistance seems futile to her. She has practiced this in the abusive event and later in life, current events may overwhelm her and return her to this helpless state. Thus she surrenders by altering her state of consciousness. It is a numbing, a trance state, a dissociation similar to a hypnotic trance (Herman, l997, p. 41). The study of hypnotic trance has been seen to produce a dissociative state similar to the use of morphine in which the perception of pain and the normal emotional responses to pain are severed. Both diminish the distress of intractable pain without abolishing the sensation itself (Hilgard, l977, p.246).

2. "feel depressed" (Beattie, l987, p. 45).

Sixty percent of the 40 incest victims Herman interviewed experienced major depression (Herman, l981).

3. "become withdrawn and isolated" (Beattie, l987, p. 45).

Most AFSCSA will try to avoid reliving a traumatic experience because it is so intensely distressing. In order to create a sense of safety and to control their pervasive fear, they may limit their consciousness, withdraw from others, live a virtually impoverished life (Herman, l997, p. 42).

4. "abuse or neglect their children and other responsibilities" (Beattie, l987, p. 45).

Fortunately, many AFSCSA are determined to raise their children in such a way to keep them from the pain they have suffered. Several of the survivors interviewed by Herman expressed that their work and the obligations of raising healthy children keep them anchored to life. Unfortunately they do not have a concept of a "good enough" parent (Winnicott, l965). The standards that they set for themselves are impossible to meet and many end up feeling worthless and intensely guilty. When they feel overwhelmed by life and their parenting responsibilities, though, they may respond with abusive rage, a result of their feeling powerless. They have great motivation to deal with this, though. They seem to need that image of the perfect mother to compensate for the identity of the bad person which is still so core to their identity. They seem stuck to the image of the ideal mother they wished for or the neglectful mother of their childhood. It is an "either-or" situation (Herman, l981, p. 106-107).

5. "feel hopeless" (Beattie, l987, p. 45).

Because of the state of powerlessness, surrender, and therefore dissociation normal to many AFSCSA, there often is little anticipation or planning for the future and taking the necessary risks that could offer new opportunities for successful coping that could mitigate the effects of the traumatic experience (Herman, l997, p. 45-47).

Another abuse dynamic is the oscillating between intrusion of the emotions of the memory or numbness. The survivor feels caught between "floods of intense, overwhelming feeling and arid states of no feeling at all, between irritable, impulsive action and complete inhibition of action" (Herman, l997, p. 47). These patterns exaggerate the sense of unpredictability, helplessness, and hopelessness an AFSCSA often experiences.

6. "think about suicide" (Beattie, l987, p. 45).

"Thirty-eight percent of the incest victims Herman studied became so depressed at some point in their lives that they attempted suicide" (Herman, l981, p.99).

7. "experience an eating disorder (overeating or undereating)" (Beattie, l987, p. 45).

Sometimes an AFSCSA develops an eating disorder in response to the abuse. In some abusive families where rigidity and emotional suppression are modeled, eating disorders or overeating may be the only outlet for stress, an attempt to control in an out-of-control situation. It might be a desperate attempt to correct body image where abuse has distorted it, to punish oneself for being bad, or to deal with the pain of suppressed feelings (Heitritter & Vought, l989). Food might be the only comfort a survivor recognizes.

9. "become addicted to alcohol and other drugs" (Beattie, l987, p. 45).

An AFSCSA who "cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol or narcotics" (Herman, l997, p.44) The pain from the memory may be so devastating that a victim may be desperate for any relief. The study of Vietnam-era veterans dealing with posttraumatic stress syndrome found that self-medicating with drugs and alcohol complicated their difficulties and added to their alienation from others (Haas & Hendin, cited in Herman, l997, p.44). Even though dissociative states are adaptive in

the original trauma, they are maladaptive once the danger is past. They keep the traumatic experience hidden from consciousness and therefore prevent the integration so necessary for healing. Kardiner & Spiegel (1947) recognized that only fragments of the memory leak out and emerge as an intrusive symptom.

Twenty percent of the incest victims studied by Herman had times of drug or alcohol dependencies. They attributed this to ineffective attempts to cope with loneliness and depression.

In summary, the researcher has attempted to show the similarities of codependency issues and the issues that AFSCSA have to deal with. These issues cover the spectrum of work of healing from childhood sexual abuse that a survivor needs to do in the areas of relationship with oneself, God and others.

Therapeutic Interventions That Facilitate Healing For AFSCSA

There are therapeutic interventions that facilitate healing for AFSCSA. Among these are a therapeutic relationship and grief and loss work. Within the scope of grief and loss work, there is mourning, developmental stage work, core belief work, and spiritual development. The following will be a discussion of ways that the therapeutic relationship and grief and loss work are healing interventions for childhood sexual abuse.

Therapeutic Relationship

Disempowerment and disconnection are basic to the psychological trauma experienced by the AFSCSA, therefore, recovery must be built upon empowerment and new connections. "Recovery can take place only within the context of relationships; it cannot occur in isolation" (Herman, l997, p. 133). Telecsan says that healing cannot take place outside of relationship. "When trauma takes place interpersonally, healing has to take place interpersonally" (Telecsan, Personal Conversation, January 7, 2000). Langberg (l997) writes

that God understood the need of people to heal in a context of a relationship. That is why he sent Jesus, God in the flesh, because humans need skin and words in order to heal and to have life. Langberg believes that God uses many therapists in healing relationships in the lives of survivors (Langberg, l997).

The first principle of a healing relationship with a therapist or anyone else is that it encourages empowerment of the survivor. She must be in control of her own recovery. One incest survivor remarked, "Good therapists were those who really validated my experience and helped me to control my behavior rather than trying to control me" (Tani, cited in Herman, l997, p. 133).

The therapeutic relationship is unique and a healing intervention in itself because of several aspects. First, recovery of the patient is its sole purpose. In this, the therapist is ally, using all of his or her resources of knowledge, skill, and experience. Secondly, the patient and therapist has an unique contract regarding the use of power. The patient enters the relationship vulnerable and submits to an unequal status in hopes of being able to acquire help for her situation. Feelings of childhood dependence are naturally aroused which further exaggerate the power imbalance. The therapist must resist all temptations to abuse this power and use it only to foster the recovery of the patient. The therapist promises to abstain from using her power to gratify her personal needs. She does not take sides in the patient's inner conflicts or try to direct the patient's life decisions. She must remind herself that the patient is in charge of her own life and not promote her personal agenda. She is aware that by being able to draw out the voice of the client who has been silenced for many years, that she has a great deal of power that she is careful not to abuse. The therapist must be found

faithful, safe and truthful in order that the client can have a safe place in which to bring the truth about herself (Langberg, l997).

By the therapist's role being both intellectual and relational, the therapist fosters healing insight and empathetic connection. Kardiner & Spiegel write that "the central part of the therapy should always be to enlighten the patient" yet with the gentleness of a protective parent (1947, p. 390). Kernberg states, "The therapist's empathic attitude, derived from his emotional understanding of himself and from his transitory identification with and concern for the patient, has elements in common with the empathy of the 'good-enough mother' with her infant.ÖThere is, however, also a totally rational, cognitive, almost ascetic aspect to the therapist's work with the patient which gives their relation a completely different quality" (Kernberg, l984, p.ll9).

Langberg speaks of the therapist knowing and loving another in truth. It is very healing to clients to have others validate what they know to be true. Langberg also speaks about therapists being a vessel of unconditional love whereby others can know the compassion of God for them. The therapist demonstrates the use of voice in the therapeutic relationship. The therapist speaks her "self" out into that relationship, not only to share herself but to model it for her clients (Langberg, l997).

The therapeutic alliance has to be built by the effort of both patient and therapist. It is a collaborative working relationship that values and restores the beliefs that were lost in the abuse, namely "persuasion rather than coercion, ideas rather than force, mutuality rather than authoritarian control" (Herman, l997, p. l36).

How the therapist deals with the inevitable transference in a therapy relationship can add to the therapeutic benefit. Because of the trauma and the

terror in it, the emotional responses of an AFSCSA to a person in authority have been deformed. This is why traumatic transference has an intense, life-or-death quality. Kardiner & Spiegel write, "It is as if the patient's life depends on keeping the therapist under control" (Kardiner & Spiegel, 1947, ll4). There is a destructive force, a terror that exists between the therapist and the patient. It is the presence of the abuser who is still demanding silence (Lister, l982, p. 872-876). Understanding this destructive force can enable the therapist to know how to deal with it with patience and insight.

The traumatic transference also reflects the experience of helplessness that pervades all relationships after the abuse. "The greater the patient's emotional conviction of helplessness and abandonment, the more she feels the need for an omnipotent rescuer" (Herman, l997, p.137). Often the AFSCSA will give the therapist this role and develop intensely idealized expectations. This idealized rescuer fantasy protects the patient, in her mind, from reliving the traumatic terror.

Discussion as to the necessity of this fantasy could be a helpful intervention as can be seen as follows:

"The therapist remarked, 'It's frightening to need someone so much and not be able to control them.'

"The patient was moved and continued this thought: 'It's frightening because you can kill me with what you say...or by not caring or [by] leaving.'

"The therapist then added, 'We can see why you need me to be perfect'" (Herman, l997, p. 137).

The patient has no tolerance with the therapist who fails to live up to these idealized expectations. Her life depends upon it. The therapist will fail to be perfect, though; it is inevitable. The result is rage. The rage is not only the rage of a victim in terror of death but the displaced rage from

abuser to caregiver whom she feels is inept and withholding of the rescue she could give but refuses. Added to the fury is the survivor's sense of humiliation and shame. She is mortified to be seen in such a humiliating state.

Trust has to be built and rebuilt for the therapeutic relationship to be healing. AFSCSA feel a desperate need to rely on the integrity and competence of the therapist but she has tremendous trouble doing so because of the damage to her capacity to trust. It is hard to trust that the therapist is willing and able to help. The therapist has to prove that she can bear to hear the true story of her trauma. If the therapist is able to listen, then the survivor mistrusts her motive for not backing away. She may suspect that the therapist is exploitive or voyeuristic, abusive like her perpetrator.

Langberg sees two dangers that can cause the therapist to live up to these fears of clients and do therapy without the needs of the client being the determining factor. The first danger is if the therapist becomes fascinated with another's pain or becomes addicted to the intensity of trauma work. There can be a high that regulates the pace and not the client's need for progress with safety. The second danger results in an unwillingness to hear clients' pain because it may tell them things about life or themselves that the therapist does not want to hear (Langberg, l997).

AFSCSA often have a great intuitive ability to evaluate unconscious and nonverbal communication. They scrutinize every word and gesture of the therapist in an attempt to protect themselves. An AFSCSA is expecting hostile reactions to her. It takes great patience and perseverance by the therapist to reassure the AFSCSA that she is not judging her but caring for her unconditionally. Sometimes the therapist does get drawn into the dynamics of

dominance and submission and inadvertently reenacts part of the abusive relationship. It is often surprising the similarity of the original trauma and its reenactment in therapy (Herman, l997). When it is understood for what it is, it many times can be turned around and used in a beneficial way.

"The reenactment of the relationship with the perpetrator is most evident in the sexualized transference that sometimes emerges in survivors of prolonged childhood sexual abuse" (Herman, l997, p.l39). The message that AFSCSA often receive from the original trauma is that they are not valued for anything other than sex. This is especially true when relating to a person of power. Some clients may be quite open about expressing their desire for a sexual relationship; some may be quite demanding. Even so, all seem to dread it for it confirms their belief in the corruptedness of all human relationships (Herman, l997). Needless to say, a client-therapist sexual relationship is not conducive to healing even if the client feels that that is what she needs to heal. In addition, it is unethical and illegal.

Herman talks about the healing aspect of work on boundaries that a therapist encourages through the therapy contract. "Therapy is both a labor of love and a collaborative commitment....Even though it evokes all the passions of human attachment, it is not a love affair or a parent-child relationship....It is a relationship...in which both partners commit themselves to the task of recovery" (Herman, l997, p. l47).

Both client and therapist are responsible for the relationship. They both are to keep appointments faithfully. "The therapist contributes knowledge and skill, while the patient pays a fee for treatment; the therapist promises confidentiality, while the patient agrees to self-disclosure; the therapist promises to listen and bear witness, while the patient promises to tell the truth" (Herman, l997, p.148).

Boundaries are the best protection against excessive, unmanageable transference and countertransference. It makes a safe arena in which to recover. The patient is made aware of the terms of availability based on what is clear, reasonable, and tolerable to both parties. The boundaries include an understanding that the contract precludes any other social relationship, the frequency and duration of sessions, and clear ground rules about emergency contact outside of sessions. Some flexibility and negotiation is necessary in boundary formation. "Negotiating boundaries that both parties consider reasonable and fair is an essential part of building the therapeutic alliance. Minor departures...may be a fruitful part of this negotiating process, as long as these departures are subjected to careful scrutiny and their meaning is fully understood" (Herman, l997, p.151).

Grief and Loss Work

The second healing intervention to be discussed relates to the ways grief and loss work is a healing intervention. Within the scope of grief and loss work, the researcher will discuss what is entailed in grief and loss work for the AFSCSA, how loss to the AFSCSA can be seen through the lack of being able to mature through the developmental stages, the healing aspects of core belief work and spiritual development.

Once a place of safety it established within a therapeutic relationship, the work of grief and mourning of losses begins. The work of grief for AFSCSA entails the following 4 tasks (Olson, Personal Conversation, December 9, l998, adapted from Wolfelt, l992). Some tasks have to come before others but no job is complete before there are glimpses of other tasks being done.

1. Naming the reality of what was lost, missing, or dead.
2. Embracing the emotions that come from naming this reality.

3. Given the reality of the loss, how does the client make life work? What is the client's new identity based on a life with the loss.

4. Given this reality, what meaning can the client develop out of the loss?

Naming the Reality of Loss

The first job in grief and mourning for the AFSCSA is to name what was lost, missing, or dead. Understanding normal developmental stages of children helps one to understand what was lost by the abuse. The AFSCSA may have a long list of what was lost in her life because of the abuse. The losses can be categorized according to Erikson's eight psychosocial stages (Langberg, l997). The following is a discussion of these stages as they pertain to a child who has lost aspects of her life because of sexual abuse.

1. "Trust versus Mistrust (Infancy: Birth to One Year)"

In this first stage, an infant develops a relationship with someone she can trust to meet her needs. If there is "good-enough" parenting, the child will develop a degree of trust. This will put a lot of "deposits in her bank account from which she can draw on all her life" (Covey, l995). Infants develop this trust by parents feeding them when hungry and comforting them when in pain or afraid. If sexual abuse or neglect happens at this time, the damage destroys a capacity for trust that is extremely difficult to regain (Langberg, l997).

First of all, the abuse breaks the child's primary attachment, the attachment to her parents. Janoff-Bulman (l985) credits this attachment as giving a child a sense of safety, a sense of her positive value, a sense that there is a meaningful order to the world.

Herman (l997) similarly sees this basic trust developed as a result of feeling safe in the world and coming from bonding with a "good-enough"

caretaker early in life. It is what sustains a person throughout the rough spots in life. It provides a basis for self-soothing. It is the basis of all relationships and faith. "The original experience of care makes it possible for human beings to envisage a world in which they belong, a world hospitable to human life" (p. 52).

The result of this loss of connection with caring people is a child's loss of her basic sense of self. She must have "a secure sense of connection with caring people" in order to have a foundation for positive "personality development" (Herman, l997, p. 52).

2. "Autonomy versus Shame and Doubt"

(Early Childhood: Two to Three Years)

The child's task in this second stage of life is "to establish that it is acceptable to be a separate person with some degree of control over herself" (Langberg, l997, p. 51). As autonomy increases, so does separation anxiety and the risk of failure. If basic trust has not been developed, or if the child is overcontrolled, ridiculed or punished for attempts at independence, shame and doubt occur in the child's life.

A caretaker's benign use of power controls a developing child's positive sense of self. If a parent shows some respect for the child's individuality and dignity, the child feels valued, respected and her self-esteem develops. Her sense of separateness within the relationship, or autonomy, also develops. Her own bodily functions are controlled and regulated by her. She learns to form and express her own viewpoint.

Abuse violates a person's autonomy at the level of basic bodily integrity. "The body is invaded, injured, defiled. Control over bodily functions is often lost." This loss is often "the most humiliating aspect of the trauma.î It is as though "the individual's point of view counts for

nothing. The traumatic event thus destroy's the belief that one can be oneself in relation to others" (Herman, l997, p.52-53).

The resulting shame and loss due to loss of autonomy is carried on into life. The "shame is a response to helplessness, the violation of bodily integrity, and the indignity suffered in the eyes of another person" (Lewis, cited in Herman, l997, p. 53). "The doubt reflects the inability to maintain one's own separate point of view while remaining in connection with others" (Herman, l997, p.53). After abuse, victims frequently doubt both themselves and others.

Naming the loss involves naming what happened. Abuse occurring with children in this stage, as well as younger and older, requires children to compensate for the failures of adult care and protection with immature psychological defenses. These children are forced to develop extraordinary capacities, both creative and destructive. Abnormal states of consciousness are developed "in which the ordinary relations of body and mind, reality and imagination, knowledge and memory, no longer hold" (Herman, l997, p.97). These states of consciousness permit an array of symptoms, both psychological and somatic, which conceal and reveal their origins. "They speak in disguised language of secrets too terrible for words" (Herman, l997, p. 97).

3. "Initiative versus Guilt (Preschool: Four to Five Years)"

At this stage the child's task is to develop competence and initiative. The child does this by "curiously investigating everything, talking incessantly, and constantly moving" (Langberg, l997, p. 51). Caregivers encourage competence and initiative by encouraging the child to make as many of her own choices as possible.

The child's growth in competence and capacity for initiative adds to her positive self-image. Conflicts with caregivers in this area are normal and if

there in unsatisfactory resolution of these conflicts, feelings of guilt and inferiority are prone to develop.

Abuse thwarts initiative and overwhelms an individual's competence. Nothing the victim was able to do warded off the disaster. In reviewing and judging their own conduct, survivors tend to feel guilt and inferiority. Amazingly it is the victims that feel the guilt, not the perpetrators (Herman, l997). Janoff-Bulman understands guilt as an attempt to draw some useful lesson from the event and regain a sense of power and control. It may be easier to imagine that one could have done better than to face the reality of hopelessness (Janoff-Bulman, cited in Herman, l997).

4. "Industry versus Inferiority

(School Age: Six Years to Puberty)"

Making things and entering the world of knowledge and work are the tasks of middle childhood. Children at this age generally strive to do things well and gain recognition and praise for accomplishments. When they experience failure, they develop a sense of inferiority and worthlessness.

Some effects of trauma can be hidden at this stage if the child is able to hold onto the desire to do well and therefore develops her own internal and external positive influences. These become resiliencies as they develop what the person has been given genetically (intelligence, character qualities such as determination, humor, resourcefulness) and from others who give positive influences. Often there are "cookie" people (Murray, l999) who supply some care along the way that helps a person to "get by" until they can do their healing work. Flannery has found that supportive people may lessen the impact of trauma, whereas hostile or negative people can increase the damage of traumatic events (Flannery, l990, p. 593-611).

Unfortunately "individual personality characteristics count for little in the face of overwhelming events" (Green, Grace, & Lindy, l990, p. 729-33). Laufer, Brett & Gallops have found a simple, direct relationship between the severity of the trauma and its psychological impact (Laufer, Brett, & Gallops, cited in Herman, l997, p. 57). With severe abuse, no person is immune.

5. "Identity versus Identity Confusion (Adolescence)"

The child has been in the process of developing her identity in all the previous stages. The need to solidify that identity becomes crucial, though, in this stage, adolescents. Young people are often determined to find out who they are apart from their parents. Often the adolescent's body feels unfamiliar as they go through rapid physiological changes. It can be a very confusing time in the midst of trying to develop a clear sense of self. Childhood or ongoing sexual abuse can add greatly to the confusion.

6. "Intimacy and Solidarity versus Isolation (Young Adulthood)"

Young adults who make it through stage 5 reasonably healthy anticipate forming intimate relationships. They are secure in their own identity and not overwhelmingly threatened by others.

Traumatic events impact an individual's sense of connection between herself and the community at large, a necessary ingredient to establishing a belief in the meaningfulness of the world. This is likely to create a crisis of faith. The question that remains is how can a God let things like this happen to little children? (Lifton, cited in Norman, l989, p. 24).

A survivor's faith and sense of community is especially damaged when the abuse involves the betrayal of important relationships (Herman, l997). The moments of betrayal, the breach of trust, bring long after its original occurrence, "intrusive images of intense emotional power" (Herman, p. 55). Kardiner & Spiegel found patients in these situations "horrified at the

realization that [they were] expendable to [their] own people" (Kardiner & Spiegel, 1947, p. 129).

Traumatic events also create oscillations in the regulation of intimacy that can greatly affect the developmental stages. Abuse impels people both to withdraw from close relationships and to seek them desperately. Withdrawal is fostered by the profound disruption of basic trust, the feelings of shame, guilt, and inferiority that are common to all, and the huge need to avoid reminders of the trauma that are triggered in community. The terror of the event and the massive loneliness that occurs because of it, intensifies the need for protective attachments. Alternating between isolation and anxious clinging are common occurrences for an AFSCSA. It is not uncommon for her to form intense, unstable relationships that fluctuate between extremes (Herman, l997). Often, survivors try to medicate their pain by activities that end up being addictive in stage 5 and 6.

Survivors find connection with others and a community most helpful when there are others who are willing to acknowledge that what happened to them was true, that it was a traumatic event, and bear witness to the event. Also helpful is when others suspend preconceived judgments and help them mourn their losses (Herman, l997, p.68-69). Mourning and reconstruction of the event is recognized as a necessary part in resolving traumatic life events. Lifton writes "unresolved or incomplete mourning results in stasis and entrapment in the traumatic process" (Lifton, l980, p.124). Often mourning entails grieving over what was never had.

7. "Generativity versus Stagnation and Self-Absorption
   (Middle Age)"

Common to traumatized people, and an issue that becomes very apparent during the years with rearing a family, is the difficulty in modulating

intense anger. It shows with survivors tending to "oscillate between uncontrolled expressions of rage and intolerance of aggression in any form" (Herman, l997, p. 56). On one hand, there is compassion and protection toward others with an intolerance toward even a thought of hurting anyone; on the other hand, there tends to be an explosive anger and irritability towards family. This inconsistency is a very real source of torment and, for some, will move them into therapy to deal with it.

This is also a common time when the defense mechanisms break down as repressed traumatic memories try to surface (Murray, l999). When this happens, it is hard to be anything else but self-absorbed. It is challenging to parent effectively even when trauma doesn't exist in the past. For the AFSCSA, life is lived out at survival level. It continues until the survivor "is able to get long-term and effective help to work through the severe damage done to her person" (Langberg, l997, p. 53).

8. "Integrity versus Despair (Late Adulthood)"

A sense of completeness and the feeling that a worthwhile life has been lived is the final stage when a person has had the the privilege of progressing through life with reasonably healthy relationships. "If not, the person is left with despair--regret, fear, and self-loathing" (Langberg, l997, p. 53).

To conclude the listing of losses an abused child must deal with, the researcher wishes to record a quote from Trauma and Recovery (Herman, l997).

> In this climate of profoundly disrupted relationships the child faces a formidable developmental task. She must find a way to form primary attachments to caretakers who are either dangerous or, from her perspective, negligent. She must find a way to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe. She must develop a sense of self in relation to others who are helpless, uncaring, or cruel. She must develop a capacity for bodily self-regulation in as environment in which her body is at the disposal of others' needs, as well as a capacity for self-soothing in an environment without solace. She must develop the capacity for initiative in an

> environment which demands that she bring her will into complete conformity with that of her abuser. And ultimately, she must develop a capacity for intimacy out of an environment where all intimate relationships are corrupt, and an identity out of an environment which defines her as a whore and a slave (Herman, l997, p.101).

This is what the AFSCSA carries with her into adulthood. It is a pitiful inheritance that ill prepares her for life.

Embracing the Emotions

The second step of grief and loss work in treatment of AFSCSA is to embrace the emotions that come from naming the reality of the abuse.

In order to preserve hope and meaning in her life and her primary attachment to her parents, the child victim has had to blame herself as innately bad to justify her parents. She has lost herself in this and in the fact that to do this, she must keep the truth from others and especially herself. "The means she has at her disposal are frank denial, voluntary suppression of thoughts, and a legion of dissociative reactions" (Herman, l997, p. 102). This is the development of elaborate dissociative states and the development of a fragmented identity.

Even though her mind has banished it, the body continues to register the effects of the abuse. Normal body processes are disrupted, seen in altered cycles of sleep and wakefulness, feeding, and elimination (Herman, l997. p. 109). There can be a variety of physical symptoms characteristic of sexual abuse as well (Murray, l985, p. 79-81).

"Normal regulation of emotional states are...disrupted by traumatic experiences that repeatedly evoke terror, rage, and grief." (Herman, l997, p. 108). Often dysphoria takes over, a state of confusion, agitation, emptiness, and utter aloneness.

Emotional states of abused children range from a "baseline of unease, through intermediate states of anxiety and dysphoria, to extremes of panic, fury, and despair" (Browne & Finkelhor, l986, p. 66-67). It is not surprising that often these children grow into adulthood with chronic anxiety and depression.

The AFSCSA has learned patterns to soothe herself that have been destructive. Perceived threats of abandonment and unspeakable pain cannot be

comforted by normal means of self-soothing. Abused children may discover that a major jolt or injury to the body somehow produces the soothing they are so desperate to obtain. The connection between childhood abuse, especially abuse beginning in early childhood, and self-mutilation behavior is well documented (van der Kolk, Perry, & Herman, l991, p.l665-71).

Dissociation precedes the act. Depersonalization, derealization, and anesthesia accompany unbearable agitation and a compulsion to attack the body. Initially it produces no pain. "The mutilation continues until it produces a powerful feeling of calm and relief; physical pain is much preferable to the emotional pain that it replaces" (Herman, l997, p.l09).

The purpose of self-injury is to soothe not to manipulate or to communicate distress or as a suicidal gesture. Many AFSCSA do attempt suicide (van der Kolk et al, l991) but there is a distinct difference. Many survivors see self-injury as a means of self-preservation.

Therefore, in order to survive, the child will likely develop three forms of adaptation--the elaboration of dissociative defenses, the development of a fragmented identity, and the pathological regulation of emotional states (Herman, l997, p. 110). In order to embrace the emotions that come from naming the reality of the traumatic event, these must change gradually.

As the survivor tells the story in detail and depth, it slowly begins to be transformed from the separately stored traumatic memory to an integration of mind, body, and emotions. The initial telling may be repetitious, stereotyped, and emotionless. It may be wordless and come out only in images. It takes a safe relationship, often a therapist, who is an ally and witness who can "negotiate a safe passage" between the present and the past (Herman, l997). Pacing and timing must be carefully attended to so that the uncovering work remains emotionally bearable.

The reconstruction of the traumatic story begins by reviewing the survivor's life before the trauma and the events that led up to it. The next step is to reconstruct the abusive event and recite it as a fact. This starts to unfreeze the imagery and emotion. It is an organized, detailed, verbal account, oriented in time and historical context (Herman, l997, p. 177). It includes the survivor's response and the responses of the other important people in her life. Often, it becomes difficult to use words and drawing or painting become more helpful expressions. The indelible images and bodily sensations may come out wordless but come out they must and eventually, into words.

The reconstruction of the trauma must include what the AFSCSA felt. Breuer and Freud wrote "recollection without affect almost invariably produces no result" (Breuer & Freud, l955, p. 6). This description of facts must include the description of emotional states. It is very difficult because this is not just a retelling of the feelings but the reliving of them. The therapist helps the client feel anchored in the present, venture into the past, and reexperience the intensity of feelings "while holding on to the sense of safe connection that was destroyed in the traumatic moment" (Rozynko & Dondersine, cited in Herman, l997, p. 178).

According to Herman (l997), the validating role of the therapist is of utmost importance. Her job is to normalize the survivor's responses, help in naming and the use of language, and share the emotional burden of the abuse. The more the client can talk about the abuse, the more confidence she has that it happened, and the more she can integrate it. Frequent reassurance from the therapist is very important to create the space to allow this to happen.

Sometimes, to resolve doubts and conflicting feelings, an AFSCSA might try to reach closure on the facts of the story before enough of them have been

discovered and recounted. She may insist on validation from the therapist on a partial or incomplete version or she may push pursuit of more memories before dealing with the emotional impact of facts already known. The goal of recounting facts and emotions and bodily sensations is to find the truth and integrate it in order to find wholeness and healing (Langberg, l997; Herman, l997). This becomes the guiding principle. Studies by Keane and Boudeyns, Hyer, & Woods show that the "action of telling a story" within the safety of a protective relationship can produce changes in the abnormal processing of traumatic memories (Keane & Boudeyns, Hyer, & Woods, cited in Herman, l997). There is great restorative power in truth-telling.

Piecing together the trauma story may be a long complicated project for AFSCSA that have endured long-term abuse. Many times patients look for powerful treatment programs to hasten the process. Herman discourages the "blitz" approach saying, "Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered" (Herman, l997, p.l84). Breaking through the amnesia is not as hard as coming face-to-face with the horrors of the memories and integrating the experiences into a life so that it is whole.

In order for feelings to be embraced, past experiences have to be remembered. The simplest technique for recovery of memories is to explore carefully what memories the AFSCSA already has. Many times this is sufficient. For clues of dissociated past memories, the client's present, daily life is usually rich, flashbacks or nightmares, observance of holidays and special occasions, emotional over-responses to daily occurrences. Most of the time this is all that is necessary (Herman, l997).

Sometimes major amnesiac gaps in the story warrant judicious use of powerful techniques such as hypnotherapy. A high degree of skill is required to resolve traumatic memories through hypnosis (Brown and Fromm, l986). Moore described her hypnotic technique in where she uses age regression techniques like holding a rope or ribbon that goes to the past. Another technique is imagining that one is watching a portable TV. There is a safe channel and the working channel is a VCR channel. Moore describes the work as "intense... but the idea is to keep it bearable....There are those moments of having to reassure yourself that this really is helpful. But people do feel better after they've retrieved the memory" (Moore, cited in Herman, l997, p. 186). Murray uses the age regression technique of being on an elevator that goes down through time (Murray, l997).

Besides hypnosis, there are many other techniques that can be used to recover dissociated traumatic memories by altering the state of consciousness. In skilled hands, these methods, like intensive group therapy, psychodrama, or sodium amytal, can be very effective. The same rules must guide each one: the patient has the locus of control and the timing, pacing, and design of the sessions are planned so that uncovered work has time to be integrated and dealt with therapeutically (Herman, l997, p. 187).

Plunging into profound grief is the inevitable response to telling the story. The mourning is what survivors fear most and yet it is the most necessary part of recovery (Herman, l997). The fear is that the grief is insurmountable and never ending.

Often survivors resist mourning also because they refuse to give victory to the perpetrator. The wise therapist will then reframe mourning as an act of courage since it is seen as one of humiliation. An AFSCSA cuts off a part of herself and robs herself of an important part of healing when she is unable to

grieve. "Reclaiming the ability to feel the full range of emotions, including grief, must be understood as an act of resistance rather than submission to the perpetrator's intent. Only through mourning everything that she has lost can the patient discover her indestructible inner life" (Herman, l997, p. l88).

Because mourning is so difficult, there is often resistance to it. The resistance can take many disguises such as "fantasies of magical resolution through revenge, forgiveness, or compensation" (Herman, l999, p.189).

In the fantasy for revenge, the roles of perpetrator and victim are reversed in a mirror image of the traumatic memory. The hope the victim has is that she can rid herself of the pain, terror, and shame of the abuse by retaliating against the perpetrator. The victim may think that the only way she can destroy her helplessness and regain her power is to take revenge. She hopes to force her perpetrator to acknowledge the harm he has done to her.

Repetitive fantasies of revenge, though, do not bring the relief imagined. They increase the victim's torment by causing her to focus on images that arouse, frighten and intrude in ways similar to the original abuse. They degrade her self image and increase her feelings of horror. Eventually she finds that no amount of revenge can ever change or compensate for the harm done and by concentrating on fantasies of revenge only increase her post-traumatic symptoms (Laufer, Brett, & Gallops, l985, p. 1304-11).

Eventually, the AFSCSA needs to realize it is impossible to get even. Righteous indignation replaces the fantasy for revenge. It is more powerful and satisfying and "begins the process of joining with others to hold the perpetrator accountable for his crimes" (Herman, l999, p.189).

Another disguise for bypassing the work of mourning could be a fantasy of forgiveness. This too, like the fantasy for revenge, is an attempt for

empowerment. The AFSCSA attempts to "transcend her rage and erase the impact of the trauma through a willed, defiant act of love. But it is not possible to exorcise the trauma, through either hatred or love....True forgiveness cannot be granted until the perpetrator has sought and earned it through confession, repentance, and restitution." (Herman, l997, p.189).
This confession, true repentance and restitution, unfortunately rarely comes (Herman, l997).

Heitritter and Vought (l989) believe that the survivors can experience and benefit from forgiveness regardless of what the perpetrator does. Nouwen (l992) says genuine forgiveness is only made possible by the knowledge that people cannot love in the way humans need...unconditionally. Therefore human love always wounds. It is always tainted by needs and unfulfilled desires, by an inability to fulfill deep and often unconscious desires for complete communion. Many perpetrators and victims alike, are caught in this tragedy as they yearn for what only God can give. Thus when we experience being loved unconditionally by God and receive complete communion with God, we can forgive. "Forgiveness is the name of love practiced among people who love poorly. We do not even know what we are doing when we hurt others. We need to forgive and be forgiven every day, every hour - unceasingly... [This in no way is to minimize what the perpetrator has done.] It has everything to do with the abundance of love that has been freely given to [us} and from which [we] freely want to give (Nouwen, l992).

Besides the fantasies of revenge and forgiveness, another attempt to bypass mourning that impedes it is the fantasy of compensation. It is legitimate to desire compensation in the form of acknowledgment of harm, an apology, or public humiliation of the perpetrator but the struggle for it ties the survivor to the perpetrator and holds her hostage to his willingness to

acknowledge his wrongdoing. The survivor tends to find more freedom from giving up hope of ever getting any compensation from him. No amount of compensation makes up for what was lost and prolonged, fruitless struggles to secure compensation can be a defense against facing that reality in its entirety. Only mourning gives due honor to the loss.

As the survivor grieves, she often comes to envision a more social, general, and abstract process of restitution. She might develop a survivor mission which fights the system that allows abuse to prevail or advocates for others caught in it. This allows her to pursue her just claims without ceding any power over to her perpetrator.

Some variants in the fantasy for compensation is when the survivor demands compensation from someone other than the perpetrator or on society. It could appear entirely economic compensation, such as a claim for disability, but it invariably holds psychological components.

Another variant of the compensation fantasy is when the AFSCSA focuses on being compensated by her therapist. She may believe that "only the boundless love of the therapist, or some other magical personage, can undo the damage from the trauma" (Herman, l997, p.191). The therapist's responsibility is to faithfully bear witness to the client's story and encourage her empowerment. The beginning of empowerment is to accept that the injustice happened. The beginning of taking control in her life is taking the responsibility for her own recovery and discovering her undestroyed strengths by using them to the fullest. That doesn't happen if the therapist infantilizes her or grants her special favors of caretaking.

The last aspect of embracing the emotions that come from childhood sexual abuse is that AFSCSA often have to face grieving for what they never had, the foundation of basic trust, the belief in a good parent. Shengold

writes, "Without the inner picture of caring parents, how can one survive?...Is there life without father and mother?" (Shengold, l989, p. 315). This brings with it a desperate despair where often people wish to reject a world where such horrors exist. It is common for AFSCSA to believe that they are already among the dead because never having this foundation in trust and parents, they never gained a capacity to love. "What sustains the patient through this descent into despair is the smallest evidence of an ability to form loving connections" (Herman, l997, p. 194).

Clues to loving connections and the undestroyed capacity to love may be found in any remote image of attachment found somewhere in the survivors life. During the descent of mourning, one positive memory of a caring, comforting person may make all the difference. Even a distant feeling of compassion for children or animals can begin to give a ray of hope to the survivor that all of her capacity to love has not been destroyed.

Naming what was lost and embracing the feelings obviously comes together as the survivor is able to join the fragmented parts of her memory. The descent into the mourning may feel like it will never end. Unfortunately, it cannot be bypassed or hurried. It will come to an end, though, where intensity of feelings lessen little by little and grieving moves out of the center of the survivor's life. The traumatic experiences move to being a part of the survivor's life, not her whole life. She begins to be able to pay attention to an ordinary life. She need not worry about forgetting what happened, though. "She will think of the trauma every day as long as she lives. She will grieve every day. But the time comes when the trauma no longer commands the central place in her life" (Herman, l997, p. l95). Her life will still be interrupted often with related conflicts and challenges but with the work she has done, she will find them interrupting less and less (Wolfelt, l992). She has

reclaimed her history by uniting the fragments of her life. The work with the therapeutic relationship and community renews her hope and energy for engagement with life. She is now ready to build a new identity and meaning of life, complete with aspirations for the future.

New Identity with the Loss

The next challenge in the steps to grieving that is really intermingled along the way is to face two questions, "Given the reality of the loss, how do I make life work?" and "What new identity can I find to replace the old identity established by the loss?" (Wolfelt, l992).

The first question of how to make life work now, given the loss, can be answered in three relationships, intimacy with self, others, and God. Life for the AFSCSA first will work as she continues to develop intimacy with herself through awareness of her thoughts, feelings, concerns, and desires (Guerney, et al., l998)

The survivor's life will work as she strives for healthy relationships where she can be intimate with others, both with individuals and with groups. Harriet Lerner (l989) defines intimacy as being who we are in a relationship, and allowing others to do the same.

> 'Being who we are' means that we can talk about things that are important to us, that we take a clear position on where we stand on important emotional issues, and that we clarify the limits of what is acceptable and tolerable to us in a relationship. 'Allowing the other person to do the same' means that we can stay emotionally connected to the party who thinks, feels, and believes differently, without needing to change, convince, or fix the other (Lerner, l989 p.3).

The object is to navigate separateness ("I") and connectedness ("we") so that there is a more defined whole and separate "I." This is the foundation for a more intimate and gratifying "we." The change is neither easy nor comfortable but an aspect of what makes life work for the healing AFSCSA.

Another aspect of what makes life work with others is connection with a group of people. Herman writes, "Traumatic events destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection to others. The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity" (Herman, l997, p.214).

Heitritter & Vought (l989), like others (Donaldson & Green, l994; Edmunds, Personal Communication, 9/99; Earle, Personal Communication, 9/99; Murray, Personal Communication, 8/99),
believe in the recovery benefit of groups. Together they created and implemented the BECOMERS program, a nine week group process designed to promote emotional and spiritual healing from the experience of childhood sexual abuse. When first implemented in l984, it was such a success that they had many requests to start groups in other cities.

What doesn't make life with others work is depending on others for what only the survivor and God can do for her. A relationship with a Higher Power and how that makes life work is what 12-Step programs base their effectiveness on (Recovery Publications, l989). The BECOMERS program has the following two spiritual objectives:

1. To provide a group support system which models healthy interpersonal relationships that can then provide a pattern to enhance the group member's experience of becoming whole in Christ.

2. To encourage group members to actively participate with God in the healing of their damaged emotions" (Heitritter & Vought, l989, p. 120).

Murray speaks about Christianity and healing connecting when one is being and doing what is respectful and loving with oneself, others, and God (Murray, l999).

Dr. Ralph Earle, a former president of the American Association for Marriage & Family Therapy, has done much work of encouraging therapists to incorporate spirituality as a valid resource for healing in a client's life (Earle, Personal Communication, 9/99).

Olson and Langberg both are very sensitive to acknowledge their awareness that as they sit with clients, they do so as "God with skin on" sharing the compassion of Christ (Olson, Personal Communication, 6/99; Langberg, l997).

Smith, in his TheoPhostic Counseling, finds that when clients are able to return to original memories, experience the feelings around the original wound and look to God's healing presence with them in that wounding, that God speaks healing through words or images that free the survivor from the wounding messages and emotions.

Life with others works when AFSCSA look to God to meet their needs for closeness, nurturing, and emotional healing and then watch to see how God uses others to be his physical servants (Nouwen, l996). When a survivor goes with these needs to others to be met, she always leaves empty and disappointed (Olson, Personal Communication, 10/99). Sitting quietly with God in a meditative or other form with these needs, a survivor can begin to experience God's loving presence and the answers that come in their relationship from within (Bridges, cited by Olson, Personal Communication, 8/99).

Often there has to be healing between a survivor and God. She often has

felt isolated from and abandoned by God. She may feel that God did not protect her. It can be very healing to her to awaken to the idea that truly God was with her in her trauma, that God allowed her perpetrator choice as God does all people, and that God stood with her, often weeping and holding her through the whole event and since. Frequently it becomes comforting to realize that God has orchestrated her healing (Murray, l997).

The second question, "What new identity can I find to replace the old established by the loss?" involves looking at the messages emitted from the traumatic memories and healing enough to be able to recognize the lie in them (Heitritter & Vought, l989; Smith, l997). Once the lie is seen, the survivor has to begin the process of discovering the truth and building it into her life. Knowing the truth of who she now is must be trained into her behavior and thought patterns so that her behavior is consistent with what she thinks and feels (Edmunds, Personal Communication, 1/99).

There are many messages that AFSCSA's receive in their childhood, as a result of sexual abuse and deprivation, that have an effect on their adult life. They are primarily transmitted through relationships with others. These messages have a powerful and devastating influence on their concept of being loved, being valuable, and belonging. The following are examples of some typical messages that give old identities. The challenge in recovery is to identify the truth and establish a new identity from it. It is common for therapists, both secular and those counseling from a Christian perspective, to use a Cognitive-Behavioral approach to find more rational responses to negative messages (Vought, Personal Communication, 1/00; Smith, Personal Communication, 12/99; Olson, Personal Communication, 9/99). The researcher has chosen to show a typical Cognitive case study, complete with a problem list and a grouping of negative messages in categories related to the life of an

AFSCSA. After each section of negative messages, the researcher will give some possible new messages and identities that bring healing to the AFSCSA that clients can adapt into their lives which will help them establish a new identity (Heitritter & Vought, l989; Murray, l999).

Cognitive Approach with an AFSCSA

The researcher has chosen to present this case by starting with the format of "The Case Formulation" (Persons, l989, p. 52).

After the researcher has made the problem list, she will return to the list to add a section on disputing the irrational thoughts. In this section she will identify cognitive distortions, add some rational responses and use other appropriate cognitive and behavioral techniques to challenge dysfunctional thoughts (Burns, l980; Rockwood, l999). Although the problem list is fairly complete, due to the length of the project, only the first three problems are taken through to completion.

Case Formulation

Identifying information: 45 year old female, mother of 5 children - ages 5-21, married for 24 years, taught children at home until 2 years ago, both parents living, divorced when she was 11, both remarried when she was 16, she's been in therapy for 3 years, also in couples therapy for 1 & 1/2 years.

Chief complaint: Continued depression and emotional pain from the childhood incest and deprivation.

Problem list:

1. Compulsive overeating for comfort

Automatic thoughts, Negative, Old Messages: "This is the only way I can get comfort. I have to do this; I can't stop. Once I start, I might as well keep going. It's not fair. Others can eat anything they want and it doesn't make them sick or fat. Nobody's gonna tell me what to do, even my wise self.

I'm entitled to eating whatever I want. I've been deprived all my life of what I really want and I'm not going to deprive myself of what I want any more! I'm fat and ugly, I can't control my eating, I am helpless and hopeless, I am ashamed of myself, I am bad, I want to die, I deserve to die."

Antecedents: Upsetting situations, situations with husband or children that make her angry, remembering the abuse or deprivation, getting angry about the food limitations (allergies and hypoglycemia), getting home for dinner and not having anything that she can eat prepared.

Consequences: Allergic reactions (immediate headaches and cold symptoms, eye twitches, eye strain, sore throat, coughing, leg cramps, stomach ache, digestion problems), Hypoglycemia (strong craving for sweets, irritability, little tolerance with children, explosive anger, excessive need to exercise, hopelessness), negative automatic thoughts.

Disputing Irrational Thoughts:

a. Cognitive Distortions: All-or-Nothing Thinking, Jumping to Conclusions, Magnification, Emotional Reasoning, Mislabeling, Personalization, Mental Filter, Catastrophizing.

b. Rational Responses, New Identities: "The comfort is only for a moment and then it brings pain. I don't have to let other things control me. I can sit quietly with God and soothing music and have more long-lasting comfort. I can face anger directly, I don't have to deal with it indirectly with food. I don't have to self-injure with food to be comforted. I can choose to stop eating what harms me. The wise adult that I am becoming can balance my needs and desire for food and not let situations in my life be out of my control.

"Kids said I was fat and ugly when I was a child. Today, adults give me opposite feedback. I am 'good enough' in the area of weight and beauty.

Cutting out everything that I am allergic to doesn't work (I binge), therefore I can have a little of what others are having and that I want."

Cognitive Interventions: Empty Chair, Reframing, Challenging Absolutes - Challenging the all-or-nothing thinking, Understanding Idiosyncratic Meaning, Daily Record of Automatic Thoughts - combine with eating record and what's going on around the eating.

Connection to abuse: The abuse was pleasurable and painful and couldn't be stopped; the same with the compulsive overeating. Every time she eats things that bring both pleasure and then pain, she triggers the connection to the abuse (Smith, l997). When issues are too painful, she self-injures with food. It is easier to feel the physical pain than the emotional pain (Herman, l997).

2. Depression

Automatic thoughts, Negative, Old Messages: "I can't fight all these thoughts and feelings. They overwhelm me. I'm just a helpless, hopeless little girl. These thoughts and feelings are too big for me. I'm making more of my problems than is really there. I've got to try harder to make things work; I'm not trying hard enough. It will work if I do it perfectly."

Antecedents: Dysfunctional, abusive, neglectful childhood that left long-term effects upon personal and present family life and interaction.

Consequences: Suppression of anger, turning it inward; Body tending to express anger and grief through physical illness. Isolation and suicidal ideation.

Disputing of Irrational thoughts:

a. Cognitive Distortions: Minimizing and Maximizing, Catastrophizing, All-or-Nothing Thinking, Perfectionism.

b. Rational Responses, New Identities: "I can, I am, and I will do something about these feelings by looking at the thoughts and telling myself more rational responses. I can and will continue to look at the distortions in the thoughts and think more helpful thoughts. When my thoughts are less distorted and more rational and include God's thoughts about me, I feel better. I am no longer a little girl. There are many things I can do and think to improve my life and feelings."

Cognitive Interventions: Daily Record of Thoughts, Labeling and Challenging Distortions, Challenging Dichotomous Reasoning, Scheduling Worries, Refocusing, Graded Task Assignment, Activity Scheduling, Acting "As If," Understanding Idiosyncratic Meanings, Guided Discovery, Challenging Absolutes, Reframing, Externalizing the Voice, etc.

3. Phobias: Nighttime

Automatic thoughts, Negative, Old Messages: "Someone will hurt me in the dark. God didn't protect me before, maybe God won't protect me again. It's a matter of time before someone attacks me in the night. When the someone attacks me, it will be a sexual attack. I'm terrified. I have to hold my breath so that person won't know I'm here. Someone will hurt me while I sleep. I feel safe when my husband is there but not when he is not. Someone will hurt me when he is not there. Someone will come up from behind and startle me and hurt me."

Antecedents: Father/Daughter incest in the night. Hypervigilence makes her constantly aware of her safety. She works overtime with thoughts of unsafety whenever she is alone at night. This includes traveling alone or when her husband is away from home.

Consequences: It increases her stress because she has to make very sure she is going to be safe. She will do things that take her out at night or keep

me home at night without her husband but she is very careful (which is not a bad idea).

Disputing Irrational Thoughts:

a. Cognitive Distortions: Overgeneralization, Personalizing, Fortune Telling, Mind Reading, Jumping to Conclusions

b. Rational Responses, New Identities: "Someone did hurt me in the night but it's not happening now. There are many things I can do to protect myself. I am an adult now. I am a wise woman who knows how to be careful so as not to leave myself open for attack. No one has sexually abused me as an adult."

Cognitive Interventions:

a. Distancing: "I can help myself separate from what happened in the past as a child (and it was a long time ago) and what has happened as an adult. I can also see that my fear that it will happen again, that it's only a matter of time, is an hypothesis, not a fact."

b. Guided Discovery: "If it happened again, what would be the worst that could happen? If that happened, what would be the worst that could happen, etc.? I think the worst that could happen is that I could be killed and that would have awful implications for my family. The next worse thing is that I could survive, but I already know how to survive a sexual trauma and I know I could make it through. I think it would be very scary, though!"

4. Anxiety

Automatic thoughts: "I have to figure everything out way in advance to be in control. I can't handle being out of control. I can't trust God to be in control. He didn't protect me before."

5. Marital and family conflicts

Automatic thoughts, Negative, Old Messages: "My husband treats our children like my dad treated us. I have to watch him carefully that he doesn't

abuse our kids. When my husband gets angry at the kids, I automatically become a kid back in my family of origin. I move into a protector and fear mode. I flashback and often dissociate.

"When my husband approaches me sexually, I automatically think he has the same motivation of taking from me as my dad did. If he does anything nice to me, I jump to conclusions about what he wants - sex. I have to be in control of the sexual area of our relationship."

6. Long-term effects of childhood sexual abuse and deprivation

Automatic Thoughts; Negative, Old Messages: "I am only good for sex. I'm not worth staying for. My needs don't count. My worth is to take care of other's needs. I'm bad. I'm ugly. The only way I can get my needs met for caring and attention is to be really sick, mentally and/or physically - maybe even hospitalized. I fear that disaster is about to strike at any time. I fear that I will lose control of my mind and behavior. I fear that I can't balance my life and so my hurting inner child will continue to control me. I'm damaged, defective. I can make people love me if I do everything right."

7. Financial difficulties:

Automatic Thoughts; Negative, Old Messages: "I'm not going to deprive the kids and myself anymore. I hate being so deprived of what I want. I can't separate my childhood deprivation from my children's financial deprivation."

8. Social isolation, difficulties feeling connected with people

Automatic thoughts; Negative, Old Messages: "People don't see me as valuable. People don't see me. People have not seen who I really am and known the truth about my pain in my childhood. I have to make people see and hear me. I have to keep secrets, especially from my mother. People don't like me. I talk too much. I'm too deep. People don't want to hear over and over my inner pain. They just wish I'd go away. I yearn to be close to people. I'll never be

able to get my needs for closeness met. I can't even get as close to God as I want and need. I do 'closeness with God' bad. I'm so lonely. I bother people with my needs and wants for closeness. I am a bother to people. They don't want me. I have more of a need for closeness than they do. I'm fine initially but I engulf. Eventually I become a bother and they reject me. I'm ashamed of myself. I need constant support of others. I will only be all right if I can talk out my inner thoughts with someone else who cares. Whenever I get close to someone, something happens and we get separated. I won't be able to get the supporting network I need. I rarely belong. If I get close, I'll get hurt."

9. Relationship with parents

Automatic Thoughts; Negative, Old Thoughts: "The only relationship that will be satisfying will be one that is in the same spirit as what I had with my dad. The relationship with my dad was so satisfying. I can't be happy unless I have both that satisfying relationship with my dad and one that is similar."

10. Anger and rage

Automatic Thoughts; Negative, Old Thoughts: "I have to curse when things don't go the way I want them."

<u>Hypothesized mechanism:</u>

"Nobody cares about and loves the real me. I'm just there for them. I am not worth loving or valuable for myself."

Rational Response; New Identity: "Someone cares about and loves the real me. It is God and God is loving me through many people in my present life. There have been people all along who have loved and cared about me and seen me as valuable. There's a growing group of people, including peers, who love and care about me now and who see and value me for who I am. I am a lovable and capable person."

In summary, the third focus in grief work involves answering how the AFSCSA makes life work, given the reality of her loss, and looking for how to establish a new identity to replace the old one established by the loss. Life for the AFSCSA begins to work when she is able to nurture and develop her relationship with herself, others, and God. Establishing a new identity is a huge process since there are so many negative messages coming out of so many losses. The grief work is worth the major effort, though, for as Herman points out, "The reward of mourning is realized as the survivor sheds her evil, stigmatized identity and dares to hope for new relationships in which she no longer has anything to hide" (Herman, l997, p. 194).

New Meaning from the Loss

The last of the four tasks of grief and loss work that an AFSCSA needs to do to heal is to establish a new meaning of life given the reality of what was lost from the childhood sexual abuse. The survivor and important people in her life have to grapple as theologian, philosopher and jurist with questions like "Why?" and "Why me?" They are looking for the means to get rid of the pain or if they can't, to find meaning in it. As a child when the abuse happened, the AFSCSA might not have even developed her own values and beliefs which the trauma challenged. Finding that there is a different way to look at life is a challenge for her.

When examining the question "Why?", the survivor stands "mute before the the emptiness of evil, feeling the insufficiency of any known system of explanation. Survivors of atrocity of every age and every culture come to a point in their testimony where all questions are reduced to one, spoken more in bewilderment than in outrage: Why? The answer is beyond human understanding" (Herman, l997, p. 178).

As "Why me?" is examined, she has to give up her faith in a just or even predictable world order. She has to examine the questions of guilt and responsibility and develop a belief system that makes sense of her undeserved suffering. It becomes an exercise of both thought and action. She has to decide about what has to be done with the perpetrator and with the recurring pain in her own life.

She has to grapple with the question, "Has she done all she can do to heal? What about the left-over pain? Can she be free of it all? Is there meaning in the pain?

The suffering that is most painful is pain that seems meaningless. It is pain that is hard to find the meaning in. Barrett talks about families that don't know how to get their needs met so they find themselves meeting their needs in damaging ways. With this in mind, the AFSCSA could decide on three meanings behind their abuse.

1. My perpetrator was an evil, hateful person that poured out that hate on me because I was so bad and worthless.

2. My perpetrator was a weak person who didn't know how to meet his own needs. His intentions were not to say that I was bad or unlovable.

3. Bad as the abuse was, the relationship I had with the perpetrator was the most nurturing relationship I had at the time.

(Miller, Personal Communication, 1/2000).

Viktor Frankl, in his Search for Meaning (l963),says that the meaning people take from the abuse makes or breaks a true survivorship. The job of the therapeutic relationship is to be a safe container that allows the AFSCSA to tolerate these contradictory truths. In the case of incest, the truth might be "My father did terrible things and in some ways, my father was a good father to me." When truths such as these are held in the same container, the meaning

of the old story can be let go and a place for a more 3-dimensional story can be found.

Conclusion

In conclusion, the review of literature for this paper was divided into three major themes taken from literature relating to treating adult female survivors of childhood sexual abuse (AFSCSA) from a Christian perspective. The themes covered were as follows:

1. Healing is a stage process.
2. Healing requires relationship work in three areas.
   a. With self
   b. With others
   c. With God.
3. There are therapeutic interventions that facilitate healing for AFSCSA. Among these include:
   a. Therapeutic relationship
   b. Grief and loss work

Included in grief and loss work is some of what grief work entails: development work, core belief work, and spiritual development.

CHAPTER THREE

Methodology

Introduction

This chapter will describe how the research questions were developed, the description of the subjects and how the study sample was selected for the qualitative interviews that follow in Chapter Four. In addition, the instrument being used to collect information will be discussed. Data collection and analysis procedures will then be presented. The chapter will conclude with some of the methodological limitations.

Research Questions

The research questions (see Chapter One) for this study were developed from the literature review and from the writer's personal knowledge and experience.

Description of Subjects and Sample Selection

Based on literature they wrote and the writer's personal contact, the subjects were chosen for interviews as mental health professionals who counseled AFSCSA from a Christian perspective. Both The American Association of Christian Counselors and The American Association of Pastoral Counselors have a directory by which the researcher has access to phone numbers and addresses.

Instrumentation

The instrument is a questionnaire with mostly open-ended questions (see Appendix). There are a few closed questions, i.e., "Yes, No." The open-ended questions are designed in such a way as to avoid "yes" and "no" responses and to provide an opportunity for any answer to be given and to allow the expansion of answers.

Data Collection

The questionnaire will be given in a semi-structured, standardized open-ended interview in person, over the phone or if an interview is impossible, through the mail. The interviewer will establish rapport with the respondent by creating a nonthreatening atmosphere and by explaining clearly the purpose of the interview. The interview will have a protocol where there will be a written set of questions to be asked in a set order (Martella, Nelson, Marchand-Martella, l999). Two weeks prior to the appointed time for the interview, the interviewee will be sent a copy of the questionnaire in order that he or she can have the opportunity to think about the questions. The interview will be semistructured in an effort to elicit more information concerning the respondent's answer to earlier questions.

In order to glean the most from the interview and to avoid inhibiting or distracting the respondent by too much note taking, the interviewer will tape record the session as long as the respondent has given prior permission (Crowl, l993).

As part of the interview, the respondents will be asked to sign the consent form at the end of the questionnaire (see Appendix) indicating his or her willingness to disclose information about his/her treatment modality for AFSCSA and his/her willingness to have this material (taken from the interview) published.

Data Analysis

Because of the nature of this study, there will be no statistical analysis. However, since the research is qualitative, themes will be derived from data and supported by anecdotal information (Gillette, Personal Communication, 7/99).

Limitations

The following is a list of some of the limitations to the methodology used in this study:

1. Because there are several research questions, the interviewee may not have time to thoroughly discuss her/his theory and methods for treating AFSCSA.

2. Because the researcher is interviewing counselors, some of whom she is personally acquainted with, she may be biased in reporting information or a personal bias may affect the answers.

3. Because the interviewer may ask probing questions to elicit more information, she may not time herself adequately to cover all the set questions.

4. Because the questions are preset, the questions are not tailored to each specific interviewee or their approach. Therefore, information may be lost if the interviewer is not able to ask a specific question. Also, the naturalness that comes from tailoring the questions to the particular situation may be lost (Martella, Nelson & Marchand-Martella, l999).

5. Because the research is not quantitative, it will be not produce empirical results.

CHAPTER FOUR

Introduction

Chapter Four consists of interviews with five therapists who counsel AFSCSA from a Christian perspective. The interviews took place between August, l999 and January, 2000. Two interviews took place face-to-face and three interviews were by phone. The questions for the interview (see Appendix) included theory and methodologies for treating AFSCSA, borrowed and personally developed theories and methodologies, specifically Christian aspects to their theories and methodologies, the length of time that they have been treating AFSCSA with these theories and methodologies, and how they were able to evaluate the effectiveness of these theories and methodologies for treating AFSCSA.

Interview with Marilyn Murray

Theory for Treating AFSCSA, Scindo Syndrome

Ms. Murray is a mental health professional who counsels from a Christian perspective (Murray, Personal Communication, August 12-17, l999). She specializes in treating clients who have experienced trauma, abuse, and/or deprivation. She is part of the staff at Psychological Counseling Services in Scottsdale, Arizona. The information given in this interview was presented by Ms. Murray in a graduate level class at Ottawa University, Scottsdale, AZ, from August l2-16, l999, in which the researcher attended. The information gathering was completed in a personal interview on August 17, l999.

Murray's theory for treating AFSCSA comes out of her own experience as an abuse victim. When she was eight years old she was raped and left for dead

by a group of soldiers as she came home from school one night. She completely repressed this memory but her body spoke out the event through horrifying dreams, asthma and later, excruciating body pain.

At age 40, her pain was so great (with no medical reasons), friends intervened and got her into intensive therapy. That experience uncovered the repressed memories of the abuse. From that extensive experience, Murray was able to begin the healing journey. She says, "I needed a safe place to lance the wound and let the pain surface" (Murray, Personal Communication, August 12-17, l999). As her healing progressed, she discovered an understanding within about what happened in and after the trauma. She says that her theory was taught to her by that 8 year old within who went through the ordeal. She calls it Scindo Syndrome. "Scindo" is Latin for "split."

Her theory begins with an understanding of what happens when we experience a physical injury. When we are injured, almost immediately our body responds with a numbness which enables us to survive, to get us to where we can get help. This numbness or shock is only temporary and is meant to be temporary or we would never attend to the injury. It would be nice not to ever have the shock wear off but if that happened, people would never feel the pain and could die (i.e. leprosy) because there would be no motivation to attend to it. The pain helps us know that there's been harm done.

The same happens with an emotional injury. We experience what is meant to be a temporary numbness. It keeps people sane until they can get help. After the initial shock, people are supposed to talk the incident out and get the help they need. Culturally, though, stoicism is considered the optimum and so there is little modeling how to deal with negative emotions. There are many reasons why our minds decide the emotional injury can not be processed but the result is permanent emotional shock. Everyone experiences this to some degree

at some time in their life. Therefore, most of us live today in a state of some degree of chronic emotional shock. We can lose our ability to feel and become emotional lepers.

When we lose the ability to feel our pain, it begins to gather in a pool. Murray calls this pool of pain, the Sobbing Hurting Child (SHC). It's a split off the normal, healthy, carefree child that we are before the injury. Murray calls this the Original Feeling Child (OFC). The split is a common, ordinary, God-given, emotional shock defense mechanism that is designed to hold the pain separate from the person. Again, this is meant to be temporary.

When the SHC is not able to speak out her pain, another split in the person occurs in order to silence the SHC and enable the child to continue living. This second split creates the Controlling Child (CC). The CC must keep the SHC from revealing her pain because she feels that if the pain is revealed, her whole self will die. When the SHC is silenced, the OFC is also oppressed. The result is that the pool of pain continues to increase, the person the child was created to be is essentially dying, and the CC is using anesthetizers and diversions to avoid the pain and believed death. Even children as young as two are able to split to protect themselves. Of course, this is not a conscious decision but unconscious and there are different levels and degrees of burying pain and splitting.

Murray proposes that when one is able to help the CC back off a bit, the wound can be lanced and the pain allowed to leak out. The goal is to allow the SHC to leak out the pain and be comforted, to have the OFC have a chance to develop her dreams of who she longs to be and what she longs to do, and the CC to be in balance. When these three inner children are all having a chance to speak and then working together to form some place of peace and unity, there is healthy balance in the individual's life. No one inner child can be in

control and dominating the individual but neither can any of the children be silenced in order to be a healthy person. Murray calls the wise inner person who listens to all the sides and helps negotiate unity, peace, and balance, the Feeling Adult (FA).

A common occurrence once the SHC has had a chance to open up her wound and spill some of the contents is to want to consume the person with a constant need for attention. She knows only two places, totally smothered, in a box or in the survivor's face. It is important to assure the SHC that she will never go back into her box again. There is no way anyone can push her back in again.

Sometimes the SHC will want to be in the client's face, fearful and needy, at a time when it is inappropriate for the client to attend to her. The therapist can encourage the client to mentally assure her SHC that she cares about her and will take time to listen and attend to her at the next available time. It's good to designate that time (e.g., when I get home from work tonight). Sometimes it could be helpful to image carrying the little SHC in a "Snuggly" or front pack

Method of Treating AFSCSA

The Murray Method entails looking at root causes and present-day behaviors. She finds clients complaining about doing what they don't want to do and not doing what they want to do. She experiences people talking about how when they are in situations where it deserves a reaction of a 2 (on a scale of 1-10, where the minimum reaction would be a 1) but gets a 8-10. There is energy from past circumstances fueling the reaction. She believes this is an example of the past affecting the present.

Murray, at present, is in a clinic where she uses a team approach in an intensive outpatient setting. She sees clients 2 sessions daily (50 minutes

each) and then they are seen by several other therapists for an average of 6 hours of therapy a day plus homework. The recommended length of therapy is 3 weeks with some clients only able to do 2 weeks at one time and then later, the third week. Some stay longer than 3 weeks. If Murray is providing therapy alone, she does 4 consecutive sessions per day and lots of homework. The tiredness from the intensity tends to be a benefit by wearing down the defenses, making the CC back off a bit. The session after session, day after day prevents the buildup of the strength the defenses have when sessions are farther apart. Then clients can stay in a deeper psychological area and continue to work and don't have to surface to deal with ordinary day to day life where the CC can take back over.

Murray's method of treating AFSCSA, then, is to begin lancing the wound, listening to the SHC. This happens both in an individual session, group work, and in homework assignments.

Theory and Treatment from a Christian Perspective used by Murray

Murray believes that a healthy person attends to four areas of his/her life in an equally balanced way. These four areas are the intellect, the emotions, the physical, and the spirit. No one area is more important than the other. If one part is nurtured, all benefit. If one part is neglected, all suffer. From that perspective, all parts are nurtured by loving and respecting God, oneself, and others.

Murray views her work as having a wide-based psychology with a spiritually Christian perspective. Murray contends that the essence of the Bible and the Christian message is loving and respecting God, oneself, and others as exemplified by Jesus. (Actually, Murray believes this is the essence of any spiritual development whether or not someone follows a Christian

perspective.) Jesus was himself a prime example of a FA balancing his SHC, OFC, and CC. He surely expressed his SHC in the times of his grieving over how he was treated and the pain he experienced in his wounding. He did not let that deter who he was created to be and what he was created to do (OFC). His CC gave him the endurance to anticipate what he knew was coming yet to not turn away. He was so in touch with these parts of himself that he could truly understand all he came in contact with and is now so able to touch humanity with his love and compassion. Often in Murray's therapy sessions, if it is within their belief, she prays with clients. The presence of Jesus often becomes involved in the guided imagery in such a way that many clients experience love, comfort, and healing in some way. It is a powerful experience.

Borrowed Modalities for AFSCSA

Murray states that she draws on the treatment modalities of Dr. Patrick Carnes, Dr. Ralph Earle, and Dr. Greg Crow, who have all done extensive work on sexual addiction. These men all write from a Christian perspective

Murray uses secular treatment modalities where appropriate. Murray believes her method supplies the missing pieces other methods leave out. She says that other theories address certain pieces to the puzzle but the pieces are "turned over and jumbled" (Murray, Personal Communication, August 12-17, l999). The Scindo theory shows people the picture on the box, using the puzzle metaphor, so that they can find how to put the puzzle of their life together.

In that light, Murray finds behavior modification to help create healthy boundaries. Experiential therapies help in the expression of the SHC. Virginia Satir's work is helpful in releasing and developing the OFC. Therapies that deal with addictions often have to utilized first before any deeper work can be done. Group therapy, psychodrama, couples communication work, EMDR, and

psychiatry are among the many treatment modalities that Murray includes in her approach.

Effectiveness and Length of Treatment

Murray began her practice in l982 at the age of 45. She has been treating AFSCA for l7 years and is now 62. The effectiveness of her treatment is based on seeing the long-term positive effects of clients. She reports that she has file cabinets full of letters from clients expressing their progress and gratefulness.

Interview with Elaine K. Olson, M. A.

Ms. Olson is a mental health professional who counsels from a Christian philosophical standpoint. She treats a variety of clients of which is included AFSCSA. She is the director of Covenant Counseling Center in Eau Claire, WI. Ms. Olson was interviewed personally in September, l999.

Theory for Treating AFSCSA

Olson draws from two primary theories when she treats AFSCSA. She uses Judith Herman's theory in terms of perspective on the trauma. Herman's stages of recovery are a healing relationship, safety, remembrance and mourning, reconnection, and commonality (Herman, l992, p. vii-viii).

The other major theory is what she brings from her Christian perspective. This is the perspective that "when you start with the wound, you find God's presence. If you start with God, it's awfully hard to get to the wound. The belief is that there is no wound that Jesus cannot heal. The gift of the Christian story is about God's embrace in the midst of pain. It's this story that is used primarily, not the story of needing forgiveness. It's the story of the suffering Jesus that comes and sits with us. This is key (Olson, Personal Communication, 9/ /99)."

The other theories she uses are a variety of current secular theories. These include Bowen theory, especially from the perspective of self-differentiation, Behavioral Health in terms of learning skills for personal safety, assertiveness training, and cognitive thinking. She uses Object Relations Theory to teach her about developmental and attachment issues. It really informs her about narcissism and borderline personality. Olson appreciates Dr. James Masterson's explanation of some causes of narcissism and borderline personality from the lack of maturation of developmental stages in childhood.

Method of Treating AFSCSA

Olson's method of treating AFSCSA is clearly based on these theories. Her method is "trying to figure out how to create boundaried trust, and in that safety zone, to allow room for the wounded heart to really speak (Personal Communication, 9/99)."

Her technique includes the following concepts: It is really important to never push someone who has been pushed. It is very important to use language where the survivor is never used as the subject of the sentence, always as the object, e.g., saying "When my father abused me..." instead of "I was abused". When the survivor puts herself as the subject of the sentence, it becomes the label of who she is. It becomes her identity. It's really important to separate who she is and the action that happened to her. It becomes an intentional effort by Olson as she makes this one of her goals.

Many of Olson's methods and techniques are arrived at by use of intuition, a sense of what is needed, and experience. "I have a reading and a sense about things and so I enter in with an intervention and see what happens. The response to it teaches me where to go next." She really is quite eclectic. Her interventions could come from a wide variety of theories. "I

really let my intuitions talk to me. I wonder if the intuition is telling me about the behavior or the feeling as I focus on what I am picking up. Because people who work from an intuitive position have acute alarm systems that pick up any noise, it's important to sort through the noise and to figure out if I am reacting out of my stuff or theirs and where I should go with it." It takes practice and outside people to help her sort that out. She states that usually if she takes a story home at night, it is about her.

The key thing about method is to go "Slow." It doesn't fit into managed care but you don't hurry it, because there are a lot of layers you have to get through first. If she suspects things such as sexual abuse with a client, she will not push it. It needs to come out of the client.

Theory and Treatment from a Christian Perspective

Olson's Christian perspective grounds her. It has much more to do with an understanding about who she is and the theories out of which she works than it has to do about clients and their dogmas. This enables her to walk more freely along side her client's story. The story of walking with the wounded as Jesus did guides her. She does not make it a point to specifically speak this out but she lives it and grounds herself in it. How this gets spoken with the client is based on the client's story rather than hers. She tries to let the client lead the way rather pushing her perspective onto the client. Sometimes she will ask a client, "Where's God in this for you or what is Jesus telling you about this? Where's Jesus with you in this?" Even so, Olson will let this direction come from her clients.

This caution comes from her Christian understanding of the suffering Jesus. She uses very little of the Proverbs and ethical guidelines for living out of the Christian perspective in her practice. "That's not a part I use in the understanding of my faith. I use much more the stories of the Psalms where

it speaks of the disorientation of life and then how God helps the reorientation of life. This is instead of the kind of moralism a lot of Christian therapies work from. For me, it is not my understanding that Christianity is a set of moral agendas. Rather, my understanding of Christianity is that it is about a Jesus who loves the suffering."

If a client is interested in talking about moral issues, Olson would talk with them from his or her perspective. She would not come at them with a "heavy-duty moral agenda that says you've got to shape up your life or God won't love you. To use a moral hammer to force them to shape up their life won't change them."

Borrowed Christian Treatment Modalities for AFSCSA

Olson incorporates a lot of theories and therapies from other people. She doesn't think anything she uses as a therapist is unique to her. She recognizes that how she integrates these theories may be unique, though. The researcher wondered if Olson's use of unconditional love and the sitting with the wounded as Jesus did was unique to her but she said that it comes out of her reading of the Christian writers, especially the mystics, Douglas John Hall, and Lutheran theology. "It's probably my Lutheran background about a grace-filled God that dares to intervene." Walter Bergamann, who has influenced her extensively, has done many writings on the Old Testament. Of special interest to Olson is his work on the Psalms. The story of Covenant Counseling comes out of some of Bergamann's work which talks about the role of pastoral counseling as being the active presence of God's covenant. "God's covenant with us, especially embraced by the Psalms, is that we experience abundant life. Unfortunately there's inevitably a disorientation in life that happens. The Psalms speaks of a reorientation after we experience God's loving presence that leads us toward hope." Bergamann teaches that the Psalms are

filled with three main voices, a voice of grief, a voice of rage, and a voice of hope. The role of covenant is that God walks with us so we can grieve, rage, and find hope. The whole basis of Olson's counseling is based on this understanding. "You grieve, you rage, and you find hope."

Psalms are the voice of disorientation, Proverbs are the voice of orientation. Proverbs won't walk with you into the "valley of the shadow of death." They just don't go there, according to Olson.

Olson has not found many Christian modalities specifically for treating AFSCSA to be helpful. If there are some available, she is open to finding them. The ones she has been introduced to, she has not found helpful. Because she has found a few that were not helpful, she has developed her own prejudices. This has made her shy away from exploring other possibilities. She has found that many Christian therapies are based on "just love Jesus and life will be fine."

Borrowed Secular Treatment Modalities for AFSCSA

Olson said that there are too many techniques that she uses to elaborate on them in this short interview. Even so, guided imagery was one that was discussed.

Some clients really find imagery work helpful and desirable. She has not had any indepth training in guided imagery and so she enters it with caution. She wants to be clear in her own mind where she is going with it and if she is unclear, tends to back off. She believes guided imagery can be invasive and easily suggestive with clients and she is committed to be neither. It is not that she does not use it; she is just careful. With clients who move into imagery very quickly and deeply, she feels she does not have the experience to ride the "waves." She does not feel comfortable because she's not sure she can help a client "ride the waves" to the right place.

In order to meet some of the need for imagery work some clients have, she has found some interesting guided imagery material by Jan Hindman that focuses

on image work in a more contained way. Hindman, who has done a lot of work with children who have been abused, has created a workbook called Just Before Dawn. One of the key things she has children do is scrapbooks, especially about their experience of abuse. Olson has also found it effective with adults.

Effectiveness and Length of Treating AFSCSA

Olson has been treating AFSCSA ever since she has opened her door and put on her hat as a therapist. She graduated from the University of Northern Colorado in l989. "Some of the very first people who walked in my office were people who were sexually abused."

Olson is able to base her effectiveness by what her clients tell her. One woman leaving treatment looked at her and said, "I finally feel whole!" Olson says, "Treatment for sexual abuse is about finding wholeness and wholeness does not mean you cut parts of yourself off. It's about holding all of you together. Treatment is effective when people are able to say that they feel whole."

Olson doesn't think effectiveness of treatment necessarily means that she has to walk with the same person all the way through to get to that wholeness. Sometimes effectiveness of treatment is only being able to walk with people with their story for a short time and letting them know that they are okay. Neither does effectiveness mean work leading to l00% healing because this takes life-long action. As a therapist, she gets to walk with different people at different parts of their journey. Some people she gets to walk with longer. If it's only a short walk together, it doesn't mean it wasn't effective. And prayer for effectiveness is a major part of the walk together with a client. "Lord, bless these loaves and fish." That's what she says she has to offer,

"two little loaves and a little bit of fish" and she trusts God to use what she has to offer to help her clients.

Interview with Dr. Ed M.Smith, M.DIV, M.S., Ph.D. in MFT

Theory for Treating AFSCSA, TheoPhostic Counseling

Dr. Smith owns and operates Family Care Counseling Center in Campbellsville, Kentucky. Dr. Smith is a pastoral counselor with a masters in education/marriage and family counseling and doctorates in pastoral ministry and education in marriage and family counseling. Dr. Smith was interviewed by phone in December, l999.

Smith's theory for treating AFSCSA comes out of his 22 years of counseling and his faith in a loving God who brings complete restoration to the wounded. He reports that he used traditional counseling methods for 18 years. The last 4 years, he and his staff have successfully treated 1000 clients using the TheoPhostic Counseling Theory (Personal Communication, Dec. 28, l999).

The best Smith could offer with traditional counseling methods was that clients could have progressive recovery. Before TheoPhostic counseling, I do not believe my clients ever actually arrived at a completed place of recovery. I can only say my clients were in the process of becoming better and better ì (Smith, l997, p. 4). Smith struggled with the concept of a getting better recovery. He wanted to believe God offers and is able to accomplish more than this in the lives of those who seek him.

In his search with God, Smith felt he was given some answers of how to assist that complete recovery in the lives of women who are adult survivors of childhood sexual abuse. Dr. Smith referred the interviewer to his book,

Genuine Recovery: Recoverer's Guide to Complete & Genuine Restoration (l997), for the details of his theory.

Smiths theory is guided by the following eleven basic principles:

1. The client's primary source of pain is not the present situation.

2. If she tries to resolve her present conflict without finding healing for her past wounds, she will only find temporary relief. If she heals the past, the present will be redeemed.

3. What she is feeling presently (negative emotions) is an echo of past situations and are open windows into the wounds of her life.

4. In order to see through the window into the past, it is important that she let go of seeing the present situation as the primary source of her pain.

5. If she chooses to see through the window, she will be faced with the wound and feel its fury fresh again. If she does not look through the window, she cannot heal.

6. The three things she must search for as she looks through the open window are the historical emotional echo, a memory picture of the event, and the original lie.

7. The pain she feels is coming from the interpretation (lie) which was given the event, not form the memory of the event.

8. The emotional pain she feels matches the lies she believes.

9. Believing the lie has destructive consequences.

10. Embracing and confessing the lie, rather than rejecting or denouncing it, allows one to be free of it.

11. The client is able to receive a healing word from God, either verbally or by image, in this hopeless, helpless state. When the way is made

clear for me to receive, God will speak his healing word into my darkness and then I will at last be free (Smith, l997, p. 17).

Method of Treating AFSCSA

The following is the treatment protocol for doing TheoPhostic counseling:

1. The client is to close her eyes, focus on her breathing and on the tension in her body. The tension should be allowed to intensify.

At this point, the therapist and client can ask God to lead the client to a place where she needs to be to find release from the lie causing her this pain. Ask God audibly to help her separate from the present situation triggering the emotions and to connect with the historical wound which is the source of this pain.

2. The client is to be instructed to focus intently on the emotions she is feeling. Encourage her to give them a name and what they are telling her about her. It is important for her to identify what she felt about herself in the situation that triggered this emotion. An example of this could be, I felt used or stupid or rejected or violated, etc. The statement(s) that best describes how the situation made her feel then is to be coupled with a statement of how she feels now.

3. Have the client keep these emotions and the statement(s) in focus; have her separate from the memory of the current situation, and instruct her to drift back through time.

Encourage her to let a memory come to her. Instruct her to not try to find one. Have her notice whatever comes to mind. It may seem unimportant but encourage her to feel her way through it and look at every part. The memory may open up and reveal things long forgotten.

Have her examine the unpleasant feelings about this memory and compare them to the feelings in the presenting situation. Help the client identify the lie. Ask her, “How does this memory make you feel?” This is the essence of the lie, the false message that comes out of the abuse. Have the client focus on the emotion and the lie.

4. Allow the intensity of the memory picture to increase. Invite Jesus to come into the memory when it is strong and uncomfortable. “Jesus, we invite you to come and stand in this memory for (the client’s name) needs to hear your truth.”

When the client sees or senses Jesus’ presence, instruct her to think again about the memory picture and feel as much of the pain of the situation as possible.

When the emotion is intense, instruct the client to look over at Jesus who is now in the midst of the memory. Encourage her to watch and listen to him. Often he will act out the truth for her to see. Encourage her to be open to what he offers, e.g., if he opens his arms to her, encourage her to walk into them.

5. If Jesus does not move or say anything, there is a reason. Emotions of revenge, hate, and anger towards the offender may keep Jesus from acting. If the client wants to be free of these, she may wish to confess these to God, admit her powerlessness to overcome them on her own, and ask Jesus to release her from them.

After this prayer, the memory and the intense feeling about it can be again focused upon. If Jesus still does or says nothing, the client may not have found the original lie. Search through the memory again, looking for clues to what the lie might be, and then follow the process.

6. After God has spoken, have the client go back to the original memory and search for feelings all through it. If there are any unpleasant emotions after Jesus has spoken, there is another lie still in the memory. This is very common. A memory can have several lies. The process can be revisited for each lie.

Theory and Treatment from a Christian Perspective

Smith's methodology is primarily from a Christian perspective. He sees God as the Great Counselor and depends on him to do the work. Smith views that the counselor's job is to help the client go safely to the memories and discern the lies. The counselor can assist them in requesting God's healing presence and word. The rest is up to God. Smith says, God is the only one who can bring total healing of the pain. If God doesn't do it, it doesn't get done. The wonderful truth is that he always speaks when the three conditions are met (Personal Communication, December 28, l999).

Methodology Developed by Dr.Smith

The TheoPhostic theory and technique was revealed to Dr. Smith after 18 years of work with AFSCSA. He was frustrated about the length of time needed to make progress toward healing and then he was not satisfied with the results. Clients got better and better but there were always recurring problems. Clients could not seem to be free from the pain of the original trauma and the messages it emitted. He asked God for a more helpful way to do therapy with these clients. Over a period of time, Smith felt God gave him the process of TheoPhostic counseling.

Borrowed Methodologies from Other Christian and Secular Theories

The application of TheoPhostic counseling follows the principles of Cognitive-Behavioral Theory by looking at an event and the resultant thoughts

and feelings. Dr. Smith says that he is sure other therapists who counsel from a Christian perspective are using parts of TheoPhostic counseling in their work in different ways. The researcher believes Dr. Smith's experience in working other therapies for so many years influenced the development of the TheoPhostic approach.

Effectiveness and Length of Treating AFSCSA with the TheoPhostic Method

Smith reports, "Those we have treated report complete resolution of pain and the effects of abuse" (Smith, Personal Communication, 12/28/99). In his last four years as a counselor, Smith has used TheoPhostic Counseling and been satisfied with the results in three to twenty sessions. Survivors with long-term chronic abuse and symptoms often take the longer time to work through the many different messages, one at a time.

Interview with Ralph Earle, M.Div., Ph.D.

Theory for Treating AFSCSA

Dr. Earle, former President of the American Association for Marriage & Family Therapy, treats AFSCSA in an integrated approach. He has surrounded himself in his clinic, Psychological Counseling Services of Scottsdale, Arizona, with 15 therapists who work intensively with clients in an outpatient setting. They each specialize in a particular aspect of treatment yet work together as a team to treat every aspect of a person's mind and emotions.

The theories Dr. Earle integrates include Cognitive-Behavioral, Gestalt, Family-of-Origin, Behavioral Therapy, Boundaries, 12-Step with survivors and perpetrators, and spiritual therapy.

Earle incorporates spirituality as a resource to make a healthy life. If spirituality has a low priority with a client, he encourages the client to

make it a more productive resource. He appreciates the emphasis 12-Step programs make in using spirituality as a resource.

Method of Treatment for AFSCSA

Earle relies on his team of therapists to work with him to integrate approaches and treatment. If he is a person's primary therapist, he helps with the diagnosis using the MMPI-II and sets up their treatment plan.

Earle works with clients in terms of where they are now, sorting out the stories of the trauma and their emotional scars.

He is supportive of Murray who uses her method of regression therapy in his clinic with his patients as well as the others who do psychodrama, anger/forgiveness groups, codependence groups, and family therapy.

Methodology developed by Earle

The methodology that Earle believes he has developed is that of encouraging therapists to integrate spirituality as a productive resource into their work with their clients. His Ph.D. dissertation pertained to this integration and he is excited about the growing interest in integrating spirituality that he sees in the mental health field. He has done lots of work to speak to and train therapists in the AAMFT and other associations.

Christian Treatment Modalities Used by Earle

Earle does not call attention to the fact that all his therapists are mental health professionals who counsel from a Christian perspective. He has nothing in his literature or advertising that identifies a Christian perspective. His purpose is not to evangelize but to help clients have a significant resource and grow spiritually. His desire is to attend to people's pain no matter who they are and what they believe and to encourage what works for them spiritually.

Effectiveness of Treatment and

Length of Treating AFSCSA

Earle has been treating AFSCSA as well as other clients for 29 years. He has done outcome studies using feedback from his patients at 3, 6, 9 month and yearly check-ups. They report the effectiveness of his method of treating AFSCSA.

Interview with Marci Edmunds, M.S.

Theory for Treating AFSCSA

Edmunds' theory for treating AFSCSA is protagonist centered psychodrama developed by Elaine Eller Goldman, a student of Jacob Levy Moren, M.D., a founder of psychodrama, sociometry, and group psychotherapy. Edmunds was trained by Goldman and is part of the staff at Psychological Counseling Services (PSC) in Scottsdale, AZ. Edmunds contributes psychodrama to the team approach with AFSCSA at PSC. Edmunds referred the researcher to Goldman's book, Psychodrama: Experience and Process (l984), for additional information pertaining to the interview which took place over the phone on September 4, l999.

The approach Edmunds uses seeks to help individuals integrate their words, thoughts, and feelings into their life experiences. People spend a large part of their lives saying one thing, thinking another, feeling a third and then doing a fourth that has nothing to do with the previous three. Psychodrama creates a place to examine and integrate these areas (Edmunds, Personal Communication, l/4/99).

Method of Treatment

Edmunds does psychodrama with a team of other therapists at PCS. They enter each session without much information in order to prejudge the client as little as possible. They want to be able to rely on their intuitions and

the information the client is choosing to give them to inform them about the direction in which to proceed.

The rules of psychodrama are as follows (Goldman & Morrison, l984):

1. The protagonist must act out her conflicts, instead of talking about them.

2. The protagonist is to act in the here and now, even with events that happened in the past. The client is to act and speak as though things are happening right now.

3. The protagonist is encouraged to maximize all expression, action, and verbal communication.

4. The warming-up period moves from the periphery to the center where one has the most traumatic events.

5. The protagonist normally chooses the other group members to be her people in her story.

6. The protagonist is permitted to be as unspontaneous or inexpressive as she is at the time. The team of therapists are trained to be supportive of her. She may also be much more spontaneous in role reversals with others.

7. The protagonist must learn to take the role of all of those with whom she is meaningfully related, to experience those persons in her life, their relationship to her and to one another.

8. The director needs to trust the method to guide in the therapeutic process.

9. Psychodrama sessions have three portions: The warm-up, the action portion, and the post-action sharing by the group.

10. The protagonist is encouraged to see that her problem is a common one to others in the group.

The following are the steps to psychodrama practiced by Edmunds:

1. The group is warmed-up by each member having the chance to express something concrete, e.g., what one thing in their life would they most like to change.

2. The protagonist, the one working on an aspect of her life for the session, is then asked to share a present problem, a feeling struggle, by acting it out and having group members participate as people in her story.

3. The director asks the protagonist to act out a situation that feels similar to the present problem that is from the recent past. The therapists notice the patterns in the two dramas. They are listening, watching, and picking up clues in order to be in touch with the protagonist's significant feelings and behaviors.

4. The director then asks for a story, a scene from early childhood, that has similar feelings to the previous scene. Here the primary feelings and the real problem is found.

5. When appropriate, the client is helped to experience a catharsis (e.g., of anger, tears, primal scream). "It is so important for the therapists to figure out who needs 'glue' and who needs 'breaking apart.' If the Controlling Child is out of balance and in control, the client often needs breaking apart. If she is fragile, she needs shoring up" (Edmunds, Personnal Communication, 9/4/99).

The mirroring technique can be used to help catharsis because when the protagonist is in the middle, it is hard for her to "see" herself. A trained therapist can mirror the feelings and/messages coming from the original event.

This is the climax of the session. The directors must keep clarity. The protagonist must understand her own motivations and actions as well as those of the others in her life. If she is angry about what her mother did to her as a child, that must be differentiated from her present anger she has toward

herself for maintaining the patterns developed in the past. Many times, survivors rationalize present destructive and negative behavior by blaming past events and/or people. Confronting self instead of blaming others can be the most difficult part of a session. "When one has the willingness to look at self, at how she has contributed to what has happened to her, she is also prepared to confront her conscious and unconscious" (Goldman & Morrison, l984, p. 31).

6. Concretizing the issues is the next step in the psychodramatic process. This is the segment where all the pieces of the puzzle come together. Many issues have been made "concrete" throughout the session by putting them into action through body work, focusing, mirroring. The final concretizing comes from the protagonist's symbols and metaphors drawn out in the beginning and used throughout the session.

Edmunds believes that clients can be responsible for the choices in their life. An AFSCSA can choose to bring growth and productivity into her life or she can continue to do whatever it is that makes her feel depressed, useless, impotent and manipulated.

This is why it is important to use the client's own symbols and use them clearly at this stage. It is important to clarify that the AFSCSA may not have had control of her life at age 5, but now at 45, she must make the choice to be in control of her life and live out the consequences of that choice.

Besides clarifying the protagonist's responsibility for change, this stage of concretization is used to validate her strengths and options for life. This stage should conclude on a high note with some positive possibility.

This concretization is bringing the protagonist back into the present and so even if some elements of past actions and feelings are included, they

need to be present oriented. Insight and integration have begun. The protagonist needs to be aware of feelings, thoughts, and actions. There has to be a link between what she is thinking and feeling in order for her to integrate the session. Even so, it may be impossible to integrate everything that has surfaced in the session.

7. The time of closure occurs when the protagonist comes full circle, back to the original problem that has been tracked and recognizing her responsibility for her choices in reference to it. The therapist directs a reenactment of the original scene or the first indication of the primary problem(s) using new insights and responsibilities. The director might use this as a chance for role training or a future projection with new found spontaneity and creativity.

8. There is a final closure of the group sharing of their own feelings and responses to what they have experienced as a result of the protagonist's sharing. It is a time when each in the group gives back to the protagonist and she finds that she is not alone with her feelings and experiences. It is not a time for the group to analyze, give advise, interpret, or ask questions (Edmunds, Personal Communication, 9/4/99; Goldman & Morrison, l984).

Theory and Treatment from a Christian Perspective

Because psychodrama integrates everything about a person, body, mind, and spirit, Edmunds does not take a spiritual approach with clients unless it comes up in the session. Her work is respectful of other faiths and she encourages clients to make sense of their own spirituality should the topic arise. Sometimes issues of guilt arise from messages from parents that are religious in nature and these are processed in the same way as any other issue is addressed.

Borrowed Secular Theories

None of what Edmunds uses is unique to her; it all comes from her training with Elaine Eller Goldman who trained with Jacob Levy Moreno, M.D. Goldman claims that her interest in the work of Adler, Jung, and Buber, along with "everything [she has] experienced in life" (Goldman & Morrison, l984, p.xii) has greatly influenced her beliefs and work. Buber writes "man must change his mode of relating himself to each and every being that confronts him. He must affirm other beings as existing in their own right and must not suppress the element of spontaneity that is possible in his relations with them" (Buber, cited in Goldman & Morrison, l984, p. xii). Alfred Adler states the idea that people seek to adapt themselves to arbitrary conditions of the environment and that this expressed by the social interest innate in each person. He states that there are three tasks for every individual, set by the human community: Work, meaning contributing to the welfare of others; Friendship, embracing relationships with peers and relatives; and Love (Dreikurs, l950). Jung influenced Goldman in his belief that all human works originate in the inherited powers of creative imagination. Moreno, Buber, Adler, and Jung also influenced Goldman in their "belief in the essential potential of the human being and the human spirit in relationship to his environment, society" (Goldman & Morrison, l984, p. xii).

Effectiveness and Length of Treating AFSCSA Using Psychodrama

Edmunds has been using psychodrama for four years in the treatment of AFSCSA and clients with other issues. Before psychodrama, she used an integrated approach of cognitive-affective-behavioral. She is impressed with how people are able to leave a session so empowered. She believes that once clients get a taste of that empowerment, they never forget it. She is making a choice to counsel in ways to enhance that empowerment.

Psychodrama is just new enough that there have been few, if any, outcome studies yet she is seeing change in clients who come back years later verifying its helpfulness.

Conclusion

In conclusion, chapter four consisted of interviews with five therapists who counsel AFSCSA from a Christian perspective. There were a variety of theories and methodologies used by these five therapists. Some used borrowed theories and methodologies and some used personally developed theories and methodologies. Some used secular theories and adapted them to their Christian perspective; some theories and methodologies were particularly Christian. All had been in practice using these theories and methods for several years. They relied on the feedback from clients to evaluate the effectiveness of the treatment.

CHAPTER FIVE

I chose to study clinical work with adult female survivors from a Christian perspective for both personal and professional reasons. Being a survivor myself and having done three years of intensive therapy and personal and graduate study, I wanted to make sure that I wasn't missing anything that would enhance my own healing.

Professionally, in preparation for a counseling career, I had to make sure that I made the transition from understanding the issues of childhood sexual abuse from a survivor's standpoint to understanding these issues from the vantage point of a clinician.

Finally, examining (through the literature review and interviews) the work done with a Christian perspective encouraged me by helping me see that I am not alone in the belief that incorporating faith and spirituality into psychotherapy is a great resource to healing. I believe, and I see that several others believe, that without it, an aspect of healing may be lost.

Commonalities in the Literature Review and Interviews

There are several commonalities among those interviewed. All the methodologies emphasize examining the original memory. Edmunds' psychotherapy and Murray's age regression and mat work have a definite, systematic way of approaching the original memory. Smith's TheoPhostic counseling has a specific means of dealing with the memory once it has been accessed. Olson, using Herman's approach, approaches the memory using a carefully developed and boundaried therapeutic relationship and grief work to desensitize, tolerate,

and incorporate the memory with its feelings into life with a new identity and meaning.

Earle, Murray, and Vought emphasize the importance of group work in addition to individual work. Edmunds values the empowerment that group psychotherapy gives to clients and says she would never go back to traditional individual therapy (Edmunds, Personal Communication, 9/99).

Vought and Smith both use TheoPhostic counseling. Olson and Murray use aspects of it.

Implications for the Church

Since childhood sexual abuse seems to be prevalent among churchgoers today as well as in the rest of society, it would seem to be very important to address the issue in the church. It is important to address the secrecy, the denial, and the attitude of male dominance over women and children which contributes to its prevalence. I believe that emphasizing that the Bible supports side-by-side male/female relationships instead of the traditionally believed interpretation of ranking in a hierarchy of authority could contribute greatly to lessening the abuse of power that encourages domestic and childhood sexual abuse. Unfortunately, tradition entrenches these attitudes and anything identified as liberalism is suspect and hard to budge.

If the subject of childhood sexual abuse were treated more openly in the church, not with vehement condemnation and shame, but with the attitude of understanding, empathy, and openness toward and availability of treatment, both the abused and abusers might begin to find the help they need.

Clinical Implications

There are several clinical implications relevant to this study. It is extremely important for the therapist to have a good understanding of

childhood sexual abuse, the stages of development and healing, the use of the therapeutic relationship as a healing intervention, and the elements of grief and loss work. In addition, this study finds relevant the need of the therapist working with AFSCSA to have an understanding of his or her own wounding and that a Christian perspective adds a piece to healing for AFSCSA that secular perspectives do not, according to those interviewed.

As I overview the research, I am struck by how much work has to be done by the client and the therapist to overcome the effects of childhood sexual abuse. The list of what is lost in the abuse is so fundamental to the core of any person. The list of what needs to be grieved and somehow built back into a life is very long. As I think about friends with similar backgrounds, I recognize their need of a therapeutic relationship in which to work on these issues. A friendship can be too vulnerable of a relationship in which to do this work. Often one needs the expertise and skill of a therapist with excellent understanding and boundaries in order to break through destructive patterns and develop healthy ways of taking care of oneself. Many people do not understand this and so they think they can do the work on their own. Sometimes they can but many times it is too hard to do alone. Then there are those AFSCSA who have gone to therapists or to their pastors who have not thoroughly understood childhood sexual abuse and have not been helpful to them. The survivors may have then been discouraged from seeking out other professional help that could have helped them.

Aspects of what must be monitored by the therapist include issues of safety and empowerment. One place these can be seen is in the pacing of therapy so that the client is able to stay in control and not reenact the out-of-control aspects of the trauma. Many times, clients push the pace of therapy, thinking it will help them get through the pain faster. Speed could

cause the AFSCSA to be overwhelmed and feel like she cannot bear the reliving of the trauma. It is up to the therapist to monitor the pacing. There must be time to integrate the uncovered material and insights.

Another aspect of the therapy in which the therapist can be especially helpful is the teaching of healthy self-soothing. To be able to self-soothe, individuals must have a source of loving memories on which to draw. The therapist, therefore, must understand developmental stages and where the client is in her personal development of these stages. In many cases, so devoid of even basic bonding, the AFSCSA is desperate for attachment. The therapist who understands attachment theory (Bowlby, cited by Cassidy & Shaver, l999) can allow for attachment and work with the survivor through its development, helping the client to weed out unhealthy patterns and develop and strengthen good ones. Good therapeutic boundaries are implicit. This is not the place for an underinvolved therapist and overinvolvement is a challenge for the therapist, as well. "Just right" (Jerrard, l995, p. l3) involvement may be a fine line based on experience, intuition, and staffing with supervisors and colleagues. Once the work of attachment has gone its course, issues of separation and detachment will need to be addressed. Many times the survivor is terrified of this but it is all part of the maturing process. It may be helpful to her to relate this to launching in adolescence, where high schoolers graduate and go on to college, but the bond of love, if well established, continues and grows between the parent and teen who is growing in autonomy.

This is not a process that can often be treated with brief therapy. Murray's method, the Becomer's program, and Smith's TheoPhostic approach could be among the briefest applicable therapies and yet even with these, it takes a long time to work through all the implications. Since childhood sexual abuse

has been established as a significant issue because of its prevalence, it would be very interesting to study how much therapy and for how long it really takes on the average for real healing. Of course, every situation is different. What concerns me is how managed care, in restricting services, may inhibit AFSCSA from attending to legitimate needs for therapy.

The process can be enhanced by the encouragement of peer support and network building. This takes time as the survivor establishes the bonding and developmental progress and then is able to generalize her learning to other relationships. Old relationships tend to be reevaluated; new relationships are sought out. Relationship building skills grow.

The last implications for treatment that the researcher will discuss is the need for the therapist to understand his/her own wounding as part of humanity in order to be helpful to the AFSCSA and that counseling from a Christian perspective may have a healing edge for AFSCSA that secular therapy does not have.

Nouwen (l979) says,

> We live in a society in which loneliness has become one of the most painful human wounds. The growing competition and rivalry which pervade our lives from birth have created in us an acute awareness of our isolation. This awareness has in turn left many with a heightened anxiety and an intense search for the experience of unity and community....The more I think about loneliness, the more I think that the wound of loneliness is like the Grand Canyon--a deep incision in the surface of our existence which has become an inexhaustible source of beauty and self-understanding....Sometimes it seems as if we do everything possible to avoid the painful confrontation with our basic human loneliness, and allow ourselves to be trapped by false gods promising immediate satisfaction and quick relief. But perhaps the painful awareness of loneliness is an invitation to transcend our limitations and look beyond the boundaries of our existence. The awareness of loneliness might be a gift we must protect and guard, because our loneliness reveals to us an inner emptiness that can be destructive when misunderstood, but filled with promise for him [or her] who can tolerate its sweet pain (Nouwen, p.83 & 84).

Nouwen goes on to say that becoming impatient with our loneliness, trying to get rid of its pain and overcome the separation and incompleteness we feel sets us up for devastating expectations from the world we live in. We

try to ignore the truth that we already know--"that no love or friendship, no intimate embrace or tender kiss, no community, commune or collective, no man or woman, will ever be able to satisfy our desire to be released from our lonely condition" (Nouwen, l979, p. 84). This truth is so difficult and painful that many tend to play games with their fantasies rather than to face it. We keep hoping that we will find someone who really understands our experiences, someone who will bring us peace, a job which will fulfill our potential, a book that explains everything, a place to which we can call home. These false hopes can lead us into making exhausting demands which could end in bitterness and hostility when we realize that no one and nothing can fill us completely and totally remove our loneliness.

If the therapist has not grappled with these false expectations and illusions in his or her life, he/she may be unable to claim his/her own loneliness as a source of human understanding, and be able to offer any real service to the many, AFSCSA and others, who do not understand their own suffering. Therapists are called upon to bind their wound of loneliness with even more care and attention than others usually do. "For a deep understanding of his own pain makes it possible for him to convert his weakness into strength and to offer his own experience as a source of healing to those who are often lost in the darkness of their own misunderstood sufferings" (Nouwen, l979, p. 87).

Making one's own wounds a source of healing does not mean inappropriate self-disclosure but "a constant willingness to see one's own pain and suffering as rising from the depth of the human condition which all men share" (Nouwen, l979, p. 88). It is about withdrawing into the center of our own hearts to face directly our own condition in all its beauty as well as misery. It involves concentration, meditation and contemplation. Coming from a

Christian perspective, Nouwen explains that we find a loving God in the midst of our center who calls us Beloved. "When we are not afraid to enter our own center, to concentrate on the stirrings of our own soul, we come to know that being alive means being loved...that we can only love because we are born out of love, that we can only give because our life is a gift, and that we can only make others free because we are set free by Him whose heart is greater than ours" (Nouwen, l979, p. 91).

Interestingly, when we withdraw into ourselves and find the anchor place for our lives in our own center, we can let others enter our lives on their own terms into the open space created for them by our withdrawal. Speaking about counseling, James Hillman, director of studies at the C. G. Jung Institute in Zurich, writes:

> For the other person to open and talk requires a withdrawal of the counselor. I must withdraw to make room for the other...This withdrawal, rather than going-out-to-meet the other, is an intense concentration, a model for which can be found in the Jewish mystical doctrine of Tsimtsum. God as omnipresent and omnipotent was everywhere. He filled the universe with his Being. How then could the creation come about?...God had to create by withdrawal; He created the not-Him, the other, by self-concentration...On the human level, withdrawal of myself aids the other to come into being (Hillman, cited in Nouwen, l979, p. 91).

This is healing, not because it takes away the pain and loneliness of the one entering the space, but because the pain and loneliness is shared. Healing takes place because the false illusion that wholeness can be given by one to another is dispelled. Healing takes place because in this place of sharing, one begins to understand that one's own wounds need not be sources of despair and bitterness, but signs that the wounded has a journey of her own in response to the "calling sounds of [her] own wounds" (Nouwen, l979, p. 92).

This means, then, that the primary task of the therapist is not to take away pain but to deepen it to a level where it can be shared. An AFSCSA can expect when she comes to a therapist that her loneliness will be understood

and felt so that she no longer has to run away from it but can accept it as her connection to humanity. The therapist's job could be seen as quite confrontive: preventing people from suffering for the wrong reasons. People suppose that there should be no fear, loneliness, confusion or doubt. If these wounds are understood as integral to our human condition, these sufferings can be dealt with creatively. Our illusions of immortality and wholeness need to be broken down and when this occurs, liberation starts. Pain no longer has to be paralyzing. When shared, it can mobilize into a common search for life. Speaking from a Christian perspective, God is what real life and love is. Pain, therefore, can transform expressions of despair into signs of hope.

This common search for life creates "community as it creates a unity based on the shared confession of our basic brokenness and on a shared hope. This hope in turn leads us far beyond the boundaries of human togetherness to Him who calls His people away from the land of slavery to the land of freedom" (Nouwen, l979, p. 93-94) and into the arms of a loving God. This perspective, according to the researcher, is the edge that secular counseling does not have.

As the therapist counseling from a Christian perspective listens to the voice within, he/she may be able to see herself and to make visible to the clients she works with, the first rays of the light of the coming Messiah. The therapist seeks to exemplify the compassion of God with man--which is visible in Jesus Christ-- so that the client can experience it.

For clients who do not view themselves as espousing Christianity, several of the therapists interviewed (Murray, Earle, Olson) incorporated developing the form of spirituality that the client sees as helpful to her. They did not advocate prescribing a certain faith. However, looking for help from a loving and caring Higher Power, someone above and beyond themselves who

could give them the help they desperately need and empower them to do what they need to do for themselves, was seen as a way to move AFSCSA out of the victim role, something very needed in the life of a survivor.

When the therapist is able to understand her relationship with her God or Higher Power, she may be able to understand and help others understand that we already carry in us the source of our own search. Thus therapy can indeed witness to the "truth that the wound, which causes us to suffer now, will be revealed to us later as the place where God intimated his new creation" (Nouwen, l979, p. 96). The words of Rueben "Hurricane" Carter, in the current movie, The Hurricane, speak loudly: "Hate put me in prison but love is gonna break me out!"

Conclusion

In conclusion, clinical work can lead an adult female survivor of childhood sexual abuse to a new identity and a new meaning about what happened. The new identity comes from looking at the developmental stages and realizing that she is meeting the goals of these stages. As she begins to make appropriate attachments, she begins to gain deposits in her "bank account" (Covey, l995). There start to be unconditional love memories that register her worth. She begins to establish autonomy where she can be herself and be okay with it. She starts to learn independence within the context of dependence. She learns that these are necessary steps to develop in order to have true intimacy and closeness, what many AFSCSA crave.

The new meaning comes from the realization that the traumatic events occurred in the survivor's life, not because of hate, but because a person in her life did not know how to meet his own needs in an appropriate way. Love is breaking her out of her old patterns.

With all this knowledge in hand, I am impelled on a mission. I am walking on my journey to which my wounds are calling me. It wells up within me to be a safe place where people can share their pain and find their own healing journey. I thank God several have been there for me. I am called to be there for others.

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APPENDIX

Clinical Work With
Adult Female Survivors of Childhood Sexual Abuse
From A Christian Philosophical Perspective

Questionnaire

This questionnaire is part of the research being done by Char Groves as part of her Graduate program at the University of Wisconsin-Stout. The purpose of this research is to determine treatment methodologies used by mental health professionals who counsel adult female survivors of childhood sexual abuse (AFSCSA) from a Christian philosophical perspective.

I understand by returning this survey, I am participating in the study either by name or anonymity. I understand that if I sign this questionnaire, I give permission for my name to be used.

Signature_____ Date _____

1. Are you a mental health professional who counsels from a Christian philosophical perspective?

_____Yes _____No

2. Do you treat adult female survivors of childhood sexual abuse (AFSCSA)?

_____Yes _____No

3. What is the theory or theories from which your treatment for AFSCSA is based?

4. What is your method for treating the effects of childhood sexual abuse on adult female survivors?

5. What in your theory and treatment is specifically from a Christian perspective?

6. What in you theory and treatment has been specifically developed by you?

7. What do you borrow from other Christian treatment modalities for AFSCSA?

8. What do you borrow from secular treatment modalities for AFSCSA?

9. How long have you been treating AFSCSA with this method of treatment?

10. On what are you able to base the effectiveness of your treatment?

11. Gender: _____Male _____Female

12. Age: _____20-30 _____31-40 _____41-5
_____51-60 _____61-70 _____71 & Above