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Te Kaporeihana Āwhina Hunga Whara

Sexual Abuse and Mental Injury: Practice Guidelines for Aotearoa New Zealand

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These guidelines were commissioned by ACC, and have been developed by the Research Team from Massey University School of Psychology (Turitea Campus).

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Part One: Principles and Recommendations

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Foreword

Prior to embarking on this project, Massey University's research team searched the international literature to ensure a wide and comprehensive coverage of the knowledge and practice base which underpins the development of evidence-based practice guidelines. After reviewing recently developed practice guidelines from the United Kingdom, Australia, the United States, and Canada, an adaptation of the key organising Principles for Practice Guidelines developed by the Canadian Task Force on Empirically Supported Treatments (www.cpa.ca) appeared to lend itself particularly well to the task of conceptualising workable guidelines for a multi-disciplinary workforce approaching therapy from a range of theoretical perspectives. New Zealand guidelines were also considered and incorporated into the research as well as being summarised in research reports.

Recommendations from the Canadian Task Force's Professional Associations emphasise the following key points:[1]

- Practice guidelines must not be academic tomes, but products designed to help practitioners make decisions in the context of daily practice
- Practice guidelines must be user-friendly in how they present core concepts
- Practice guidelines cannot become a "straitjacket" that supplants individual professional judgement and decision-making, and the development of new and creative approaches
- Practice guidelines are most applicable when they focus on the broad context of assessment and decision-making and leave the details of implementation up to the practitioner
- Practice guidelines cannot appear to reflect specific guild or association interests
- Practice guidelines cannot favour any particular type of treatment (eg, medication versus psychotherapy, long-term versus short-term psychotherapy) unless there is an agreed-upon evidence base for such a recommendation.

The research underpinning the New Zealand guidelines also incorporated the experiences and views of clients. Therefore, the following series of recommendations for guideline development produced by the Canadian Task Force's Consumer Association was especially relevant:

- Practice guidelines need to attend to the best interests of the client and their immediate family members
- Clients of health services must be a significant source of information about the preferred outcomes of those services
- Practice guidelines should not make treatment recommendations that place undue hardship on significant others as a part of treatment
- Practice guidelines should state clear parameters for the appropriate assessment of therapeutic and functional outcomes, and recommend procedures for assessing those outcomes.

Treatment versus Practice Guidelines

In addition to incorporating these key organising principles into the construction of these guidelines, it is important to clarify for readers the distinctions between treatment versus practice guidelines. These terms are sometimes used interchangeably. This can often lead to confusion about what guidelines are meant to

1 Adapted from: Hayes, S. (1997). National planning summit on practice guidelines. *The Behavior Therapist*, 20, 160–162. Cited in: Hunsley, J., Dobson, K. S., Johnston, C., & Mikhail, S. F. (1997). *Empirically supported treatments in psychology: Implications for Canadian professional psychology*. Task Force Report for CPA Section on Clinical Psychology, Ottawa: Canadian Psychological Association.

accomplish and how they are structured.[2] Treatment guidelines emphasise and recommend specific disorder/problem-oriented interventions. The literature search revealed that many excellent guidelines have been developed which deal with specific difficulties such as post-traumatic stress disorder (PTSD) and acute stress disorder.

However, the research brief was to develop guidelines dealing with the wide range of consequences experienced throughout the lifecycle as a result of childhood sexual abuse (henceforth, CSA), adult sexual assault, intimate partner violence, and ongoing adult sexual abuse. It was also important to develop guidelines appropriate to the unique needs of males as well as females, while also taking into account cultural considerations of various ethnic groups. For this reason, practice guidelines which recommend appropriate professional conduct as opposed to specific disorder treatment guidelines or compulsory standards were developed following the criteria outlined above.

Addressing the Needs of a Multidisciplinary Workforce – Generic Principles

As mentioned earlier, sexual abuse counselling in New Zealand is carried out by practitioners from a variety of disciplinary associations, including counselling, psychotherapy, social work, psychology, psychiatry, and child psychotherapy to name a few.

Core versus therapy-specific principles

Accessing a common language which is relevant, yet not discipline-dependent, has necessitated an approach in which the "core" curative elements have been teased out from the "front" of psychotherapy. The "front" in psychotherapy refers to the terms, disciplinary-specific language, and therapy techniques which are implemented by practitioners according to the theoretical orientations they espouse. The "core" refers to the underlying curative factors which underpin all effective approaches to psychotherapy. These comprise factors that in addition to the therapy techniques include therapist variables such as empathy, the ability to establish rapport and develop a therapeutic relationship with the client, and the capacity to conduct therapy in a non-judgemental manner.

Process and context

Process variables, such as the timing and pacing of specific interventions dependent on client readiness (eg, Briere's therapeutic window), being able to individualise treatment to client need, sensitivity to contextual information such as the role and impact of the client's family, ongoing legal processes, and other contextual factors make up the mix of ingredients contributing to effective curative factors in therapy.[3]

The practice guidelines, Part One and Part Two, have been designed to be self-contained as a basic guide for professional practitioners from a range of disciplines conducting sexual abuse counselling in New Zealand. However, links to New Zealand literature reviews, research reports, and the research findings underpinning

2 American Psychological Association (2002). Criteria for practice guideline development and evaluation. *American Psychologist*, 57(12), 1048–1051.

3 For thought-provoking literature raising some of these issues, see:

Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.) (2005). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.

the guidelines are available on the websites for the Accident Compensation Corporation of New Zealand (ACC) at www.acc.co.nz and Massey University at http://whatumanawa.massey.ac.nz. These include results of both quantitative and qualitative components of the research conducted with both practitioners and clients, ensuring the production of guidelines which not only reflect international best practice principles but are also tailored to the individualised needs and conditions embedded within the New Zealand context.

Some practitioners may have specific training and links to professions which have schooled them in empirically-based treatments such as cognitive behavioural therapy, while others may have been educated to emphasise the importance of the therapist-client relationship rather than more goal-focused treatment techniques. The research has indicated that, from a client perspective, both factors are equally important. Clients value goal-setting, a sense of movement in therapy, and clear progress towards the future. If this is not present, they feel the therapy is not sufficiently focused. They also value a good therapeutic relationship with their therapist, responding well to a sense of caring, empathy, and warmth.

Recommendations

As well as accessing an annotated bibliography of New Zealand-based research, it is recommended that practitioners continue to upgrade their knowledge and skills on an annual basis by attending professional training and development opportunities provided by the various professional bodies and ACC as mandated under the Health Practitioners Competence Assurance Act 2003.

These guidelines are intended to unpack the knowledge practitioners already possess, develop new insights, and reinforce the core principles for best practice in Aotearoa New Zealand. Part Two operationalises and reinforces these principles in the same sequence as the reader is introduced to them in Part One for ease of cross-referencing.

Cheryl Woolley
Principal Investigator

General Introduction

Purpose

This document describes best practice guidelines within Aotearoa New Zealand for professionals from all disciplines providing therapeutic services to people who have experienced sexual abuse. Through the sensitive claims process, ACC makes counselling available to children and adults who have sustained a "mental injury" as a result of sexual abuse (see Appendix 1 for notes about terminology). These guidelines were designed specifically for ACC providers, although they are relevant to practice regardless of whether such services are being delivered under an ACC entitlement.

Best practice guidelines promote the aspirations of all practitioners to provide the highest possible quality of service to clients. They are not intended to be a set of basic or minimal standards and do not delineate the terms and conditions whereby ACC approves services to people who have been sexually abused. Standards are mandatory rules that imply enforcement, while practice guidelines are recommendations for professional behaviour. The purpose of these principles is to inform and guide practice, as well as encourage professional development and further understanding.

The guidelines are based on evidence that is directly relevant to professional practice in Aotearoa New Zealand. The evidence arises from a series of research studies conducted for the development of this document, as well as a critical analysis of international research as it might apply in the New Zealand context.

The guidelines are generic and should be meaningful for professionals from many different disciplines. However, they are not all-encompassing as they are specifically focused on the provision of counselling services. Counselling is a general term that covers a variety of activities and is described by different labels within different professions, generally referring to therapy (treatment, rehabilitation, or intervention) that is directed towards the mental health needs of the client and is provided in a formal way by a qualified mental health or health practitioner.

Structure

The practice guidelines developed by the Rāranga Whatumanawa project are organised into two important documents:

Part One comprises the **Principles and Recommendations** designed for work with child, adolescent, and adult clients within bicultural Aotearoa New Zealand. The recommendations are the best practices identified by the research. The document also includes an explanation of the origin, purpose, and process of the development of the guidelines, as well as appendices that provide the names and affiliations of the members of the research team, the members of the project's interdisciplinary Advisory Committee, and notes on terminology.

Part Two is the **Practice Guide** that addresses assessment issues and considers therapy strategies with children and adults, and is designed to provide additional, detailed information for practitioners. The Practice Guide gives further explanations of the rationale for the recommendations, as well as representing the voices of the clients and practitioners who contributed during the course of gathering evidence. The Practice Guide is not a manual and draws primarily on findings that emerged from the programme of research work carried out for this project. Listed in Appendix 1 in the Practice Guide are the reports written by members of the research team

during the course of the project. These reports are available upon request from ACC at www.acc.co.nz and Massey University at http://whatumanawa.massey.ac.nz.

The two components are designed to work together for practitioners, not in isolation. Because the supplemental guide contains information and insights provided during the development of the guidelines, it enriches and elaborates on the more formal recommendations. The Practice Guide also contains checklists of items for practitioners to consider when addressing client needs according to the practices specified in the Principles and Recommendations document.

Developmental considerations. Another feature of the structure of the guidelines relates to the age or developmental stage of the client. Much of the material applies to best practice irrespective of the client's developmental stage, but obviously there are a wealth of practices that are germane to children and others that are more suitable for adults. The organisation has been kept general (in other words, there are not two sets of guidelines), but when necessary, specific sections have been provided according to work with children and adolescents.

Cultural considerations. Where possible, the research team has tried to adopt a bicultural stance across the two documents, in recognition of the importance of adherence to professional principles derived from the Treaty of Waitangi. At the same time, there are some additional considerations that need to be addressed when the client identifies as Māori, and specific sections have been included where that is deemed necessary. (Related to these sections, see Appendix 3 for a glossary of Māori words.) Separate from the bicultural imperative is the fact that there are other cultural groups in New Zealand (defined both ethnically and in terms of lifestyle, gender identity, and so on) who may have particular needs as clients receiving counselling services under ACC Sensitive Claims.

By identifying these particular groups of clients, it is important to emphasise that generalisations may or may not apply to the individual client. It is very important for professionals to avoid making assumptions about individuals based on the group in the population to which they appear to belong. Ethnic and cultural identity is a complex matter and the inclusion of sections tuned to different possible groupings must not be taken as a guideline that supersedes best practices for the individual client, who is always unique.

Development of the Guidelines

Origin of the Project

These guidelines build on previous ACC guidelines for working with people who have been sexually abused. The present research brief was to expand the breadth of inquiry in the following ways:

- The current guidelines were developed for clients across the lifespan, and were intended to have a developmental focus
- There was a need to consider a broad range of client groups, such as children, men, the elderly, people with disabilities, and those with different cultural beliefs, sexual orientation, and gender identity
- There has been considerable additional work related to the treatment of mental injury following sexual abuse within the past five years
- There was a need to develop insights and understandings based on research specifically relevant to New Zealand conditions.

In addition, ACC has conducted research, generally in the form of surveys of practitioners. The present materials are thus only part of an evolving body of knowledge. It is especially important to be cognisant of overseas research and developments, but at the same time create a body of local knowledge that is suitable for Aotearoa New Zealand.

Methods of Inquiry

Evidence-based practice: What is it and is it useful to us?

The term "evidence-based practice" refers to the results of the best available research that is consistent with therapeutic practice and client values, and is conducted to determine which therapies are most likely to be beneficial to a specific client group (eg, clients with depression, anxiety, or PTSD). A range of demographic information about the participants of the research is included (age range, gender, socioeconomic status, level of education, ethnicity, employment status, etc).

The "gold standard" of evidence-based research is generally considered to be research which compares at least two groups of research participants (clients who have agreed to participate in a research project) who have been randomly assigned (without prior knowledge of any information other than demographic information) to one of the two or more research groups. Although randomly assigned to a specific therapy or "treatment as usual" group, the researchers ensure there is a reasonable equivalence of demographic characteristics across all groups of participants. These participants then receive a therapy which has been pre-planned in terms of the components of therapy, the length of sessions, the number of sessions, and the period of time over which therapy takes place. Other groups may receive either a different type of therapy (eg, one group receives 15 sessions of cognitive behavioural therapy while another receives 15 sessions of a comparative therapeutic approach such as interactive drawing therapy) or treatment as usual. Comparisons may also occur

with a "waitlist group" which receives no therapy until the first group of research participants has completed therapy. Research participants are likely to complete questionnaires, provide details on their quality of life (eg, number of visits to their general practitioner), or be interviewed about their current functioning (eg, depression, anxiety, trauma symptoms) prior to beginning therapy, during therapy, and at the end of therapy. They are also followed up after the conclusion of therapy (perhaps after 3, 6, or 12 months) and again asked to complete questionnaires and other measures of outcome. This enables researchers to ascertain whether any gains achieved during therapy were sustained over time.

Therapists can use the information generated by this research to guide them in selecting a therapy model which has been demonstrated to have beneficial outcomes for a specific client group. When there are numerous studies which all find a particular therapy type to be beneficial for a particular set of symptoms, our confidence in using that particular therapy model is increased: it has become "evidence-based therapy".

Unfortunately, it is not always quite so straightforward. It cannot be assumed that any interventions not studied using strict controlled trials are ineffective. Furthermore, it becomes evident when reviewing the therapy literature that some researchers or practitioners who favour specific approaches are active in undertaking research that supports their preferred practice, whereas other research favours integrated or eclectic styles. Two problems with this are that not all specific approaches are equally represented (eg, compare the number of cognitive behavioural therapy studies to the number of studies on cultural models of therapy) and research using integrated approaches is seldom applied consistently across studies.

Another issue is the selection criteria that researchers use for including or excluding participants (therapy clients) in their research. Using a carefully selected sample can mean that the favourable outcomes reported are only relevant to clients with relatively straightforward symptoms (eg, depression, anxiety, or low self-esteem). This is of course very helpful information for therapists working with those client groups. However, some clients seen for therapy for CSA and other types of sexual abuse have a complex range of symptoms which may include depression and anxiety, but with the addition of attachment or relationship issues, substance abuse difficulties, and perhaps self-harming behaviours, including chronic suicidality (often referred to as complex PTSD). In most of the outcome literature reviewed, clients with more complex presentations were excluded from the research (this may be an ethical requirement for many researchers, who wish to "first do no harm"). Another complication is that the "shape" of therapy changes over time as new and integrative therapies are developed and researched.

It is clear that the best value from research is achieved when practitioners and researchers combine their efforts to ensure that practice-based research is both clinically relevant and carefully designed. For these reasons the current research team elected to thoroughly review the literature available in the area of CSA and rape or sexual assault, and to combine this information with the information collected from local therapists (survey, focus groups, and key informant interviews) and clients (focus groups and key informant interviews). From this breadth and depth of information, the team extracted the common factors that provided good outcomes for clients, and also noted factors that therapists and clients identified as being unhelpful. This means the important components of good therapy can be used in a variety of therapeutic models. Specific information about current evidence-based practice can be found in the Technical Reports that underpin the guidelines.

Multi-method approach

In developing the guidelines, a multi-method approach was used that involved quantitative and qualitative analysis. The following means of obtaining research data were used:

1. **Archival file analysis**. This involved the auditing and analysis of case reports of a sample of 125 archived sensitive claims files by an appropriate professional employee of ACC.
2. **Literature reviews**. The international literature was reviewed narratively and analysed by means of meta-analysis, a statistical method allowing the quantitative synthesis of findings.

3. **Annotated bibliography**. In order to ensure a full coverage of all written reports and materials by New Zealand researchers, published and unpublished reports, theses, papers, and commentaries of work conducted in New Zealand were gathered. These sources were drawn from as much as possible in the development of the guidelines.
4. **Multidimensional scaling**. These methods were used to map New Zealand practitioner and client attributions regarding the effects of sexual abuse.
5. **Questionnaire survey to practitioners**. A survey of service providers requested information on a range of practices, attitudes, and beliefs, including a professional judgement task.
6. **Focus groups with service providers**. A broad representation of practitioner discipline and length of counselling experience was a feature of the focus groups with service providers that occurred throughout the country. Focus group transcripts were analysed for significant themes and major content using standard methodology for qualitative analyses.
7. **Focus groups with consumers/clients**. These were conducted across Aotearoa New Zealand by team members with experience in counselling clients who have been sexually abused.
8. **Key informant interviews**. Interviews were conducted with individuals who had specialised knowledge of the needs of different groups of clients.
9. **Critical discussion and analysis of findings**. This was undertaken by the broadly skilled research team.
10. **Refinement of principles**. Principles were developed by the research team and refined through systematic feedback from all members of the Advisory Committee.

In preparing the guidelines, an extensive review of national and international literature related to CSA and rape or sexual assault was conducted. Specific reviews were undertaken for child and adolescent survivors of CSA, adult survivors of CSA, and adults who have experienced rape or sexual assault (as a single event, rather than chronic abuse). Literature was obtained from searches on databases which included publications in the areas of counselling, social work, psychology, and psychiatry, including chapters from relevant therapy books and publications. The national literature review resulted in an annotated bibliography of New Zealand literature on sexual abuse. This document was given to all practitioners who participated in focus groups or key informant interviews, and can be downloaded from the websites for ACC at www.acc.co.nz and Massey University at http://whatumanawa.massey.ac.nz. The international literature review resulted in a number of project reports relating to CSA with adult and child populations as well as rape and sexual assault.

The full details regarding the methodology of these studies, the findings, and the conclusions have been documented in a series of project reports written by members of the research team. These are available to download should the reader require a more in-depth review of the research that contributed to the development of these guidelines. A full list of project reports is provided in Appendix 1 of the Practice Guide. Throughout the project, the emphasis has been on developing principles and recommendations that are supported by the research findings, and the origin of the evidence can be found in the various project reports.

The New Zealand Context

It was important to the success of the Rāranga Whatumanawa project that the research team was able to gain the confidence and cooperation of those who contribute to this important domain of practice. A roadshow was undertaken nationwide that involved a series of meetings with practitioners to explain the purpose and goals of the project and respond to questions. Initially, stakeholder groups expressed concern that the development of the guidelines might be designed to restrict practices and create more barriers to service delivery. The research

team has made a genuine effort to avoid such limitations and has incorporated both practitioner and client perspectives into the current guidelines on best practice.

Throughout the work conducted by Rāranga Whatumanawa, the research team has been very cautious regarding objectivity. Experienced practitioners and clients raised some administrative issues in the course of the research that were related to principles of effective practice. These issues were taken into account both as the research was conducted and as the guidelines were developed in accordance with the emerging evidence.

It was important to ensure breadth and inclusiveness in the project, and the research team and Advisory Committee represented all of the disciplines involved in service provision, including medicine (both general practice and psychiatry), social work, psychology, counselling, psychotherapy, and child and family therapy. Clearly evident were the care and passion of the practitioners, whose aims and philosophies of practice were to create the best outcomes for clients. It was encouraging to have committed and passionate therapists participating in the project. The courage of clients in coming forward was also apparent as they recounted their experiences in therapy, and client representation and active participation was of special value. Many clients expressed the motivation to help other clients through the provision of insights for practitioners, and they undertook to do this even though the task of participating in focus groups was a challenging one for them.

The Vision

Kei raro i te korowai tuku iho o tātou mātua tūpuna

Sheltered by the cloak handed down from our ancestors

The name Rāranga Whatumanawa was offered to this project by a kuia from Te Tai Tokerau. The meaning and significance of this name can be understood at a number of levels, although its basic meaning is *weaving the patterns of the heart* and it symbolises the principles, ethics, and values that have gone into this project. The research team feels a strong sense of privilege to be able to address issues of such a sensitive nature as sexual abuse and its mental health implications. Many practitioners and clients willingly came forward to offer their insights and understandings. Māori professionals were also generous with their time and expertise, contributing as partners on the research team and Advisory Committee.

It was widely affirmed by practitioners and clients that New Zealand enjoys a unique situation in which it is possible for those who have experienced sexual abuse to access, if needed, some form of mental health service. Practitioners commented that these services indicated that New Zealand was a forward-thinking society. It was recognised that the opportunities created by publicly-funded specialised counselling were very important. There was a universal feeling of commitment to the enhancement of services and the provision of professional guidance and development that would ensure best practices and maximum benefit for clients. The recommendations of this project will not always match practitioners' ideals, clients' expectations, or ACC's administrative constraints, but by outlining the principles of best practice, suitable accommodations can be facilitated.

It is the hope of the Rāranga Whatumanawa team that these guidelines will (in the spirit of the project's name) be taken to heart by professionals of different disciplines and orientations. They reflect local needs and local knowledge, but will have validity and value only to the extent that practitioners take ownership. As every nuance of different approaches cannot be anticipated, it is hoped that practitioners will incorporate these principles in the inclusive spirit in which they were intended. It is expected that the experience and professional judgement of practitioners will find accommodation within these guidelines, that sound practices will be affirmed and strengthened, and that new priorities and practices will be encouraged.

Principles and Recommendations

Twelve broad principles have been identified, each representing important components or domains of practice. Each principle is presented in a logical order that approximates procedures followed by experienced practitioners.

There are certain pre-conditions to counselling, such as safety considerations, which occur at the same time that a meaningful therapeutic alliance is being developed. Emphasising cultural issues, understanding some of the key likely effects of sexual abuse, and conducting some form of further assessment are common precursors for setting goals and developing a therapeutic plan in conjunction with the client. Throughout the course of therapy, some system for obtaining feedback regarding progress is usually implemented, and this may require consideration of challenges to progress as well as opportunities to enhance the client's gains. It is also necessary to think of the wider context of the client's life circumstances and perhaps anticipate future growth and development through a well-planned strategy for concluding the therapeutic relationship.

These common therapeutic activities may not occur in exactly the sequence presented and often co-occur. It is also possible that different orientations to therapy may emphasise one or two of these activities over others. Some therapists talk about these activities using a slightly different language, terms, and concepts. Despite these variations, the following 12 principles provide a broad framework for organising recommendations for practice.

Principle 1: Safety

Safety is a priority. The safety of the client and relevant others is paramount throughout the therapy process. Different aspects of safety need consideration, including:

(a) risks to self (internal) such as suicidality, self-harm, medical and extended mental health needs;

(b) external risks to self such as substance abuse and unsafe sexual practices;

(c) risks from others, such as further sexual or physical abuse, witnessing domestic violence, and neglect; and

(d) risks to others, including abuse or neglect of children. (See the Safety Decision Tree in Appendix 4.)

When working with children and youth, other potential sources of risk include how the primary caregivers are coping with the child's abuse, whether they are able to provide appropriate support, and whether their information needs and the child's needs are being attended to. Often these needs can be addressed by the therapist in the course of counselling by developing plans that are designed to include caregivers or other family members.

Cultural safety is also an important consideration. Culture includes ethnicity, religion, gender, age, sexual orientation, gender identity, and (dis)ability (see Principle 4: Culture – Identity and Diversity). Differences in culture between the client and the therapist can impact on therapy and require consideration.

A combination of formal and informal assessment can identify safety issues (see Principle 6: Assessment). It is the responsibility of the therapist to ensure that the client and relevant others are safe, and it is essential to access additional appropriate resources when necessary.

The process of assessment and therapy needs to be safe. Various aspects of the therapy process also contribute to a sense of safety for the client and can prevent (or trigger) acute safety issues. An effective therapeutic relationship contributes to a safe counselling process. Some clients identify specific attributes of their therapist that provide a sense of safety, such as an appropriate cultural and gender match, no session interruptions, clear and appropriate boundaries, and containment of emotions, while others express a general sense of safety in their relationship with the counsellor. Safety is also reflected in the therapist's understanding of the amount and type of information the client can cope with, in order to keep the client from being re-traumatised. The way in which the overall therapy process is planned and sessions are structured contributes to client safety. For example, the way in which sessions conclude is important for ensuring that clients leave feeling safe rather than highly distressed, which can lead to acute safety issues such as suicidality, self-harm, and high-risk behaviours as a way of dealing with negative emotion.

The safety of the client and relevant others may change during the course of therapy. Clients may become more vulnerable at certain times during therapy, and they may be at increased risk at those times in terms of their safety or the safety of others. Ongoing monitoring of the safety of the client and relevant others will help the counsellor to anticipate and respond to safety issues as they arise.

Safety: Recommendations

1.1 Consider safety issues during assessment and throughout the process of therapy. Ascertain whether the client is safe from further abuse, including sexual, physical, and emotional abuse. Additional abusive situations for children include circumstances where they are being neglected or witnessing violence. Address these circumstances directly within the therapy context and be clear about the need to involve other people or agencies if necessary to ensure safety.

1.2 Establish whether the client is suicidal or self-harming, which may range from having fleeting thoughts about death, self-harm, or suicide to specific plans and behaviour, and whether suicidality is acute or chronic. Ascertain whether the client is engaging in high-risk behaviour, such as unsafe sexual practices or substance abuse.

1.3 Determine whether the client is a risk to others or is homicidal. This may also range from momentary fears of harming others to actual homicidal thoughts, plans and behaviour. If there are children involved, either as the client or in the care of the client, check whether there are any such risks to them and develop a plan of action and monitoring.

1.4 Check if the client is in need of medical or additional mental health assessment and treatment. The client may have specific medical conditions that need to be addressed (eg, pregnancy or risk of pregnancy, sexually-transmitted infection, urinary tract infection, physical injury) or severe mental health needs (eg, psychosis, severe dissociation, medication needs). Referral to a doctor trained through Doctors for Sexual Abuse Care (DSAC), who is specifically trained in the assessment of people who have been sexually abused, is recommended if available, especially for the assessment and examination of children. Forensic assessment, preferably by a DSAC doctor, should also be undertaken if a formal complaint could be made by the Police.

1.5 Respond to identified safety issues as a matter of priority. The most appropriate response depends on the specific nature of the safety concern (eg, fleeting as opposed to chronic suicidal ideation, or multiple safety issues such as suicidal thoughts and behaviour, substance abuse, and additional mental health needs). In circumstances where the risk is imminent or life-threatening (eg, acute suicidality or homicidality, ongoing abuse, imminent risk to others such as children), make appropriate notifications and arrange the involvement of relevant services (eg, Child, Youth and Family, Police, emergency mental health services).

1.6 Arrange supervision and consult with colleagues at appropriate times. Be familiar with any policies and procedures of the specific work setting in relation to safety issues, as well as how to access other appropriate services such as emergency mental health services and general practitioners.

1.7 Establish the cultural safety of the therapy. When working with a person from another culture, consider whether you are the appropriate therapist to work with this client and check this with the client. Avoid assumptions about what is best for the client. Obtain the client's consent to consult about issues that you are unsure of or need to learn about and consider the need for cultural supervision.

1.8 Recognise that cultural safety, or feeling culturally unsafe, may be an issue raised by the client. This may be in reference to the therapeutic relationship, or may refer to the client's perceptions of their interactions with other individuals and agencies during the therapeutic process. Cultural considerations are more fully discussed in Principle 4: Culture – Identity and Diversity.

1.9 Ensure that the process of therapy is as safe as possible and ask the client what they need to feel safe. If they are unsure, ask them what they found helpful and less helpful in terms of the process of the session. Make sure that the client is comfortable with the amount and type of information covered in sessions, and that they leave the session feeling safe.

1.10 Monitor safety throughout the therapy process, from the time of initial contact to the last session with the client. Be alert to particular times during therapy when the client or relevant others may be more at risk, such as at the start of counselling, when recalling details of the sexual abuse, where disclosure is imminent or has recently been made, or towards the end of therapy.

Principle 2: Client Focus

Individual tailoring of therapy is important. Therapy that is focused on the specific needs of the client can be developed from the assessment and the resulting framework that provides an understanding of the client's situation. Clients find it helpful when therapy is tailored or matched to their specific situation, and there is no "one rule for all" when it comes to what works best for people who have been sexually abused. A case formulation or targeted multi-method approach (see Principle 6: Assessment) fosters a supportive and collaborative relationship that validates the uniqueness of each client and demonstrates special consideration for the client's particular circumstances and responses. (See the Therapy Decision Trees in Appendices 5 and 6.)

The most appropriate therapy approach for each client depends on a number of factors. These include the client's age, culture, type of sexual abuse, and the frequency and severity of abuse. Trends in the therapy outcome research can be identified, although they do not account for the complexity of sexual abuse. For example, in therapy with adults, individually-based therapies have been found to be more effective than group therapy approaches. Adults tend to benefit most from therapy that has some level of structure, is time-limited (fewer than 30 sessions), and incorporates some type of instruction or direction from the therapist. Children and adolescents tend to respond best when therapy is flexible, less intense and, as appropriate, involves multiple environments and systems, including family. Generally, the majority of clients with routine presentations of mental injuries arising from sexual abuse/assault benefit more from short-term, time-limited therapy. However, with confirmed complex presentations the duration of therapy will be determined by the level of complexity, reaction to therapy, etc.

However, it is impossible to conclude that these trends will always result in better outcomes, given the complexity of sexual abuse. Furthermore, current analytic techniques make it impossible to consider multiple factors at once. For example, although adults tend to benefit more from individual therapy, some may still benefit from group therapy because of individual factors such as a need for interpersonal connection. The research suggests that group therapy is more helpful when it follows, or is concurrent with, individual therapy. Therapeutic techniques must also be selected on the basis of the practitioner's competence and training within different therapeutic modalities (see Principle 10: Opportunities and Challenges).

Focused versus broadened therapy. Therapy that is focused on dealing with particular sexual abuse-related problems is helpful for some clients, but for others a broader holistic approach is needed. Factors that inform a decision on the value of a broad approach are derived from the assessment and framework for understanding the particular client, such as the frequency and severity of abuse, concurrent mental health problems, and culture.

An exclusive and continual focus on the past is less helpful than a focus on current and future functioning. Case formulations balance the need to understand the past as it affects the present, and they provide strategies to assist current functioning, while planning and moving towards a positive future. Clients consistently reported responding best to being given specific tasks and activities that addressed current difficulties and specific issues.

Clients with highly complex therapy needs are likely to benefit from early identification and multidisciplinary rehabilitation. In particular, early recognition of mental health issues will help to ensure that the person receives multidisciplinary rehabilitation. Other factors that indicate complex therapy needs include developmental stage and involvement with multiple agencies.

Clients need to know their rights. It is important for clients to be aware of their rights, including the right to be treated with dignity and respect, to be treated fairly and have their views considered, to have their culture, values and beliefs respected, to have a support person(s), to effective communication, to be fully informed, to have privacy respected, and to make a complaint. Clients need to be clearly informed about and consent to the therapy that they are undertaking.

Client Focus: Recommendations

2.1 Adapt the therapy approach to the individual client according to the specific requirements identified from careful assessment, including their needs as a person in a particular cultural context. A case formulation or targeted multi-method approach (see Principle 6: Assessment) is often most useful when working with clients who have experienced sexual abuse, given their diverse circumstances and experiences.

2.2 In therapy with adults, aim to incorporate some level of structure and direction into counselling. The duration of therapy will depend on the complexity of the client's range of effects. This approach may also be appropriate for older adolescents.

2.3 Therapy with children and younger adolescents needs to be more flexible or semi-structured. Where appropriate, also include family or caregivers in counselling with children and young people, and incorporate multiple environments and systems into the therapy approach (eg, it may be necessary to liaise with the child's teacher and other professionals to ensure that services are coordinated and the child's needs are being met). There may be a need to assist family and caregivers to access therapy for themselves.

2.4 On the basis of the assessment of the client (see Principle 6: Assessment), determine whether the client needs a focused approach to therapy as opposed to one that is more broad and general. Talk with the client about the approach that is recommended on the basis of the assessment, and make sure that the client's cultural context is considered in making this recommendation.

2.5 Identify clients who have complex therapy needs early on in the process of assessment, so that the most appropriate assistance can be provided. Complex therapy needs include severe mental health issues, deep disturbances in relationships with self and others, difficulties tolerating and managing emotion, substance abuse, learning difficulties, and legal proceedings. For children, this may include involvement in custody disputes, or forensic and statutory child protection processes with agencies such as the Police and Child, Youth and Family. In such cases, ensure the client receives additional specialist involvement from the appropriate services and liaise as needed.

2.6 Ascertain that the client has sufficient resources to cope with therapy, such as their ability to regulate emotion, tolerate distress, access social support, and seek assistance when required. Where internal resources are insufficient for the client to cope with therapy, skill development such as grounding, appropriate self-soothing, emotional regulation, effective communication, relationship skills, or problem-solving skills needs to be undertaken before more abuse- and trauma-targeted therapies are considered.

2.7 Respect well-established coping mechanisms (eg, dissociation, intellectualising, avoiding painful emotion) that the client has developed, and accept their continuation until alternative coping mechanisms are established.

2.8 Provide the client with appropriate control over the process of therapy. Inform them of what to expect from counselling. Ensure that they feel ready to start counselling and that they continue to feel comfortable during the course of therapy.

2.9 Inform the client of their rights at the beginning of therapy. These include the right to request a new counsellor should they wish to do so without having an adverse effect on their claim with ACC. They should also be made aware of their right to lodge formal complaints with the Health and Disability Commissioner (www.hdc.org.nz) and to discuss any ethical concerns with their case manager, counsellor, or counsellor's employer.

Principle 3: Therapeutic Relationship

The therapeutic relationship is one of the foundations upon which the success of therapy rests. The building and maintenance of a safe therapeutic relationship are essential for positive outcomes, although they should occur alongside ongoing assessment and therapy. This was a strong finding arising from both the international literature and the New Zealand-based research. An effective therapeutic relationship is developed when the practitioner demonstrates a range of attributes that are important, regardless of the model of therapy, specific techniques, or theoretical orientation. These include trustworthiness, assurances of safety (including cultural safety), a non-judgemental, common sense, "unshockable" attitude, mutual respect, and a belief in the client's ability to progress and improve.

Although a sound therapeutic relationship is key to positive change, it is not sufficient alone to initiate and sustain constructive change for clients. It is one of three elements of the therapeutic alliance, along with establishing agreed goals, as well as collaboration on the process and tasks of counselling. Therapy should be based on a comprehensive understanding of the individual client's needs, and targeted to address those needs efficiently in a carefully prioritised manner.

The quality of the therapeutic environment will influence the outcome of therapy. The therapeutic environment is an important context within which the development of an effective relationship occurs. It includes the physical setting in which the therapy takes place, as well as the qualities of the client, therapist, and agency (if applicable) where the counselling occurs. The therapeutic relationship should be evaluated in a cultural context. Cultural preferences may be pivotal in developing a positive therapeutic relationship.

The therapeutic relationship must strike an appropriate balance between personal boundaries and engagement. While a high level of connectedness is crucial to effectiveness, a relationship where the client and therapist become overly reliant on the relationship may have a detrimental influence on the outcome for the client. However, it is also important to acknowledge the developmental needs of the adult client, which may mean the client being dependent on the therapist as a transitional attachment figure for a period of time. During this time when client dependence may be necessary, it is the responsibility of the therapist to maintain boundaries so that therapy can be experienced safely by the client. It is this experience that allows the client to contrast a safe therapeutic relationship with earlier abusive experiences and enables re-learning to occur. Nevertheless, the therapy will always work towards facilitating the empowerment of the client, with less dependency on the therapist over the course of therapy. A parallel outcome of the therapeutic relationship should be the ability of the client to develop a range of healthy and supportive relationships with others in their family/whānau, or community setting.

Therapeutic Relationship: Recommendations

3.1 Consider the following attributes of effective relationships regularly throughout the course of counselling:

- Trust
- Empathy (includes allowing the client to see that their therapist is moved by the details of their story)
- Hope

- Humour
- Honesty
- Openness and being open to challenge
- Being non-judgemental and believing the client
- Demonstrating understanding and acceptance of the client's worldview
- Using language appropriate to the client and avoiding jargon
- Developing mutual respect
- Appearing "unshockable" (although acknowledging the facts are distressing, the therapist demonstrates an ability to tolerate hearing about them)
- Being responsive to the client in each session and being willing to deviate from planned content.

3.2 Attend to the quality of the therapeutic environment, which includes the physical location in which therapy takes place as well as the agency (if applicable) in which the therapy occurs. The aspects of the environment that may be important are that it feels safe, warm, welcoming, inviting, comfortable, private, accessible, homely, and non-intrusive.

3.3 Making connections and acknowledgement of whānau are important aspects of commencing therapy with Māori clients. Acknowledge the client's whānau and hapū by the process of whanaungatanga. Some consider it appropriate to include the presence of a relative in therapy. It may also be appropriate for the therapist to disclose their own origins and cultural affiliations. It is important to have an understanding of tikanga Māori. Prepare in advance of first seeing the client to be respectful of the client's origin and name, using appropriate pronunciation. Anticipate the need to act sensitively with respect to the client's beliefs and practices.

3.4 With children, develop a warm and nurturing presence that cultivates trust, as this will enhance outcomes. Consider developmentally appropriate interventions, plan interesting and engaging materials, and use appropriate humour, play, and fun where appropriate.

3.5 Time and pace therapy according to the child's and parents' resources to cope, and the meaningful social supports available in the child's life. Consider the young person's internal and external resources, for example developing coping skills, building on strengths, developing mastery, and fostering success. Recognise that this is most likely to occur when therapy is supported by the caregiving adults in the child's life, within a physically safe and emotionally secure environment.

Principle 4: Culture – Identity and Diversity

New Zealand has a unique and dynamic culture. Culture is defined as the ideas, preferences, symbolism, values, and beliefs shared by a group of people. While British culture still predominates, the culture of Aotearoa New Zealand is slowly changing to a fusion of Māori, Polynesian, and European cultures influenced by many subcultures that make up contemporary New Zealand society. Most research undertaken in the area of sexual abuse comprises participants who are white female adults. With limited amounts of formal data gathered in New Zealand, the application of these studies must be tempered by sound knowledge of the diverse cultural values and expectations in this country.

The cultural ideology of European or Pakeha New Zealanders tends to be influenced by Westernised notions of individualism. This includes values of self-discipline, self-sufficiency, individual accountability, and autonomy. Individualism promotes the view that both problems and solutions reside within individuals, in contrast to groups or societies valuing a collectivist philosophy of life that emphasises cooperation and closeness between people and groups.

Culture impacts on therapy. Cultural groups include clients of differing ethnicity, religion, gender, age, sexual orientation, (dis)ability, and gender identity. A lack of knowledge and respect for differing cultural ideologies, systems of belief, social customs, and ways of being can lead to misunderstandings between the therapist and client and an undermining of the therapeutic relationship. Accordingly, practitioners need to be aware of cultural aspects and how they might influence the presentation and discussion of sexual abuse and the development of therapy approaches.

Where possible and favoured by the client, a therapist and client match is preferable, whether this be ethnic, religious, gender, or otherwise. Mismatches of cultural ideologies, systems of belief and social customs may undermine the relationship and understanding between therapist and client. At the same time, a therapist who is open and sensitive to different worldviews can be acceptable and effective.

The practitioner needs to have a good understanding of their own culture as well as the culture of their client and how it might impact on the expression and articulation of the effects of sexual abuse and progress in therapy. When working with a client whose culture is different from one's own and where understanding of that culture is limited, it is important that the therapist recognise their limits of competence. Where possible, the client may be referred to a therapist who has the requisite expertise. When this option is not viable, cultural supervision or consultation may be useful. At the very least, it is important for therapists to educate themselves about the cultural and social requirements of their client, by both professional development activities (reading, attending workshops) and responding respectfully and carefully to the client's expressed preferences.

Culture – Identity and Diversity: Recommendations

4.1 Recognise the limits of competence when working with a client whose culture is different from one's own, and where understanding of that culture is limited. Consider referring the client to a therapist who has the requisite expertise if there is not sufficient knowledge of relevant cultural aspects. When this option is not viable, obtain close cultural supervision.

4.2 Become educated about the cultural and social requirements of the client. This can be done by asking the client, professional development activities such as reading and attending workshops, and cultural

supervision. Take appropriate steps to manage any communication difficulties arising from a disability or limited English proficiency.

4.3 Respond respectfully to the client's expressed preferences and be accommodating of particular cultural beliefs. Where necessary, adapt practice. However, the overarching feature of good practice ensures a therapeutic culture of safety, respect, and acceptance.

4.4 Use the language appropriate to the cultural identity of the client to talk about what has happened, using the following recommendations:

- Accommodate the differing ways people have of expressing themselves. While being congruent, the therapist attempts to talk in a way that blends with the client's ways of communicating
- Clients from a different ethnic group from the therapist often appreciate a therapist who will, for example, greet them and incorporate appropriate phrases or terminology in their language. Such efforts can help strengthen the therapeutic relationship
- If the client speaks another language, arrange for a translator or refer the client to an appropriate counsellor.

4.5 Each client is unique, and assumptions cannot be made that Māori models of therapy are appropriate or desirable for all Māori clients, noting too that there are tribal preferences that may need to be accommodated. However, the following practices are generally recommended:

- As a therapist, talk about one's own origins and cultural affiliations
- Where appropriate, refer to any shared experiences with the client
- Where appropriate for the client, support the use of karakia (prayer)
- Where appropriate, embrace the wairua (spiritual aspect) in therapy.

4.6 While there is no one model of practice that is appropriate for all Pacific groups, recognise (in addition to the concepts already mentioned) that the church, Christianity, and spirituality are strong elements of the family as the central unit and the community. Be prepared to visit families in their own homes where appropriate.

4.7 Invite clients who might be immigrants to talk about their immigration background, such as whether they are recent immigrants and what life changes they have experienced in coming to New Zealand. Ask them to explain the particular cultural values they consider to be important, especially if, as is common in Asian culture, an individual's honour and shame are a reflection on the entire family group.

4.8 When working with a client with an intellectual disability, communicate trust in the client's story (taking care to not communicate disbelief), explore the client's understanding and knowledge of appropriate sexual behaviour, and be sensitive to the possibility of diagnostic masking, in which challenging behaviours are attributed to intellectual disability rather than revealing undiagnosed mental health problems.

4.9 Adopt a non-judgemental and respectful attitude towards those whose sexual orientation and/or gender identity might be different, as respect should be emphasised as a vital ingredient to therapy with clients who are gay, lesbian, bisexual, or transgendered (for whom there is a high incidence of CSA although no causal relationship should be assumed).

4.10 Develop a sound understanding of the issues commonly reported by men who have been sexually abused, which include:

- Concerns about sexuality

- Shame associated with being a “victim” and feeling “less of a man”
- Shame about normal male physiological responses to genital touching
- Not being taken seriously when the perpetrator was a woman.

4.11 For men who have become abusers, first address the issue of the client abusing, owing to the priority of the duty to protect potential victims, and by implication, the future safety of the client himself.

4.12 Recognise that older clients who have experienced CSA may not conceptualise the experience as abuse, may be reticent, secretive, or accepting, carrying the shame and blame of being a victim, and may never have spoken of the abuse before. This may also relate to the meanings that they give their marriage vows, which may have been made at a time when it was legal for rape to occur within the context of marriage.

Principle 5: Effects

Sexual abuse always affects the person abused in some way. The literature has suggested an increased prevalence of a wide array of effects for children, adolescents, and adults who report sexual abuse. The life course following CSA can encompass effects that can be continuous, solitary, and/or a combination of outcomes. Children and adults can also experience temporary, discontinuous, or "sleeper" effects that remain undetected but emerge at key times in their lives, or in new situations.

However, severe long-term effects following sexual abuse are not inevitable. Most studies on the impact of sexual abuse have described a group of victims with few or no negative consequences.

Coping strategies and effects serve a function. The close interplay between coping and effects is one way to describe a person's current functioning. Effects and coping need to be viewed as interacting, in order to replace possibly maladaptive coping strategies with helpful, constructive ones. Some coping strategies, such as avoidance, are of short-term benefit for the client. For some clients, additional coping strategies are needed to provide long-term relief, and some coping strategies might prove to be less effective over time as the client's circumstances and developmental stages change.

Effects will differ for each individual depending on a variety of factors. Variations may be due to type of abuse (eg, sexual assault or CSA), relationship to the perpetrator, nature of force used, age at onset and frequency and chronicity of abuse, as well as non-abuse-related variables such as social and family support, relationships, resiliency, and experience of disclosure (see also Principle 11: Context). In addition to this, the effects of sexual abuse are best considered in light of developmental variables such as the developmental stage when the abuse occurred and at the time of therapy.

Effects may be expressed in a cultural context. Clients may describe effects that are consistent with their values and worldviews, and may refer to tapu, tikanga, whakapapa, and identity issues.

Sexual abuse is a complex life experience, not a diagnosis or disorder. It is not helpful to view sexual abuse as a single homogenous traumatic event that leads to a discrete disorder or pattern of trauma symptoms. The nature and impact of sexual abuse vary according to several dimensions, levels, stages of development, contexts, and time. Those who have experienced sexual abuse can display a variety of effects at any point in time, emphasising the need for dynamic assessment.

For a child, sexual abuse may manifest differently depending on the age at the time the abuse occurred, the degree of severity and length of time the abuse persisted, developmental stage, and reactions of adults in the child's environment. Knowledge about these factors is essential when developing therapy approaches for children.

Effects: Recommendations

5.1 Determine the client's current functioning by attending to the following issues:

- Age and developmental stage
- Nature of abuse (type, frequency, intensity, and chronicity)
- Relationship to perpetrator and number of perpetrators
- Response to disclosure

- Life stressors prior and subsequent to the abuse (such as family dysfunction or other types or incidences of abuse)
- Presenting problems
- Resilience and support networks
- Use of current coping strategies.

5.2 Be mindful about culture- and language-specific concepts as expressed by clients, since these shape the client's attributions of the link between sexual abuse and current functioning.

5.3 Understand how individuals differ in their expression of the effects of sexual abuse. Effects are different for each individual and are influenced by a range of variables. Do not assume that an individual will experience severe and long-term effects as a result of sexual abuse. Do not assume that an individual will experience simple and short-term effects as a result of a single event in adulthood, as degree of victimisation is determined by a number of factors, including prior experiences of victimisation.

5.4 Work collaboratively with clients to identify the nature of sexual abuse effects and their coping responses to these effects.

5.5 Develop helpful coping responses alongside dismantling old harmful strategies.

5.6 Continually monitor changes in effects and coping responses.

5.7 Be aware of how effects can change across the lifecycle. Situations triggering effect changes include puberty, the onset of the first or a new intimate relationship, pregnancy, childbirth, divorce, loss, and abuse reminders (eg, when a child is a similar age to when abuse occurred).

5.8 Seek to understand protective factors and strengthen the client's resilience.

5.9 It is recommended that practitioners provide education about natural physiological responses in the context of touch. When working with male clients, it may also be important to address issues surrounding male-to-male sexual contact (depending on the gender of the perpetrator) and common social attitudes regarding males and sexual abuse.

5.10 In cases of drug-assisted sexual assault, all preventative interventions for pregnancy and sexually-transmitted infection screening should be covered.

Principle 6: Assessment

Assessment is an essential process for understanding the client and formulating a therapy approach. The purpose of assessment is to develop a conceptualisation of the client's needs and to understand individuals in the context of their lives, including intimate relationships, family, school or work settings, community, and group identity (see also Principle 11: Context). The assessment process needs to be clear, reliable, and able to be used as a marker of change and as an indicator that therapeutic goals are being met. (See the Assessment Quick Reference in Appendix 7.)

Assessment should use a variety of approaches and sources. An approach that balances informal methods (such as careful observation, and astute listening to client discourse) with formal assessment methods (such as psychometric measures) is preferred. Informal assessment occurs in the course of verbal interactions, observations, or interviews, while formal assessment tools are those such as checklists and self-rating questionnaires. Both strategies are able to track progress across time. Exclusive reliance on either informal or formal approaches is unsafe. A variety of sources in the case of adolescents and adults may mean interviews with the client and significant others (assuming consent), observations, and formal self-report. With children, information can be obtained from the child, parent(s) and/or caregivers, teachers, and other involved professionals. Practitioners need to be aware of the varying degrees of reliability of information derived from others. Accuracy will depend on the informant's relationship to or knowledge of the child's life, memory limitations, and overall positive or negative perceptions of the child.

Assessment is an ongoing process. Practitioners continually observe, reflect, listen and, when appropriate, ask. This communicates a sense of space for the client to tell their story, coupled with pacing and guidance offered by the therapist. The interaction, emotion, experiences, and content of conversation contribute valuable information about the client. Ongoing assessment is commensurate with reflective practice and encourages the therapist to be open to new insights and understanding of the client.

Assessment accounts for lifespan development. Assessment needs to take into account the age, stage, and developmental level of the child or adolescent. Understandings of significant life stages are also important when undertaking assessment with adults. For instance, effects may emerge at particular times, such as during the development of a new relationship. Assessment approaches are tailored to the individual client. For example, standard interviewing and self-report procedures must be significantly adapted when assessing children and adults with intellectual disabilities.

Formal assessment requires adherence to additional professional standards. While all forms of assessment require concern for accuracy, the use of certain psychometric measures requires additional considerations such as prior training in test use, ensuring the current version of the test is being used, being aware of the possible cultural bias in tests, the availability of New Zealand norms, and respect for copyright.

Assessment: Recommendations

6.1 Undertake assessment routinely with clients and make assessment an ongoing component of the professional interaction with clients.

6.2 Use assessment to guide therapy and as a marker of change for the client and practitioner.

6.3 Obtain from the interviewing process (usually over a number of occasions) information on the following domains:

- Safety
- Purpose of the referral
- History of trauma and abuse
- History of loss and major life events
- Perception of the effects of abuse, including overall wellness, cultural, educational, and financial considerations
- Insight into life events
- Thoughts, feelings, and behaviours that together suggest specific syndromes of mental disorder
- Coping, strengths, and protective factors
- Pre-abuse functioning
- Developmental and family history
- Attachment and trust
- Physical health
- Current context of the client and their relationships with family and whānau, social supports, their community (peers, school, and work), and the involvement of other agencies
- Education and/or occupation
- Information on caregivers and upbringing, for example parental history of trauma and abuse
- Family of origin
- Relationship problems, including sexual and marital concerns
- Substance use/abuse and other possibly defensive strategies
- Legal involvement.

6.4 Ensure that the information gathered is clear, reliable, accurate, and relevant. Through training, obtain or maintain skills in collecting information.

6.5 When providing an explicit psychiatric diagnosis that has not been ascribed by a psychiatrist or clinical psychologist, the practitioner needs to affirm that they have the relevant training and/or qualifications to make this assessment, and that the diagnosis given meets the criteria for the problem provided in the diagnostic system used.

6.6 Supervision from senior professionals and/or cultural advisors is a recommended source of guidance for carrying out assessments.

6.7 Consider the client's culture and worldview when choosing assessment methods. Tailor assessment approaches to each client.

6.8 Pay close attention to the interview process and ensure it is comfortable for the client. Involve process techniques such as pacing, timing, and rapport-building, coupled with reliable information-gathering. Reflect, listen, and ask open-ended questions. Be mindful of the interactions, emotion, experiences, and content of the process of assessment, which can contribute valuable information about the client.

6.9 Complement informal assessment procedures, such as verbal interactions and observations, with formal assessment tools such as structured interviews or checklists that are able to track change and progress across time.

6.10 Select formal measures on the basis of their known psychometric properties, relevance to the client's needs, sensitivity to change, ability to be used as feedback, and professional training and experience.

6.11 Gather information from a variety of sources. Obtain information about children and adolescents from observations, checklists, corollary documents or reports, and interviews with the client, parent(s) and/or caregiver(s), teachers, and other practitioners and professionals involved with the child, while being aware of the limits of confidentiality.

6.12 Involve more than one location or setting when carrying out an assessment, remembering that people act in different ways in different contexts. With children, this may involve gathering information from significant others who have observed the child in different environments. With adults, this could include record-keeping tasks such as daily diaries or charts.

6.13 When assessing children or young people, always take into account the developmental level of the client. Use age-appropriate play sessions or interviews to gather information and observe behaviour. Conduct interviews with safe and relevant family members and other extra-familial sources to gather information that the child is unable to provide directly. With consent, talk with other informants such as teachers, social workers, day-care workers, and former therapists. Take into consideration other processes in which the child and family may be involved that could affect assessment and therapy outcomes, such as forensic, statutory, or court involvement.

6.14 With children and adolescents, it is useful to observe the client within the therapeutic setting. Observations should evaluate the child's communication, understanding and management of emotions, relationship to others (eg, informally before and after sessions, or in joint sessions with the parent(s) and/or significant others), and problem-solving ability. Observations can include interactions, task completion, drawings, sand trays, sculpture, and play, however caution should be exercised when drawing inferences from symbolic or imaginative activities. It may be appropriate to carry out observations of children at home or school to provide additional assessment information and meet therapeutic goals.

6.15 With adults, observe and monitor the interpersonal interactions and dynamics during the session, such as how the client relates to the therapist, their ability to discuss psychologically meaningful topics, and their emotional state.

6.16 Therapists are advised to observe and reflect on their own emotions, behaviours, and thoughts as part of the assessment process. To provide further clarity on this process, it is helpful for therapists to reflect on their own responses with their supervisor.

Principle 7: Goals

Collaborative goal-setting is an essential component of effective therapy. Goals should be collaboratively developed and prioritised according to what is important to clients.

Client-focused approaches are important for good outcomes. Clients should be equally involved in determining which effects are most problematic (eg, safety issues or effects that most interfere in daily living) and developing strategies to reduce these effects and improve quality of life. This means the therapeutic approach should be transparent, acceptable, and well understood by the client.

Some goals are short term in nature and represent a step in the counselling process in which it may be necessary to work on one issue in order to make a long-term, more meaningful goal more likely to be achieved. Short-term goals are a means to an end. As they are developed according to a plan, the rationale can be explained to clients in such a way that their purpose is clear. Goals such as re-establishing cultural connectedness are a means to an end.

It is always possible to represent goals in a positive form. For example, the goal of reducing social anxiety might be expressed as gaining confidence. A focus on the development of positive skills and competencies is more affirming for clients than a focus on reducing negative attributes. At the same time, a positive goal might not be to reduce negative affect but to reduce the struggle to control it. Accepting, tolerating, accommodating, and redirecting negative feelings are increasingly recognised by practitioners as legitimate therapeutic goals.

Emphasise realistic goals. It can be counterproductive to develop long-term therapy goals that are overly optimistic or grandiose. This can place clients under pressure in therapy and can put them at risk of not experiencing success if the goals are not achieved. Goals need to be relevant and valuable, while also being attainable. It is better to set small goals that are later reviewed and revised, than to set goals that are never achieved.

With families, certain educational goals are implicit. It is implicit that, when working with families, counsellors should listen to concerns being expressed by parents or other family members and be able to address them using sound educational information. For example, parents (non-perpetrators) may express fears about their child's future and the impact of the abuse on their sexual development and gender identity. A goal would be to discuss these concerns and reaffirm the value and impact of ongoing good parenting. Another implicit goal that may require reassurance for parents is to assist parents to re-establish boundaries for their child's behaviour.

Goals: Recommendations

7.1 Establish goals collaboratively early in the counselling process, encouraging modest, small goals initially, and review and re-evaluate them with the client on a regular basis.

7.2 Decide on and prioritise goals according to what is important to clients, even if they appear immediate or limited in scope.

7.3 With Māori clients, reconnection with personal and cultural identity may be particularly relevant, as well as re-establishing connection with whānau. Whakapapa and whānau, however, have been described as a double-edged sword. Whānau involvement provides togetherness but can also lead to concerns about confidentiality, and, in some cases, can be an unhelpful and unsafe environment for someone who has been sexually abused. For this reason, re-establishing connections is a delicate process that should be undertaken only when conditions related to appropriate timing, client readiness, expertise, and physical

and cultural safety are satisfied. These caveats apply to all families, regardless of cultural group, in which there may be a history of lack of protection of the child or there is the possibility of ongoing contact with the perpetrator.

7.4 With Pasifika clients, issues the client might bring to therapy include forgiveness (of the perpetrator) and strengthening cultural identity.

7.5 With child clients, strengthen family connections to enhance their ability to protect and take care of the child. However, note that the important caveats specified in 7.3 also applies here.

7.6 With child and adolescent clients, plan short-term goals and anticipate longer-term goals. As adolescents often come to therapy briefly, it is advisable to set short-term goals with a view to anticipating that they will return some time in the future. Ensuring that the adolescent's encounter with a therapist is productive, non-threatening, and involves psycho-educational approaches is a valuable strategy for increasing the likelihood of therapeutic engagement.

7.7 Express goals in a positive form, emphasising new competencies and a greater acceptance of feelings, and encouraging new learning and accurate predictions regarding future outcomes.

7.8 With children and adolescents especially, emphasise building on strengths, mastery, and success.

Principle 8: Rationale and Process

Explaining the process and rationale of therapy is essential. Preparing clients for therapy and providing them with information about what to expect reflect the ethical principle of informed consent and can help clients engage in counselling and increase their sense of safety.

Clients benefit from shared information. Providing the client with information about sexual abuse and its consequences can help them understand their own reactions both historically and in the present. Sharing and checking with the client the framework for understanding their particular difficulties assist the client to understand their situation and gain a sense of collaboration in the counselling process. Information shared can relate to the therapist's belief in the client's progress. Information on progress can be expressed at most therapeutic stages and is a continuous and vital component of therapy.

Children and adolescents need to be aware of the rationale of therapy and the boundaries regarding confidentiality and privacy. Practitioners need to encourage the sharing of appropriate information with caregivers.

Pacing and timing of therapy should be in accordance with the needs and ability of the client and balanced according to collaborative and prioritised goals. Pacing and timing are particularly important aspects for Māori and Pasifika people. The ability of a therapist to hear and understand clients with an unconditional, positive view leads to enhanced therapeutic relationships, better understanding of the client and their needs, and the identification and prioritisation of therapeutic goals.

Rationale and Process: Recommendations

8.1 Prepare the client for therapy and provide them with information about what to expect, as this assists the client to engage in counselling and understand their own reactions.

8.2 At all times remain mindful of the pacing and timing of the therapy process and consider this in accordance with the needs and ability of the client and their goals. The pace of therapy is best managed in collaboration with the client, although it must also be balanced with making sure that it is not promoting client avoidance. Consistency of appointments is also useful.

8.3 Develop strategies that are transparent, acceptable, and well understood by the client. Ensure that the rationale for any proposed therapeutic approach is explained to the client and accepted by them. Check that the client is in agreement with the proposed strategies or therapeutic tasks.

8.4 In deciding approaches with a particular client, both initially and when a change of approach is indicated, give priority consideration to those approaches in the literature for which effectiveness has been demonstrated for specific issues. Practitioners are responsible for not letting the situation continue when progress is not being made.

8.5 Where necessary, provide the client with skills or tactics for self-soothing early in counselling, prior to significant trauma-processing work. Also, focus on strengths, build capabilities, and convey belief in the experience of the client as well as faith in their ability to make progress.

8.6 Exercise extreme caution with respect to techniques that may generate traumatic content outside the counselling setting, and any technique for which the therapist or client lacks resources or which is outside the therapist's training or scope of practice.

8.7 In work with children and adolescents, it is recommended to:

- Pay particular attention to explaining the principles of confidentiality and privacy, while encouraging the client to share appropriate information. The level and importance of confidentiality in the therapy relationship should be developmentally based
- Highlight for adolescents the importance of honesty and openness by both parties
- Explain clearly the purpose of counselling and the rationale for each approach
- Be aware of any avoidance by the client of particular topics, emotions, thoughts, or images, but at the same time be very cautious about excessive probing for assumed avoidance
- Take the developmental level of the client into account
- Make efforts to normalise the client's feelings
- Consider the young person's attention span. Brief topics complemented by the use of multi-modal approaches such as play and other sensory techniques involving visual and tactile strategies, may be useful
- Maintain consistency in session structure, making the experience of counselling safe and predictable
- Respect boundaries of children, adolescents, and the practitioner. For example, the choice to divulge particular information remains with the client
- Monitor and regulate one's own responses to the client. This can shed light on what the client may be feeling or how others may respond to them.

Principle 9: Monitor and Feedback

Monitoring is a dynamic, collaborative feedback process. Monitoring is undertaken collaboratively with clients and guided by formal and informal measures as well as peer supervision.

Monitoring can guide direction. Where progress is not occurring, ongoing assessment, re-conceptualisation, peer supervision, and trying different approaches may help.

Monitoring needs to be regular. To ensure the best outcome, therapists strive to monitor progress regularly with their clients according to the goals they have set, such as enhanced positive mood and optimism (eg, reduction in symptoms of depression) or improvement in important interpersonal relationships (eg, changes in coping behaviour) and other reliable measures of change (eg, observed behaviour, checklists).

It is crucial that the level of client risk to self and others is monitored throughout therapy. Practitioners are aware of the limitations of their practice and, where appropriate, consult with and refer to relevant professionals in accordance with the needs of the client.

Therapeutic services need to be judged in terms of the extent to which they are benefiting the client.

Feedback to clients based on monitoring is a useful process that enables clients and therapists to reflect and evaluate progress. Practitioners should use evidence of progress to encourage and motivate clients. Verification from clients about progress also validates or challenges practice.

Progress is consistently checked against goals that have been set and against other formal or informal forms of evaluation. Monitoring includes direct feedback from the client, observation, how the client behaves during and out of therapy, goal attainment, changes in coping, and reduction in symptoms.

Monitor and Feedback: Recommendations

Monitor

9.1 Monitor the client's progress and risk to self and others throughout therapy.

9.2 Evaluation of outcome should consistently and accurately reflect the overall status of the client. Practitioners are encouraged to monitor client progress regularly during therapy using reliable indicators of change.

9.3 Consistently check progress against goals that have been set and organised collaboratively between the client and practitioner.

9.4 Use combinations of monitoring approaches as indicators of progress, such as formal and informal monitoring. Formal monitoring of the client's status occurs at different stages of therapy, but especially when therapy is nearing completion or during any follow-up sessions. Informal monitoring of progress during the course of therapy is typically carried out by the therapist to gauge the progress made by the client.

9.5 Use different levels of change when judging the success of outcomes, such as individual and environmental change. Individual change includes the reduction of the negative effects of sexual abuse, improvements in responses to life events, coping, attitudes and perspectives and quality of life, and changes in outcome measures. Change in interaction with the environment can be related to improved family functioning and school functioning, better integration with peers, engaging with life, achievements, going to the marae, attending a social event, and accomplishing goals.

9.6 Therapeutic services need to be judged in terms of the extent to which they are benefiting the client. A positive outcome means no further need for services, at least in the short term.

Feedback

9.7 Provide feedback to the client and make use of evidence of progress to encourage and motivate the client. Provide an honest account of happenings in the client's life and tangible evidence of change.

9.8 Obtain feedback from clients, including children and adolescents. Where possible, allow clients to provide feedback on their therapeutic progress. Verification from clients about progress validates or challenges therapy.

9.9 Gather feedback from significant others where informed consent has been provided by the client (including clients who are children and adolescents). For example, in working with children, practitioners should invite key caregivers and/or family members to provide information about a child's outcome using formal and informal methods. This could include other people involved in the child's life, such as peers, teachers, and other professionals. Caution is needed regarding who should be invited to participate in this way, and ensure the client's rights are not compromised through breach of confidentiality. Note also that, for children, feedback from different sources may vary (eg, a parent or teacher may not be as aware of a child's internal world, compared to their observable behaviour).

9.10 Empower the client through feedback. Use feedback as an opportunity to convey belief about a client's ability to progress.

Principle 10: Opportunities and Challenges

The opportunity to work with people who have been sexually abused is both daunting and uplifting. It is a privilege that cannot be taken lightly. There are responsibilities to provide the most effective professional service, as well as considerable challenges to ensure clients are protected from further harm. This requires highly responsible professional behaviour, a commitment to professional development, and recognition of important ethical standards such as knowing one's limits and managing professional boundaries. The provision of professional services to this group of clients provides opportunities for new learning and understanding as well as challenges to overcome practical difficulties.

Therapy with clients who have been sexually abused requires specialised training and supervised experience. Work with children and adolescents, as well as adults, requires knowledge of developmental principles and family systems. People who have experienced sexual abuse might experience difficulties with current relationships. This requires the therapist to be knowledgeable about couple issues and know when to refer to a counsellor specialising in couples work. Some adult clients experience difficulties in sexual functioning which also requires special expertise.

The principle of evidence-based practice is increasingly accepted internationally with regard to professional practice in counselling, social work, medicine, education, psychology, nursing, and psychotherapy. It is generally preferable to draw skills and knowledge from research and other forms of scholarship, including traditional knowledge, rather than from personal beliefs and intuition alone. However, there are different ways of deciding what constitutes evidence and how it informs practice. Evidence and evidence-based practice are based on clear principles, standards for ensuring objectivity, and openness to new knowledge from various sources. Documenting therapy approaches and gathering information on outcome have the potential to provide a growing evidence base for local models of practice that can be shared and developed. One way to achieve this is for practitioners to work collaboratively with others in their profession and with professionals from other disciplines.

At a personal level, practitioner stress, fatigue, and burn-out can lead to a loss of objectivity in therapy and personal difficulties. Counsellors in New Zealand recognise the importance of consistent supervision and peer supervision, using an educative model, especially when working predominantly with clients having difficulty in managing emotions and close relationships. Flexibility of approach and understanding of the complex effects of sexual abuse can be compromised by stress and by clients with highly complex mental health disorders and self-harming behaviours, which often result in the frequent use of emergency or out-of-hours sessions.

Opportunities and Challenges: Recommendations

10.1 Practise in an ethically and professionally responsible manner, knowing one's limits and effectively managing professional boundaries.

10.2 Engage in formal professional development activities related to the needs of people who have been sexually abused, according to the standards and requirements of one's professional discipline.

10.3 Obtain or refresh training in developmental principles and family systems before engaging in work with children or adolescent clients.

10.4 Draw on the evidence in support of any approach used with clients and be able to explain the approach with reference to documentation in either the New Zealand or international literature. Remember that some sources of evidence, particularly with respect to indigenous knowledge in New Zealand, might be based on well-established traditions.

10.5 Establish collaborative relationships with colleagues and other professional groups in order to access new and innovative principles that are emerging from recent research (where there is an evidence base relevant to New Zealand). Consider documenting therapy approaches and gathering therapy outcome information that can contribute to an evidence base for local practice models. This can be shared with colleagues through peer supervision, publications, or conference presentations.

10.6 The effects of sexual abuse (see Principle 5: Effects) can have a marked impact on different aspects of everyday functioning, such as sexuality, personal relationships and, in the case of children, academic performance at school. Consider such specialty areas as important to therapy. Before doing so, obtain appropriate training or supervision, or refer to a specialist practitioner.

Principle 11: Context

Clients live within a social, physical, and emotional context. Understanding the social, familial, and physical environments of each client is pivotal to ensuring the delivery of effective therapy. As part of sound assessment and the development of an effective therapeutic relationship, practitioners seek to understand the breadth and depth of their client's living situation, relationships, cultural affiliations, belief systems, sexual orientation, gender identity, personality traits, and their unique range of effects which may be attributable to the experience of sexual abuse.

Sexual abuse, especially of children, does not occur in isolation. Even though they are not the perpetrators, parents and other family members may have not exercised due diligence in the care and supervision of the child. This can contribute to emotional contexts such as family guilt and unreasonable blaming of the victim. Managing such contexts is an integral part of the counselling process.

Ethnic and/or cultural identification may influence the effects of sexual abuse experienced by the client, or the ability of the client to disclose abuse. Some ethnic groups are likely to report physical rather than psychological difficulties. Māori, Pasifika, and Asian practitioners report greater difficulty for these groups in disclosing sexual abuse, particularly when it occurs within the family.

Effects can be triggered or can re-emerge with a changed environment. This may include living situation, social or intimate relationships, or a subsequent triggering event (for example, sexual harassment in the workplace).

Developmental stage and lifespan events can intensify or trigger effects of sexual abuse. Lifespan events such as puberty, the first (or any) intimate or sexual relationship, pregnancy and childbirth, or children reaching the age at which the client experienced sexual abuse, can result in intensified effects which necessitate therapeutic assistance. These events may either require a return to counselling or trigger the need for counselling for the first time, as the person's previous coping mechanisms are no longer proving effective. Ongoing assessment ensures changing contexts (including the possibility of increased safety risk) are recognised and taken into consideration by the practitioner. Regular monitoring of the client's context and experience of effects ensures that therapy remains effective and focused.

Assessment and ongoing monitoring of the environmental context of children and adolescents require particular diligence. A change in the behaviour, demeanour, or school performance of children and adolescents may signal a change in their environment and level of safety. Practitioners are aware of their responsibility in noticing and attending to possible indicators that their client's situation may have changed.

Context: Recommendations

11.1 Understand the client in the context of their life. This is an essential component to planning effective therapy, building a sound therapeutic relationship, and maximising the potential for a positive therapeutic outcome.

11.2 Ensure the assessment covers the breadth and depth of information required to situate the client within their unique context. It is recommended that over time an understanding is gained of the client's:

- Living situation
- Cultural and/or ethnic affiliations and associated belief systems
- Relationships

- Systems of belief which influence how they view themselves, others, the world, and the future
- Individual personality traits
- Range of effects which may be related to the experience of sexual abuse, and how they are currently impacting on their life
- Financial situation.

11.3 Be aware of how ethnic and/or cultural identification may influence the client's experience of effects. To do so, it is recommended that the practitioner:

- Seek appropriate cultural supervision if they are unfamiliar with a client's cultural customs and beliefs
- Check with the client to ensure they are comfortable working with the therapist as someone from a different culture (or gender)
- Ask the client to discuss any particular requirements they may have to help them feel culturally safe and respected.

11.4 Attend carefully to any change in reported effects and how they may relate to the client's environment. When new effects emerge, or existing effects appear to worsen, carefully check for the possible reasons for this.

11.5 Understand that the relationship between developmental stage and lifespan events can intensify or trigger effects of sexual abuse. To do this:

- Have knowledge about human development and the particular challenges associated with different stages in the lifespan
- Anticipate the possibility of challenges that may accompany important developmental stages
- Respond to client crises related to life events with reassurance and appropriate information and education.

11.6 Regularly assess changes in the client's environment or context to ensure therapy remains focused and effective.

11.7 Monitor the environmental context of children and adolescents by being alert to:

- Any deterioration in the behaviour of children and adolescents, including withdrawn behaviour or acting out
- Any regression from previously attained developmental milestones
- The possibility that a change of location, school, or caregiver may trigger a crisis for a child or adolescent.

Principle 12: Therapy Completion

Finishing therapy requires collaboration between therapist and client and can be planned for (and further needs anticipated) early in therapy. Relatively short-term, time-limited therapy is more beneficial for clients than therapy that continues for a long period of time. It is therefore necessary for practitioners to plan constructively for the end of therapy, and to begin this process early.

Finishing therapy is not the end of the client's journey. Bringing the therapeutic relationship to a formal conclusion does not necessarily mean that all of the initial expectations have been met and that the client is free of difficulties, challenges, or problems. Many clients and therapists use the metaphor of a journey, and therapy may be the beginning of a new journey or represent a new direction in a life's journey. Either way, it can be considered that the formal conclusion of therapy is not the end of the journey. Instead, it is hoped that therapy will set the client on a new and more productive pathway, and it is helpful to encourage clients to think of finishing therapy in this way. The client will be able to cope, solve problems, and manage emotional needs by making use of the new insights and learning derived from therapy, as well as being able to make good use of natural supports and positive social relationships in their community.

The therapeutic relationship can have emotional significance. Because of disrupted attachment and the lack of trusting and intimate relationships in the past, the close personal relationship between therapist and client may have greater emotional significance for clients who have been sexually abused. These issues need to be addressed openly and collaboratively with the client. However, there are always exceptions and therapists should not anticipate that ending therapy will always result in feelings of loss, anxiety, or abandonment for clients.

Help clients to anticipate and plan for setbacks. The concept of relapse prevention is often useful in planning the end of therapy. In the present context, relapse prevention means allowing clients to experience or anticipate setbacks without these signalling to them some sense of failure, resignation, or hopelessness. It also involves helping clients to recognise situations in which they might be especially vulnerable and developing strategies for avoiding or managing these situations, and encouraging clients to recognise feelings that indicate they may need special support or a return to therapy before a more serious crisis develops. It can be explained that returning to counselling is normal rather than an indication of a major problem.

Therapy Completion: Recommendations

12.1 Plan for the end of therapy early in the process and in conjunction with the client.

12.2 During the course of therapy, check that the client is demonstrating increasing levels of independence, particularly in sources of emotional support and with respect to sustaining relationships with a widening circle.

12.3 Establish an expectation with the client that the period of therapy will accomplish some but not all of the goals identified, and that some of the goals will be accomplished after therapy by the client themselves.

12.4 During the course of therapy, anticipate future probable setbacks and develop strategies that the client can use to deal with them.

12.5 Plan with the client formal times for further contact once therapy has come to an end. Such follow-up contact might be in the form of an individual therapy session and/or telephone or email contact.

Appendix 1: Notes on Terminology

Client/Consumer

These terms are used somewhat interchangeably. The difference between the two is that a person is only a client during the period that a formal service is being accessed, whereas they could be a consumer for a longer period of time, which implies the potential for making use of services. The term used in Māori mental health services, tangata whaiora (person seeking healing), has not been used, although practitioners should remember that this term (and a variety of others, such as survivor) might be preferred by the clients themselves.

Therapy/Counselling/Treatment

Again, these terms have been used interchangeably. They are not meant to imply the activities that are engaged in by one professional group (counsellors or psychotherapists), and refer to any mode of professional involvement in which the focus is on improved mental health and the enhancement of personal, social, and emotional life. Generally, therapy or counselling in the present context will be a "talk" or experiential activity; however, qualified medical practitioners might well add the use of psychotropic medication. Treatment may have the connotation of having to remedy a defect, and thus is different from healing, although it denotes the same process. Intervention is another term often used in behavioural psychotherapy or in outcome research, and is used when it suits the context.

Therapist/Counsellor/Practitioner

These terms are used interchangeably to refer to any mental health practitioner providing counselling services. They are not meant to designate only those practitioners whose professional qualifications are in the field of counselling or psychotherapy. The implication is that the person is qualified and registered with their appropriate disciplinary body, and is providing services formally (for a fee if in private practice, or as an employee of an agency). Members of the community, non-mental health professionals (eg, teachers), volunteers (eg, Victim Support), friends, and family may all provide counselling in some form or another. However, the meaning here is limited to a formal, professional role and activity.

Childhood sexual abuse (CSA)

By custom, this term has come to mean the experience of sexual abuse during childhood years in the history of adult clients who are seeking treatment for emotional distress. The experience of sexual abuse during childhood can vary dramatically from incident to incident and experience to experience, thus it is difficult to draw general conclusions regarding its impact on adult functioning. International and New Zealand research indicates that, in addition to the initial effects of CSA (see the next definition), up to one-fifth of those who have experienced CSA show long-term effects of impaired functioning and adjustment needs during the lifecycle.

Child sexual abuse/Sexually abused children

This term has been used to describe children who are known to have been abused, either in the recent past or currently, and who are receiving therapy or counselling to deal with its effects or to mitigate future difficulties.

Sexual assault/Rape

Rape is understood as "non-consensual oral, vaginal or anal penetration obtained by force, with threat of bodily harm, or when the victim is incapable of giving consent". The inability to give consent includes states of intoxication, unconsciousness, or severe mental disability. Sexual assault, as frequently used in the multi-disciplinary literature, is non-consensual or forced sexual activity not involving penetration such as attempted rape, forced sexual play, or fondling, as well as other types of sexual coercion. Similar to the field of sexual abuse research, the study of rape and sexual assault suffers from definitional flaws as legal definitions differ within and across countries. Due to the unsystematic use in the literature, these guidelines use the term sexual assault to refer to rape as well as coerced sexual activity not involving penetration.

It should be noted that, according to the above definition, the sexual abuse of children would fall into the category of sexual assault. However, for the purpose of these guidelines, the use of the term is restricted to single incidents (not necessarily single occasions) of assault occurring for adolescents, young adults, and adults including the elderly.

Effect

The term effect is preferred to symptom to describe the behavioural, cognitive, emotional, and physical consequences or sequelae of sexual abuse, as sexual abuse is an experience not a medical illness or disease. The effects of sexual abuse will not be one-dimensional and will usually constitute a pattern or dynamic sequence of interrelated consequences. These are sometimes referred to as pathways or effect patterns over a longer period of time following the abuse or assault and in directions that are influenced by pre- and post-abuse circumstances. It should also be noted that not all effects are necessarily damaging, at least insofar as some effects may be positive developments, such as the development of effective and constructive coping skills.

Therapy effect/Outcome

These terms are used interchangeably to refer to the benefits (or, in rare cases, the negative consequences) resulting from a formal period of therapy. The immediate outcomes observed or reported by clients, it is hoped, will lead to a trajectory of continuous growth, further improvement, and enhanced quality of life. Thus, some positive outcomes might not be detected until later. As not all therapeutic goals might have been achieved by the end of the therapy, we prefer terms like therapy outcome to recovery, which has become the standard terminology in the mental health field. Recovery is a term arising from the medical model and implies the client is no longer unwell. Outcomes are rarely as clear-cut as this.

Mental injury

This term is used in the ACC environment, and when used here refers to ACC criteria. Mental injury is defined by the Injury Prevention, Rehabilitation, and Compensation Act (2001) as "a clinically significant behavioural, cognitive, or psychological dysfunction" (and is more than an immediate reaction to events). The definition was drawn from DSM-IV^{TR} and requires "a medically identifiable psychiatric illness or injury necessitating something more than a transient trauma". For clients to be eligible to receive cover and entitlements, it is also necessary to show "on a probability basis that the mental injury was directly caused by the event".

Disorder/Syndrome/Mental illness

These are all terms commonly used in psychiatric and mental health services. They reflect a medical model or a disease concept of interpersonal, social, or emotional needs in clients. As much of the literature is dominated by psychiatric terminology, it is not useful to try to avoid diagnostic labelling, even though these labels are considered in some professional contexts to be misleading or even harmful to clients. Generally, such terms are used with caution, as they often imply that there is a single and easily definable psychiatric entity, as opposed to a complex pattern of personal distress. Similarly, words such as maladjustment, problem, and difficulty all tend to emphasise negative features of the client's adaptation to harmful experiences. These words have been used with caution and respect, recognising how easy it is to stigmatise individuals by implying they have a deficit when they have a need for solutions, support, and understanding.

Appendix 2: Guideline Development Team[1]

Research Team Members

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1 In alphabetical order (except for Principal Investigator and Team Leader).

2 Also contributed as a client advocate during the development of the guidelines.

Additional consultants and research staff

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3 Also contributed directly to the Palmerston North research team.

Appendix 3: Glossary of Māori Words

Hapū	Sub-tribe.
Iwi	Tribe.
Karakia	Incantation (prayer) or recitation of a chant over a being.
Kuia	Older Māori woman of high standing in her whānau, hapū, and/or iwi.
Tangata whaiora	In the health sector this term is used to describe a patient. Can literally mean a person in search of health/well-being.
Tapu	Sacred, restricted, inaccessible.
Tīkanga	Protocols, customs, ethical conduct.
Wairua	Spirit.
Whākapapa	Genealogy.
Whanaungatanga	Relative or blood relative. The process of whanaungatanga may broadly be defined as inter-relationships, creating and/or maintaining connections to those who are regarded as family in the broadest sense.
Whānau	Family, to be born.

Appendix 4: Safety Decision Tree

Are there safety issues for this client?

YES → Self and/or others

NO/UNSURE → **Comprehensive assessment**

Risk factors

- Mental health problems?
- Drug and alcohol?
- Current stressors?
- Support systems?
- History?

→ High/Immediate risk?

NO → Develop and initiate therapy plan

- Evaluate frequency of contact when risk is present
- Periodically evaluate risk
- Collaborate with other professionals when necessary

OTHER → **Degree of risk**

- Plan?
- Intent?
- Availability of means?
- Anger/Revenge?
- Barriers?
- Previous attempts?

→ High/Immediate risk?

NO

Adults

Do others need to be warned?

Children/ Adolescents

Develop safety plan

Have 3 contact people

Phone numbers for support services given to parent/caregiver eg, Parentline, Youthline, Barnardos, Open Homes, church-based social service agencies (Presbyterian Social Services, Across, Methodist Social Services)

YES

Adults

Immediate referral to Mental Health Emergency Team

If not available, phone Police

Children/ Adolescents

Notification to Child, Youth and Family. If not available, phone Police

Ensure follow-up from Mental Health Services, yourself, and appropriate family members

SELF → **Degree of risk**

- Plan/Preparations?
- Intent?
- Availability and lethality of means?
- Hopelessness?
- Barriers (reasons for living)?
- Seriousness of previous attempts?
- Psychological disorder present?
- Isolated?

→ High/Immediate risk?

NO

Adults

Develop safety plan

Have 3 contact people in case feeling unsafe

Develop and practise emotion-regulation and distress-tolerance skills

Provide contact details for support services (Mental Health Emergency Team, Lifeline, Samaritans)

Children/ Adolescents

Develop safety plan with safe family members and client

Phone numbers for support services given to parent/caregiver and client eg, Youthline, Parentline, What's Up Children's Counselling Line, Barnardos, Open Homes, church-based social service agencies (Presbyterian Social Services, Across, Methodist Social Services)

YES

Adults

Immediate referral to Mental Health Emergency Team

If unavailable and risk is imminent, phone Police

Children/ Adolescents

Refer to Child and Adolescent Mental Health Services

Ensure follow-up from Child and Adolescent Mental Health Services, yourself, and safe family members

Appendix 5: Adult Therapy Decision Tree

Establish and maintain rapport/trust

Comprehensive assessment

Investigate:

- Risk factors (see Safety Decision Tree)
- Range of presenting difficulties (see Assessment Quick Reference)
- All facets of client's life and circumstances
- History

Develop a case formulation (see examples):

Prioritise issues according to:

- Client safety
- Importance of issues to client
- Impact on client's life

Match therapy model to client's individual needs and your competencies

Chronic or severe sexual abuse or assault?

Complications? eg, interaction with personality

YES

CHRONIC/SEVERE/COMPLICATIONS
Longer-term integrative therapy most useful

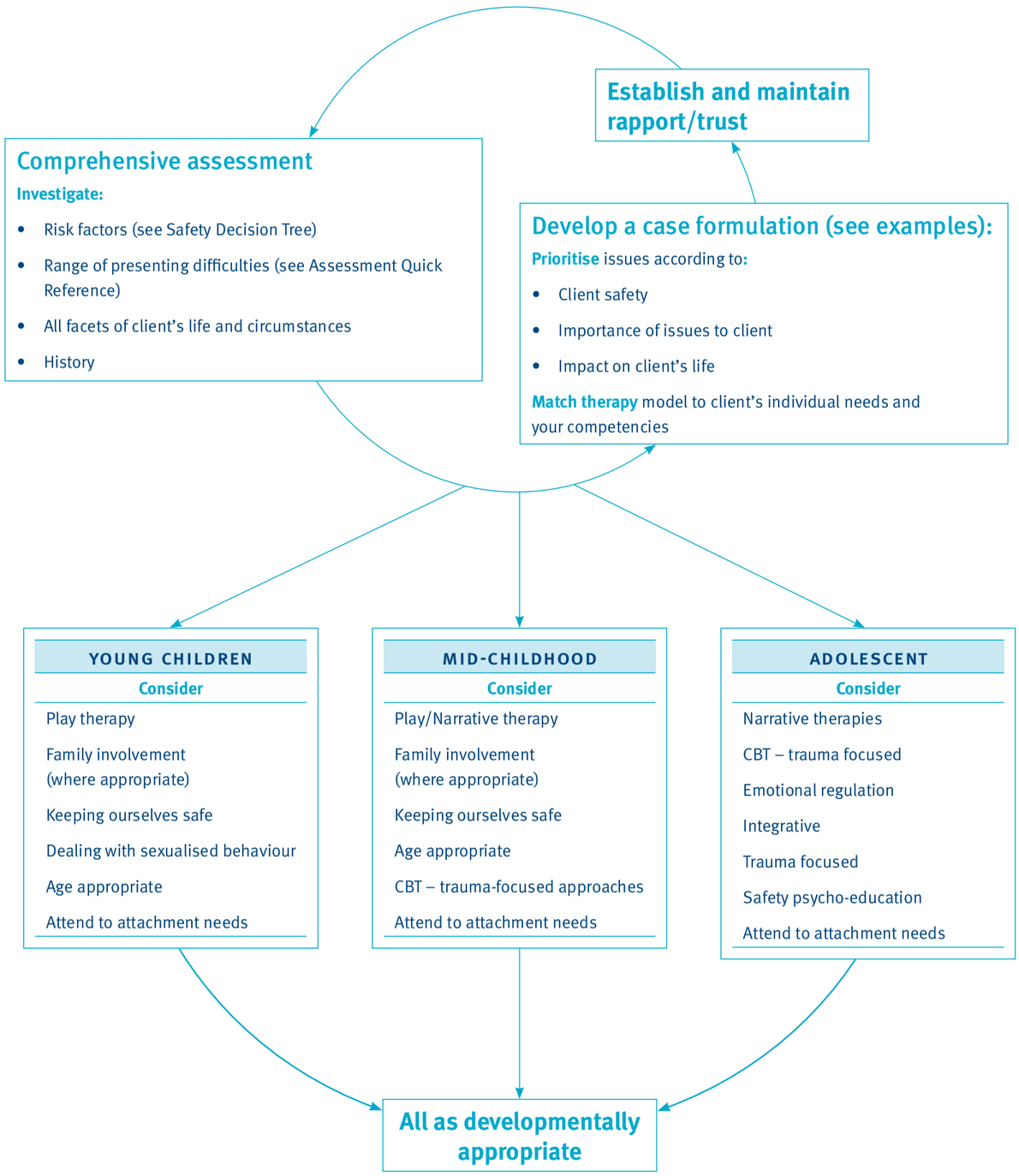
ADULT	
EFFECTS	**POSSIBLE THERAPIES**
As with short term but with possible addition of the following:	
CHRONIC SUICIDALITY	Refer to and maintain links with Key Worker at Community Mental Health Service
HIGH-RISK BEHAVIOURS • Self-harm • Chronic suicidality • Unsafe sexual practices • Excessive risk taking **Emotional dysregulation or emotional constriction**	**Integrative trauma-focused therapies** • Briere (Self trauma model) • Courtois (Complex PTSD) • Herman (Complex PTSD) • Linehan (DBT) • Ryle (Cognitive-Analytic Therapy)
ATTACHMENT ISSUES (repeating pattern of unhealthy relationships)	• Young (Schema Therapy) • Kennerly (Cognitive-based Integrative Therapy)
SEXUAL DYSFUNCTION • Inability to sustain intimate sexual relationship • Sex addiction • Risk of sexual offending	**Sex therapy** ACC Case Manager can approve referral to Sex Therapy New Zealand (STNZ) for specific therapy for sexual problems which are a result of sexual abuse/assault
ALCOHOL/DRUG/ GAMBLING ADDICTION	Consider referral to A & D Service or Dual Diagnosis Service at local DHB

NO

SINGLE EVENT TRAUMA
EG, RAPE/SEXUAL ASSAULT
Short-term therapy of up to 20 sessions. Trauma-based/CBT approach developed for PTSD is useful

ADULT	
EFFECTS	**POSSIBLE THERAPIES**
Nightmares/Sleep problems Flashbacks Hypervigilance Hyperarousal Emotional numbing Avoidance of reminders Social isolation Depression	**EMDR** • Shapiro • Devilly & Spence • Scheck, Schaffer & Gillette **NARRATIVE THERAPY** • Denborough • Drauker • Durrant & White • Harker **CBT FOR PTSD** • Ehlers • Follette & Ruzek • Resick • Schnicke • Owens, Pike, & Chard **INTEGRATIVE TRAUMA-FOCUSED THERAPIES** • Briere • Courtois • Herman

Appendix 6: Child Therapy Decision Tree



Appendix 7: Assessment Quick Reference

Acknowledge the reason the client has come to therapy (if known).

Ask about what has brought them along at this time.

Build rapport through gathering background information:

- Family/Partner
- Living situation
- Friends/Social support
- Interests/Hobbies
- Employment/Study.

Gather details about the presenting problems (the effects of sexual abuse, rather than the occurrence of abuse):

- What has brought them to see you?
- When did it start?
- Has it been a problem before?
- How severe is it? (Perhaps use a 0–10 scale to gauge severity)
- How often is it a problem?
- In what contexts is it a problem?
- What helps?
- What makes it worse?
- What effect is it having on their life? (ie, relationships, social life, employment, study, enjoyment of life).

Check for symptoms of **depression, anxiety, post-traumatic stress, and psychosis**.

If present, follow up with more in-depth assessment (in Part One, see Principle 6: Assessment).

Check any **previous history of mental illness** (self or family).

Directly enquire about any thoughts of suicide, self-harm, harm from others, or harm to others.

If yes, follow this up carefully and thoroughly (eg, any previous suicide attempts, self-harm, or harm to others).

Check suicide risk factors – see **Safety Decision Tree** (Part One, Appendix 4). Risk factors include:

- Psychological disorder
- History of suicide attempts (lethality, how many, how long ago)
- Sense of hopelessness
- Impulsivity

- Family history of suicide
- A specific plan
- Making preparations
- Severe symptoms of depression and anxiety
- Social isolation and withdrawal
- Perception of insufficient reasons for living
- Presence of a firearm, other lethal weapon, or access to other lethal means (including stockpiled medications or other drugs).

A useful anagram to determine risk quickly is:

Specificity of plan

Lethality of means

Availability of means

Proximity of help

Check use or misuse of **alcohol and recreational drugs**.

Check **current medications** (consider interaction effects of medications and/or alcohol/drugs).

Check **general medical health**.

Check what the client would like to be different (**initial goals**).

Check the client's **willingness** to engage in therapy at this time.

When sufficient rapport has been established and the therapist is persuaded that therapy will be helpful for this client at this time, details of the sexual abuse are gathered for the purposes of the Cover Determination Report (ACC 290) form.

Further information regarding the abuse is gathered as judged therapeutically appropriate by the therapist. (Some clients prefer to tell the full story early on, and others need to wait until they feel they can trust the therapist sufficiently.)

Elicit hope. Tell the client that working on the issues will bring about positive change (but not immediately).

References: Decision Trees

Bacon H, Richardson S. Attachment theory and child abuse: An overview of the literature for practitioners. *Child Abuse Review* 2001;10: 377–397.

Bagley C, La Chance M. Evaluation of a family-based program for treatment of child sexual abuse. *Child and Family Social Work* 2002; 5: 205–213.

Berliner L. The results of randomized clinical trials move the field forward. *Child Abuse & Neglect* 2005; 29: 103–105.

Berliner L, Elliott DM. Sexual abuse of children. In JEB Myers, L Berliner, et al (Eds), *The APSAC Handbook on Child Maltreatment* (2nd ed) 2002; 55–78, Thousand Oaks, California, Sage Publications.

Berliner L, Saunders BE. Treating fear and anxiety in sexually abused children: Results of a controlled 2-year follow-up study. *Child Maltreatment* 1996; 1(4): 294–309.

Berliner L. Intervention with children who experience trauma. In D. Cicchetti & S. L. Toth (Eds), *Developmental perspectives on trauma: Theory, research, and intervention* 1997; 491–514. Rochester, NY: University of Rochester Press.

Berliner L, Wheeler JR. Treating the effects of sexual abuse on children. *Journal of Interpersonal Violence*. Vol 2(4) Dec 1987; 415–434.

Bonner BL, Walker CE, Berliner L. Children with sexual behaviour problems: Assessment and treatment. Retrieved 30 May, 2002, from: http://www.calib.com/nccanch/pubs/otherpubs/childassessment/index.cfm.

Briere J. *Therapy for Adults Molested as Children: Beyond survival* 1996; New York: Springer.

Briere J. An integrated approach to treating adults abused as children, with specific reference to self-reported recovered memories. In JD Read, DS Lindsay (Eds), *Recollections of Trauma: Scientific evidence and clinical practice* 1997; New York, Plenum Press.

Briere J. Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In JEB Myers, L Berliner, et al (Eds), *The APSAC Handbook on Child Maltreatment* (2nd ed) 2002; Thousand Oaks, California, Sage Publications.

Briere J, Scott C. *Principles of Trauma Therapy: A guide to symptoms, evaluation, and treatment* 2006; Thousand Oaks, California, Sage Publications.

Briere J, Spinazzola J. Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress* 2005; 18(5): 401–412.

Carlson R, Arthur N. Play therapy and the therapeutic use of story. *Canadian Journal of Counselling* 1999; 33(3): 212–226.

Carr A. *The Handbook of Child and Adolescent Clinical Psychology: A contextual approach* 2006; London, Routledge.

Chaffin M, Friedrich B. Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review* 2004; 26: 1097–1113.

Cicchetti D, Rogosch FA. A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology* 2002; 70: 6–20.

Cohen JA, Berliner L, Mannarino AP. Treating traumatized children: A research review and synthesis. *Trauma, Violence & Abuse: A review journal* 2000; 1(1): 29–46.

Cohen JA, Berliner L, March JS. Treatment of children and adolescents. In EB Foa, TM Keane, MJ Freidman (Eds), *Effective Treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* 2000; 106–138. New York, Guilford Press.

Cohen JA, Deblinger E, et al. A multisite, randomized controlled trial for children with sexual-abuse related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry* 2004; 43: 393–402.

Cohen JA, Mannarino AP, et al. Trauma-focused cognitive behavioural therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence* 2000; 15(11): 1202–1223.

Cohen JA, Mannarino AP, Knudsen K. Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect* 2005; 29: 135–145.

Cohen JA, Mannarino AP, Rogai S. Treatment practices for childhood posttraumatic stress disorder. *Child Abuse & Neglect* 2001; 25: 123–135.

Cook A, Spinazzola J, et al. Complex trauma in children and adolescents. *Psychiatric Annals* 2005; 35(5): 390–398.

Courtois CA. *Healing the Incest Wound*. 1988; New York, WW Norton & Company.

Courtois CA. Theory, sequencing, and strategy in treating adult survivors. In J Briere (Ed), *Treating Victims of Child Sexual Abuse* 1991; 47–60. Newbury Park, California, Sage Publications.

Courtois CA. The aftermath of child sexual abuse: The treatment of complex posttraumatic stress reactions. In LT Szuchman, F Muscarella (Eds), *Psychological Perspectives on Human Sexuality* 2000; 549–572. New York, John Wiley & Sons.

Courtois C A. Treatment of incest and complex dissociative traumatic stress reactions. In L VandeCreek, S Knapp, et al (Eds), *Innovations in clinical practice: A source book* (Vol. 13) 1994; 37–54. Sarasota, FL: Professional Resource Press/Professional Resource Exchange.

Crisci G, Lay M, Lowenstein L. *Paper Dolls & Paper Airplanes: Therapeutic exercises for sexually traumatised children* 1998; Indianapolis, Kidsrights.

Davis L, Siegel LJ. Posttraumatic stress disorder in children and adolescents: A review and analysis. *Clinical Child and Family Psychology Review* 2000; 3: 135–154.

Denborough D (Ed). *Trauma: narrative responses to traumatic experience*. 2006; Adelaide, Dulwich Centre Publications.

Devilly GJ, Spence SH. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of posttraumatic stress disorder. *Journal of Anxiety Disorders* 1999; 13: 131–157.

Draucker CB. Unique outcomes of women and men who were abused. *Perspectives in Psychiatric Care* 2003; 39(1): 7–16.

Draucker CB, Petrovic K. Therapy with male survivors of sexual abuse. *Issues in Mental Health Nursing* 1997; 18: 139–155.

Dulwich Centre Publications. *Responding to violence: a collection of papers relating to child sexual abuse and violence in intimate relationships*. 2003

Durrant M, White C (Eds). *Ideas for therapy with sexual abuse*. 1990; Adelaide, Dulwich Centre Publications.

Ehlers A, Clark DM. A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy* 2000; 38(4): 319–345.

Feather J, Ronan K. Trauma-focused cognitive behavioural therapy for abused children with posttraumatic stress disorder: A pilot study. *New Zealand Journal of Psychology* 2006; 35(3): 132–145.

Finkelhor D, Berliner L. Research on the treatment of sexually abused children: A review and recommendations. *Journal of the American Academy of Child and Adolescent Psychiatry* 1995; 34: 1408–1423.

Finkelhor D, Browne A. The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry* 1985; 55(4): 530–541.

Foa EB, Keane TM, Friedman MJ. Guidelines for the treatment of PTSD. *Journal of Traumatic Stress* 2000; 13(4): 539–588.

Foa EB, Rothbaum, BO, et al. Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology* 1991; 59(5): 715–723.

Follette VM, Ruzek J. *Cognitive-Behavioural Therapies for Trauma* (2nd ed). 2007; London, Guilford Press.

Friedberg RD, McClure JM. *Clinical Practice of Cognitive Therapy with Children and Adolescents: The nuts and bolts*. 2002; London: Guilford Press.

Friedrich WN. An integrated model of pyschotherapy for abused children. In JEB Myers, L Berliner, et al (Eds), *The APSAC Handbook on Child Maltreatment* (2nd ed) 2002b; 141–158, Thousand Oaks, California, Sage Publications.

Gartner, RB. *Betrayed as Boys: Psychodynamic treatment of sexually abused men* 1999, New York, Guilford Press.

Girling-Butcher RD, Ronan KR. *Brief Cognitive-Behavioural Therapy for Anxious Children: The coping Kiwi treatment manual* (2nd ed). 2002; Massey University, Authors.

Harker T. Therapy with male sexual abuse survivors: Contesting oppressive live stories. In G Monk, J Winslade, et al (Eds), *Narrative Therapy in Practice: The archaeology of hope* 1997; 193–214, San Francisco, Jossey-Bass.

Hecht DB, Chaffin M, et al. Treating sexually abused adolescents. In JEB Myers, L Berliner, et al (Eds), *The APSAC Handbook on Child Maltreatment* (2nd ed) 2002; 159–174, Thousand Oaks, California, Sage Publications.

Hendricks CO, Fong R. Ethnically sensitive practice with children and families. In NB Webb (Ed), *Working with Traumatized Youth in Child Welfare* 2006; 135–154, New York, Guilford Press.

Herman JL. Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress* 1992a; 5(3): 377–391.

Herman JL. *Trauma and Recovery* 1992b, New York, Basic Books.

James B. *Handbook for Treatment of Attachment-Trauma Problems in Children*. 1994; New York, The Free Press.

Johnson SP. Short-term play therapy. In GL Landreth (Ed), *Innovations in Play Therapy: Issues, process, and special populations* 2001; Philadelphia, Brunner-Routledge.

Kelly MM. Play therapy with sexually traumatized children: Factors that promote healing. *Journal of Child Sexual Abuse* 1995; 4(3): 1–11.

Kennerley H. Managing the sequelae of childhood sexual abuse in adults. In D Miller, J Green (Eds), *The Psychology of Sexual Health* 2002; 236–252, Oxford, Blackwell Science.

King N. Childhood sexual trauma in gay men: Social context and the imprinted arousal pattern. In J Cassese (Ed), *Gay Men and Childhood Sexual Trauma: Integrating the shattered self* (Vol 19–35). 2000; New York, Harrington Park Press.

Labovitz-Boik B, Goodwin EA. *Sandplay Therapy: A step-by-step manual for psychotherapists of diverse orientations* 2000; New York, WW Norton & Company.

Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder* 1993a; New York, Guilford Press.

Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder* 1993b; New York, Guilford Press.

Lisak D. The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress* 1994; 7(4): 525–548.

Lisak D. Male survivors of trauma. In GR Brooks, GE Good (Eds), *The New Handbook of Psychotherapy and Counseling with Men: A comprehensive guide to settings, problems, and treatment approaches* (Vol 1) 2001; 263–277, San Francisco, Jossey-Bass.

Lowenstein L. *Creative Interventions for Troubled Children and Youth* 1999; Toronto, Champion Press.

Macdonald G. *Effective Interventions for Child Abuse and Neglect: An evidence-based approach to planning and evaluating interventions* 2001; Chichester, England, John Wiley & Sons.

MacDonald K, Lambie I, Simmonds L. *Counselling for Sexual Abuse; A therapist's guide to working with adults, children, and families* 1995; Oxford, Oxford University Press.

McGregor K. *Warriors of Truth: Adult survivors healing from child sexual abuse* 1994; Dunedin, New Zealand, University of Otago Press.

McGregor K. *Warriors of truth – Surviving Child Sexual Abuse* (revised ed) 2007; Auckland, New Zealand, Random House.

Myers JEB, Berliner L, et al (Eds). *The APSAC Handbook on Child Maltreatment* (2nd ed) 2002; Thousand Oaks, California: Sage Publications.

Ollendick TH, King NJ. Empirically supported treatment for children and adolescents: Advances towards evidence based practice. In PM Barrett, TH Ollendick (Eds), *Handbook of Interventions that Work with Children and Adolescents: Prevention and treatment* 2004; 3–26, New York, John Wiley & Sons.

Owens GP, Pike JL, Chard KM. Treatment effects of cognitive processing therapy on cognitive distortions of female child sexual abuse survivors. *Behavior Therapy* 2001; 32: 413–424.

Perry BD. The Neurosequential model of therapeutics: Using principles of neurodevelopment to help traumatized and maltreated children. In NB Webb (Ed), *Working with Traumatized Youth in Child Welfare* 2006; 27–52, New York, Guilford Press.

Pescosolido FJ. Sexual abuse of boys by males: Theoretical and treatment implications. In SM Sgroi (Ed), *Vulnerable Populations: Sexual abuse treatment for children, adult survivors, offenders, and persons with mental retardation* (Vol 2) 1989; 85–109, New York, Lexington Books.

Pierce LH. Father-son incest: Using the literature to guide practice. *Social Casework: The Journal of Contemporary Social Work* February 1987; 67–87.

Ray D, Bratton S, et al. The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy* 2001; 10(1): 85–108.

Resick PA, Schnicke MK. *Cognitive Processing Therapy for Rape Victims: A treatment manual* 1993; California, Sage Publications.

Romano E, DeLuca RV. An individual treatment programme for sexually abused adult males: Description and preliminary findings. *Child Abuse Review* 2005; 14: 40–56.

Runyon MK, Kenny MC. Relationship of attributional style, depression, and posttrauma distress among children who suffered physical or sexual abuse. *Child Maltreatment* 2002; 7(3): 254–264.

Ryle A. *Cognitive Analytic Therapy for Borderline Personality Disorder* 1997; London, John Wiley & Sons.

Schaefer CE. Prescriptive play therapy. *International Journal of Play Therapy* 2001; 10(2): 57–73.

Scheck MM, Schaeffer JA, Gillette C. Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress* 1998; 11(1): 25–44.

Shapiro F. Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress* 1989; 2: 199–223.

Shelby JS. Brief therapy with traumatised children: A developmental perspective. In HG Kaduson, CE Schaefer (Eds), *Short-Term Play Therapy for Children* 2000; New York, Guilford Press.

Solomon MF, Siegel DJ (Eds). *Healing Trauma: Attachment, Mind, Body and Brain* 2003; New York, WW Norton & Company.

Streeck-Fischer A, van der Kolk BA. Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry* 2000; 34: 903–918.

Talley PF, Knight MO. Foundations of clinical work with children: The therapeutic relationship. In PF Talley (Ed), *Handbook for the Treatment of Abused and Neglected Children* 2005; 123–143, New York, The Haworth Social Work Practice Press.

Tremblay C, Hebert M, Piche C. Type I and type II posttraumatic stress disorder in sexually abused children. *Journal of Child Sexual Abuse* 2000; 9(1): 65–90.

Wolfe DA, Francis KJ, Straatman A-L. Child abuse in religiously-affiliated institutions: Long-term impact on men's mental health. *Child Abuse & Neglect* 2006; 30(2): 205–212.

Wolfe DA, Mosk MD. Behavioral comparisons of children from abusive and distressed families. *Journal of Consulting and Clinical Psychology* 1983; 51: 702–708.

Wolfe VV, Birt J. Child sexual abuse. In EJ Mash, LG Terdal (Eds), *Assessment of Childhood Disorders* (3rd ed) 1997; 569–623, New York, Guilford Press.

Wolfe DA, Jaffe PG, Jetté JL. The impact of child abuse in community institutions and organizations: Advancing professional and scientific understanding. *Clinical Psychology: Science and Practice* May 2003; 10: 2.

Woolf LJ. *Playing for Real: Play therapy with children traumatised by maltreatment – A pilot study* 2002; Unpublished Masters thesis, Massey University, Palmerston North, New Zealand.

Woolley C, Gregory M. Child abuse and neglect: Prevention and intervention. In IM Evans, JJ Rucklidge, M O'Driscoll (Eds), *Professional Practice of Psychology in Aotearoa New Zealand* 2007; 397–413, Wellington, New Zealand Psychological Society.

Young JE, Klosko JS, Weishaar ME. *Schema Therapy: A practitioner's guide* 2003; New York, Guilford Press.

Part Two: Practice Guide

Table of Contents

Link to Principles and Recommendations

> *... the other thing I'm really hopeful will come out of this [study] is not just a New Zealand way of doing things and a broader way of doing things but also a collecting together of the skills and the knowledge because we still suffer from this little country down at the bottom of the world syndrome...*[1]

This Practice Guide was designed to support the work of professionals providing counselling services to people who have been sexually abused. It constitutes Part Two of the Practice Guidelines for Aotearoa New Zealand for providing treatment for mental injury resulting from sexual abuse. The Practice Guide should be used in close conjunction with Part One, Principles and Recommendations, which outlines general principles of best practice and provides a series of specific recommendations for practitioners. This Practice Guide intends to complement the Principles and Recommendations.

The Principles and Recommendations are based on a synthesis of both New Zealand and international research, as well as a series of research projects conducted by the team that developed the guidelines, Rāranga Whatumanawa. In the Practice Guide, the research findings are elaborated and greater detail is provided to support some of the Principles and Recommendations. As much as possible, the Practice Guide provides information for practitioners that is based on New Zealand research, from both Rāranga Whatumanawa (see Appendix 1: Project Reports) and researchers across the country (see the annotated bibliography of relevant research conducted in Aotearoa New Zealand listed in Appendix 1). However, it is not the goal of the Practice Guide to summarise or repeat the information that is available elsewhere. The Practice Guide is closely related to the Principles and Recommendations and aims to provide further detail in an accessible and user-friendly way.

Each section corresponds to the 12 principles set out in Part One. There is some overlap across sections because the intention is for sections to be able to be referred to independently as much as possible. Links to the research findings are numbered and listed at the end of the Practice Guide in Appendix 3: References. The voices of both practitioners and clients are emphasised by providing representative quotes from the many outstanding individuals who contributed their expertise and knowledge to this project.

The Practice Guide is not intended to be a prescriptive and rigid "how to" therapy manual. Instead, it serves as a resource or workbook to guide practitioners and complement their traditions of practice. Irrespective of each therapist's practice model, it is envisaged that practitioners will find this a useful guide for their work with clients.

1. Safety

Principle 1: Safety identifies issues of safety as paramount in the therapy process. Specific aspects of safety need to be determined and can change during the course of therapy, and safety in the process of therapy is important.

Prioritise Safety

Issues of safety in therapy with people who have been sexually abused were raised consistently, particularly by therapists and clients. When practitioners responded to the Rāranga Whatumanawa survey questionnaire and described the specific steps they would undertake with a hypothetical client, most of them responded by saying that the client's immediate need for safety was a major priority:[2]

> *Ensure client is safe at home. Has s/he seen a doctor? Does s/he need medication?*
>
> *I would be looking to the client's safety rather than validating the occurrence of sexual abuse at this stage; acknowledging presenting issues is part of safety…*
>
> *Concentrate on safety first. Ensure adequate support. Teach and monitor self-care…*

Similar comments were made in the focus groups with practitioners, such as:

> *If I know the first thing I've got to do is ensure that the person feels and is going to continue to feel safe… then all my strategies have to be around creating safety…*[1]

There was widespread agreement on the issue of safety as a priority, but there may be much less agreement on exactly how to assess a client's needs in this regard.[1–3] There were also many different aspects of safety that were identified. The following series of questions might be usefully considered by a practitioner during the early stages of the therapeutic relationship (as well as at times during therapy when safety issues arise).[2–4]

A useful resource is the New Zealand guideline on *The Assessment and Management of People at Risk of Suicide*, which is available to download from the New Zealand Guidelines Group website at www.nzgg.org.nz. This resource includes specific information for various client groups, including children and adolescents, the elderly, Māori, Pacific peoples, people of Indian descent, Asian populations, refugee groups, and those with chronic suicidality. The website also includes client resources on suicide and self-harm.

Safety Checklist

IMPORTANT SAFETY AREAS TO CHECK INCLUDE:		
Is the client safe from further abuse? This includes sexual, physical, and emotional abuse and violence, as well as neglect and witnessing violence.	YES	NO
Is the client suicidal or self-harming? This may range from fleeting thoughts about death, self-harm, or suicide to specific plans and behaviour.	YES	NO
Is the client a risk to others or homicidal? This may range from momentary fears of harming others to actual homicidal thoughts, plans, and behaviour.	YES	NO
Is the client engaging in high-risk behaviour? High-risk behaviour is any activity that could have serious negative consequences for the client. It is not always obvious and may not always seem to be directly linked to prior sexual abuse. Examples include petty crime, minor anti-social acts, unsafe sexual practices, and substance abuse.	YES	NO
Is the client in need of medical or mental health attention? The client may have specific medical conditions that need to be addressed (eg, pregnancy or risk of pregnancy, sexually-transmitted infection, urinary tract infection, physical injury, medication needs) or mental health needs (eg, psychosis, severe dissociation, medication needs).	YES	NO
Is there a safety risk to others? If there are children involved, are there any risks to them from the client or others?	YES	NO
Has the cultural safety of the therapy been established? Check with the client that they feel culturally safe in therapy, particularly given the characteristics of the client and therapist, such as age, gender, and ethnicity.	YES	NO
Are the assessment and therapeutic interventions safe for this client at this stage of therapy? Check with the client that they feel safe and are not overwhelmed with emotion that will destabilise or retraumatise them.	YES	NO

2. Client Focus

Principle 2: Client Focus emphasises the importance of tailoring therapy to the client on the basis of a detailed assessment as well as various client- and therapist-related factors. Complex needs can be identified early in the process through assessment so that the relevant services are accessed for the client. Client readiness for therapy and an awareness of their rights are other important issues in targeted therapy.

A diagram of a notional client's therapeutic journey (see Appendix 2) is a guide to the decision-making processes and inner thoughts of clients as they contemplate and progress through therapy and beyond. This is provided to assist the practitioner to view engagement and progress through therapy from a client viewpoint.

Tailoring Therapy

Many practitioners mentioned the need to tailor therapy to the specific needs of each client, which was echoed by the clients themselves:[1,3]

> *... match therapy to client.*
>
> *... integrative approach as no one model suits individuals.*
>
> *... adapting to how the client works best is needed, therefore I need a range of possibilities.*
>
> *What works for one will not work for another... as long as it is done and interpreted within respect and safety, then what works is great.*
>
> *Tailoring it to me.*

The type(s) of sexual abuse experienced by the client can have implications for the therapeutic approach that is most appropriate for them.[1] Clients who have experienced a single abuse event are likely to have different counselling needs from clients who describe a history of CSA as well as sexual victimisation in their adult lives, in terms of factors such as the amount and type of counselling required.

The counselling needs of clients who have experienced "blitz" rape or other types of stranger rape are likely to be different from those who have experienced "date rape" or rape by a marital partner or authority figure. Sexual assault in the context of a home invasion may lead to the client feeling unsafe in any environment. Victims of drug-assisted rape have experienced multiple violations, including being drugged, loss of memory, and possible sceptical reactions, as well as the sexual assault. Therapy may need to be adapted to cater for this group of clients due to the memory impairment and associated issues.

Consulting research that has investigated the outcomes of various types of therapy following sexual abuse and assault can be a useful part of the decision-making process when planning therapy for a particular client. The literature reviews conducted as part of this research project provided information from the published and unpublished literature about therapy outcomes for people who have experienced sexual abuse or assault. These reviews were conducted in a traditional narrative fashion as well as in a numerical and statistical manner using meta-analysis. Narrative reviews and meta-analyses assist in identifying trends in outcome research, such as the types of therapy approach that confer greater or lesser benefit to clients and the specific components of these approaches that might also contribute to outcome (eg, amount of structure, individual or group focus, inclusion of family, and length of therapy).

One overall trend found in the meta-analysis was that individually-based approaches may be the most appropriate and most effective for most clients.[1,3,5] In counselling with adults, aim to incorporate some level of structure and direction into counselling, and keep it time-limited. (The duration of therapy will depend on the complexity of the client's range of effects. For example, time-limited may mean up to 20 sessions for most clients, while other clients may require a more long-term approach to attain a sufficient degree of wellness.) In contrast, counselling with children and young people needs to be more flexible or semi-structured.[6] Where appropriate, also include family or caregivers in counselling with children and young people, and incorporate multiple environments and systems into the therapy approach. Family and caregivers may also need counselling services themselves.[1,7]

In summary, the trends in the narrative and meta-analysis reviews were that:

- Most group therapies were more effective than no therapy
- Most individual therapies were more effective than no therapy
- Individual therapy alone was more effective than group therapy alone
- Mixed therapy (individual and group therapy offered concurrently or sequentially) was most effective for adult survivors of CSA
- Individual therapy was most effective for adult survivors of rape or sexual assault
- There was no strong indication of one particular theoretical model being more effective than others for adults, adolescents, or children who had experienced CSA
- Eye Movement Desensitisation and Reprocessing (EMDR) and CBT were more effective therapies for adult survivors of a single event of rape or sexual assault (which is more similar to PTSD)
- Longer-duration group therapy (15+ sessions) was more effective than short-term group therapy (6–10 sessions)
- Short- to medium-term therapy was most effective for a single event of rape or sexual assault for an adult (7–16 sessions)
- Many adult survivors of CSA did well with medium-duration therapy (10–16 sessions). With a small group of clients with confirmed complex presentations, longer-term therapy may be appropriate in some situations
- Therapy including the family was most effective for children.

However, there are some important limits to these findings that cannot be separated from the findings themselves. Current meta-analytic techniques permit the consideration of the effects of single factors in therapy, such as whether group or individual approaches have better outcomes, or whether an optimal length of therapy can be identified. However, meta-analysis is not yet able to account for the many complexities found in practice with those who have experienced sexual abuse. In particular, it is currently not possible to simultaneously consider multiple or co-occurring factors that might account for differences in therapy outcome.

For example, individual therapy approaches may furnish a better outcome than group approaches overall, but it is not yet possible to tease apart whether this occurs regardless of the context of other aspects of the client's situation, such as the specific characteristics of their abuse, their individual demographic and background characteristics, and other complex features of the therapy. Individual therapy may be appropriate for many clients, although for some clients, group therapy alone or in combination with individual therapy may be more beneficial. As another example, children may benefit more from family therapy if no other variables impact on outcome. However, some children will gain more benefit from individual therapy, a combined approach, or significant variations in the way therapy is delivered, based on their individual needs.

Another limitation of meta-analysis and examining treatment outcome studies is that the types of client commonly seen in practice may be excluded from research studies because they present with multiple

difficulties or have issues beyond the scope of the study. The "gold standard" studies using randomised therapy and control groups may be inappropriate when working with distressed clients who have been sexually abused.

Although a useful method to help identify relevant trends in therapy outcome, these issues limit the findings of meta-analytic reviews for therapy practice. It is likely that a multiple-factor approach that considers the characteristics of the client and the therapy, not one based on single factors, best accounts for therapy outcome. As yet, meta-analysis cannot examine multiple factors at once, which may mediate or moderate therapy outcome. Therefore, while trends can be identified, it is impossible to conclude that the trends will always result in better outcomes, given the complexity of sexual abuse and the limitations of current meta-analytic techniques.

Aspects of counselling identified by clients as helpful included:[3]

- Setting goals collaboratively and working through them
- Feeling heard, believed, validated, and affirmed
- Counsellor qualities (eg, being caring, sincere, and calm)
- Having some sense of control of the counselling process
- For some, drawing and writing to help express emotion
- Information and education (eg, handouts, audiotapes)
- Empty chair and two-chair techniques
- Psychodrama and role play.

> *… I felt beautifully listened to, which turned out to be a crucial part of the healing.*
>
> *Someone to listen without making judgements.*

Aspects of counselling identified as less helpful included:[3]

- Rebirthing
- Group therapy
- Some therapy processes, such as feeling forced to participate in a technique that is uncomfortable, feeling scrutinised and overly attended to, sessions moving too fast, no feedback about lack of progress, sharing of counsellor's issues.

As well as tailoring therapy to the needs of the client, clients identified a need to be matched with a practitioner with whom they feel comfortable working, which was echoed by practitioners (also see 3: Therapeutic Relationship).[1,3] Clients benefit from being made aware of their rights, which include the right to lodge formal complaints with the Health and Disability Commissioner (www.hdc.org.nz). Counsellors should also be aware of the Code of ACC Claimants' Rights as outlined below:

Right 1 The right to be treated with dignity and respect

Right 2 The right to be treated fairly and to have your views considered

Right 3 The right to have culture, values, and beliefs respected

Right 4 The right to a support person or persons

Right 5 The right to effective communication

Right 6 The right to be fully informed

Right 7 The right to have privacy respected

Right 8 The right to complain

In particular, Right 6 outlines that clients will be provided with information about entitlements and how services are provided and accessed. While information regarding rights is made available to clients by ACC staff, clients benefit from this information being discussed as it relates to therapy, such as being made aware that choice of and changing counsellors is an option.

Clients with Complex Therapy Needs

RELEVANT INDICATORS TO IDENTIFY CLIENTS WHO HAVE COMPLEX THERAPY NEEDS INCLUDE:[5]		
Does the client have a history of mental health difficulties? Are there current mental health issues?	YES	NO
Is the client involved in legal processes (eg, custody proceedings)?	YES	NO
Is the client's family involved with a statutory child protection agency?	YES	NO
If the client is a child, has the caregiver received sexual abuse counselling or do they require services to address other issues?	YES	NO

The issue of early identification can be problematic when the needs of some clients may not become apparent at the time of assessment. In such cases, further assessment and possible referral to a multidisciplinary team for therapy may be appropriate. The above indicators can signal that the client requires additional specialist involvement with a multidisciplinary team. It is preferable for this client group to receive services from a wider variety of disciplines than counselling alone.

Client Readiness

IMPORTANT AREAS TO CHECK INCLUDE:[1, 2]		
Does the client have sufficient resources to cope with therapy? Check their ability to regulate emotion, tolerate distress, and access social support.	YES	NO
Can the client seek appropriate assistance when needed?	YES	NO
Does the client know how to access emergency services if required (eg, Lifeline, Youthline, Mental Health Emergency Team)?	YES	NO
Is the client using alcohol, drugs, gambling, unsafe sexual practices, self-harm, or other risk-taking and addictive behaviours to self-medicate strong emotional responses?	YES	NO

3. Therapeutic Relationship

Principle 3: Therapeutic Relationship outlines one aspect of the therapeutic alliance that provides a foundation for successful therapy. The relationship is developed through the qualities of the practitioner and client and their interaction, as well as various features of the therapeutic environment.

Not surprisingly, the therapeutic relationship emerged as one of the most important ingredients of therapy, based on information gathered from practitioners and clients.[1,3,8] Practitioners were unanimous in reporting that the therapeutic relationship is the foundation upon which the success of therapy rests.[1, 2] Clients also identified it as pivotal to their recovery, and the important attributes of therapists that were identified by clients are listed below under "*Therapist variables*". The international literature also clearly described the therapeutic relationship as the major agent of therapeutic change.[9] Both the international literature and New Zealand practitioners reported that particular attention should be focused on attachment issues, given that many people who are sexually abused during childhood develop an ambivalent or avoidant attachment style.[9]

The relationship makes up one of three components of the therapeutic alliance:

- Principle 3: Therapeutic Relationship. This includes the development of a relationship bond between the counsellor and client
- Principle 7: Goals. The collaborative agreement on therapeutic goals
- Principle 8: Rationale and Process. This forms the basis for therapy direction, how to achieve therapy goals, what the tasks of counselling are, and the dynamics of therapy.

These three areas were strongly represented in the findings of the research and the general counselling outcome literature.

Relationship-Enhancing Strategies

Several approaches were recommended for developing healthy rapport with clients that enabled progress. In particular, the initial sessions were reported to be crucial in building and sustaining strong therapeutic relationships with clients. Strategies that both clients and practitioners reported as useful for developing rapport included:[1,3]

Therapeutic relationship

- Working immediately on building safety for the client and others
- Availability
- Friendliness
- Empathy
- Belief that the relationship between counsellor and client matters
- Matching the language of the therapist and client regarding abuse, effects, and goals.

Therapeutic environment

- Preparing the room and making it pleasant
- Having tea, coffee, water, and healthy food available
- A comfortable therapy setting.

Structure

- Behaving consistently
- Working quickly on self-soothing
- Discussing and collaborating on the pace of therapy
- Working on goals that are meaningful to the client, even if these goals are immediate or limited in scope
- Ability to explain clearly and fully
- Tailoring the approach to the style and values of the client
- Ability to educate clients about abuse and its effects
- Ability to normalise reactions to abuse.

Client-centred

- Willing to respond to the client's needs, including cultural needs, and deviate from the arranged plan
- Conveying belief in the experience of the client
- Having faith in the client's ability to recover
- Being responsive to how the client is in each session
- Accepting that sometimes therapy does not work
- Suggesting a break and knowing when it is time to refer
- Affirmation of the client's resilience.

Therapist variables

- Ability to tolerate the content of the discussion
- Being honest, real, and "down to earth"
- Being well-trained and professional
- Being open to the client's worldview and willing to put aside their own
- Gentle but firm, ability to gently challenge and be challenged
- Respectful, non-judgemental, and accepting of the client
- Good listener.

Cautions

It is important to note that, while a sound therapeutic relationship is central to positive change, the relationship alone is inadequate for initiating and sustaining therapeutic outcomes for clients. A consistent balance between maintaining personal boundaries and connectedness was found to create the best therapeutic outcomes for clients. Just as research confirmed that a good relationship enhanced outcomes, it was also found that the amount of therapeutic contact a therapist had with adult clients at either extreme reduced effectiveness.[6]

A minimal degree of therapeutic contact was less effective, as was too much therapeutic contact. The latter is often seen in co-dependency relationships between practitioners and clients.[3] A considerable proportion of adult clients who required long-term services were found to have developed co-dependent relationships with their therapists.[4] Amongst other things, co-dependent relationships can be characterised by high attachment but low personal boundaries and mutual dependence between the client and therapist. While deep attachment and client dependence are often necessary for a period of time in order to re-learn appropriate relationships, this best occurs within the constraints of safe and appropriate boundaries. Furthermore, conclusions about the nature of beneficial therapeutic relationships are impossible to describe because this will differ according to each client and therapist. It should also be noted that the nature of the therapeutic relationship (ideally) fluctuates according to client need at any given time. For example, more frequent contact during times of crisis may be required, with intervals between sessions extending nearer the conclusion of therapy.

Finally, as in Principle 6: Assessment, therapy needs to be based on a sound analysis of each client's needs and targeted to address those needs efficiently in a carefully prioritised manner.

KEY RELATIONSHIP ISSUES TO THINK ABOUT:		
Has the client's safety been ensured?	YES	NO
Is the client being heard and their needs understood?	YES	NO
Is the therapy setting warm and inviting? Does the client feel comfortable in this setting? Have they been offered a refreshment?	YES	NO
Are the therapeutic pace and timing consistent with the needs of the client?	YES	NO
Is collaborative goal-setting taking place? Are the goals meaningful for the client?	YES	NO
Are the client's boundaries being respected? Are the therapist's boundaries being compromised?	YES	NO
Is there a clear and consistent structure? Is there a clear direction? Is there enough flexibility to respond to the needs of the client?	YES	NO
Is there belief in the client's ability to progress? Is lack of progress being attributed to the client?	YES	NO
Is the client being guided to deal with future issues?	YES	NO

4. Culture – Identity and Diversity

Principle 4: Culture – Identity and Diversity acknowledges the unique and dynamic culture of Aotearoa New Zealand and the impact of culture on therapy. (Related to this section, see Appendix 4 for a glossary of Māori words.)

Cultural Awareness

Considerations of culture, identity, and diversity emerged as a strong principle to be included in the guidelines based on discussions with clients and practitioners. Important as this is, there is a risk in generalising about culture. This is clearly problematic in that any statements made are unlikely to relate to all who identify with particular cultural groups. In this section, therefore, some details of the possible attitudes, values, and needs of different groups reflected in our research findings have been provided.

A lack of knowledge and respect for differing cultural ideologies, systems of belief, and social customs can lead to misunderstanding between therapist and client and an undermining of the relationship. If favoured by the client, a therapist and client match may be preferable that may, for instance, reflect culture, age, or gender. Obviously, this is not always possible and sometimes not desirable. It is important to consider each situation in terms of what is most useful for the client. A helpful practice is to ask the client whether they have particular preferences. An alternative is to suggest reviewing therapy after a few sessions and provide the option to refer on if appropriate.

If the client is of a particular ethnic, gender, religious, or other cultural group, do not assume that they would prefer to work with a therapist of the same ethnicity, gender, or religion. Some Māori for example, may not identify as Māori, so be careful to avoid assumptions regarding identity based on factors such as the client's name or appearance. Sometimes a Māori client does not want to work with a Māori counsellor due to concerns about confidentiality, and it is always best to ask the client.

With respect to religious beliefs, if, for example, the therapist adheres to a Christian framework, they may not be an appropriate person to work with a client who, for example, has no religious affiliation. Likewise, a practitioner who has no religious affiliation may not be the most appropriate person to work with someone who is Christian. A client who follows a particular religion may prefer not to work with a practitioner of the same religion due to concerns about confidentiality or being seen as having weak faith.

Generalisations about any group lead to a danger of creating false expectations. In practice, there is no substitute for two important strategies:

- Ask the client to share information about cultural priorities in a collaborative way
- Seek advice and consultation, without breaching confidentiality, from well-informed members of the particular group or community.

In the event that no other therapist is available, it is important to remain culturally aware and be cognisant of the cultural and social needs of the client. Therapists should receive cultural supervision and remain well informed. The elements of safety, pacing, tailoring of therapy, working collaboratively in setting goals,

monitoring of progress, and planning for the completion of therapy are fundamental to sound therapeutic practice in general. The following comment from a practitioner is helpful to bear in mind if the client is of a different culture from the therapist:

> *Rather than try to adapt our practice to reflect the many cultures of our clients, we offer our own culture of safety, respect and acceptance which seems to work just fine for our clients in a multicultural forum.*[1]

CULTURAL ISSUES TO CHECK:		
Is there a good understanding of the cultural needs of the client?	YES	NO
Is the therapist appropriate for this individual?	YES	NO
Has the client been asked about their specific needs?	YES	NO
Is the therapist receiving appropriate cultural supervision?	YES	NO
Is the therapist knowledgeable about cultural aspects, whether they relate to ethnicity, religion, gender, sexual orientation, age, (dis)ability, or gender identity?	YES	NO

Māori Clients

The following techniques and models were found useful when working with Māori clients. However, it is important to consider each client as unique and to not assume that Māori models of therapy are appropriate or desirable for all Māori.

- Using a kaupapa Māori approach that acknowledges the wairua (spiritual aspect) is considered paramount to the healing process.
- Te Kao o Te Ao Rangi. Some practitioners mentioned this approach which was described as "*helping them to reconnect and re-establish a sense of who they are in the widest possible sense, so in terms of order of priority, fire, wind, water, and earth in that order. So the fire will cover issues in terms of tapu and identity (ie, atuatanga) within that, the wind will cover the thought process, the water the emotional body, and the earth, of course, the physical body*".[1]
- Te Whare Tapa Whā and Te Whare Tapa Whā o Poutama were specific models recommended by Māori practitioners. Te Whare Tapa Whā symbolises the four walls of the house, with each wall signifying different dimensions of mental health: Te Taha Tinana (physical), Te Taha Wairua (spiritual), Te Taha Hinengaro (psychological), and Te Taha Whānau (family). Within this model, the importance of taha wairua (spirit) and taha whānau (family) were stressed. The Poutama model was described as:

  > *... you start with the encounter. It is reaching out until you get there and by then you should be walking hand in hand. You come to an understanding of each other and from there on it's time for the healing. But it is going through those stages... it is about taking the time to build up trust, those steps going up that poutama.*[1]

- Weaving the wairua with other Western models is another approach that is considered appropriate.
- The use of symbols is encouraged, such as rito in the flax, unfolding and blooming. Story, narrative, and metaphor can play useful roles in the development of shared and new understandings for the client.

Māori practitioners explained that there are cultural issues such as tribal preferences and styles that need to be considered. Shared whānau understandings and beliefs are important. The process of whanaungatanga (making family and ancestral connections) and references to shared experiences are seen as important elements in establishing a therapeutic relationship as well as reinforcing the focus on whānau.

> *It's about finding themselves first, and part of that is whakapapa; knowing where they come from, what makes up who they are, where their history comes from.*[1]

Beginning and ending sessions with a karakia (prayer) has both fundamental spiritual meaning as well as an expectation that will be familiar and comfortable to many Māori clients. Check with the client whether they would like a karakia, and if the therapist cannot provide a karakia, ask the client if they would like to do this.

Children. It was noted by some Māori practitioners that children who are sexually abused often have behavioural problems and, when they first see a counsellor, will often use a variety of "*diversion tactics as a defence measure*". They can be very "*closed, shut down*", and the building of a relationship with the child is the primary focus when starting therapy. It was also noted that embracing American ghetto culture is currently popular with young Māori and this was seen as an isolating factor for these young people.[1] For these reasons, it can be useful to use Māori models in working with children and adolescents.

Pasifika Clients

There can be a dilemma in aligning what European models define as safe practice with customary Polynesian culture. There is no one particular model of practice that is recommended for all Pacific groups. However, the following aspects were noted by Pasifika practitioners with respect to working with Polynesian people:

- Models of practice need to be suitable for clients' specific Pacific nations. There is no "one size fits all", and there are differences between what is appropriate for Samoan, Rarotongan, Tongan, and Niuean clients, for example
- Models should accommodate the needs of the community, incorporate spirituality, and allow high levels of consultation and collaboration between the therapist, client, and community
- An integrated and collaborative "wrap-around" service is favoured, whereby once a family with problems is identified, a number of community workers and professionals become involved, helping the family and monitoring family activities
- Therapists need to be able to ensure the family is strong and to enable the family to make sure the child who has been abused is kept safe
- The values of love, respect, honesty, patience, and support were emphasised
- Therapists need to acknowledge the importance of Christianity, spirituality, and generally, the important role of the church in Pasifika families and their communities
- It was noted that Pasifika practitioners are much more likely to visit families at home
- The Polynesian perspective is collective and family based. Pasifika clients are rarely seen as individuals. Accordingly, family participation and the maintenance of family ties are central to good practice
- It is difficult for many Pasifika clients to talk about sexual matters or disclose family abuse. Sexual abuse within the family is believed to affect everyone and the effects can reverberate throughout the community. Practitioners advised that sexual abuse is felt as a community issue.

> *You go to the family through the parents, if the child is the victim, you go through the parents, and you can't really do it without the parents because that's respect... Because if you respect them, they will respect you and then co-operate with you.*[1]

Asian Clients

Emphasis on family. While there is diversity within Asian cultural groups, there is generally a strong emphasis on the central importance of the family. The traditional Chinese family, for example, is inclined to be vertical and hierarchical, with well-defined roles for its members. Asian culture emphasises collective values rather than considering the individual's rights as primary. Consequently, any honour attained by an individual will reflect well on the status of the family, and, conversely, shame incurred by an individual will inflict shame and loss of face on the entire family group. Many Asian people have been resident in New Zealand for 10 years or less and will hold traditional Asian values.

BE SURE NOT TO MAKE ASSUMPTIONS. CHECK WITH THE CLIENT:		
Are they a recent immigrant to New Zealand?	YES	NO
Were they born in New Zealand?	YES	NO
What are the particular cultural values that are important to them?	YES	NO

Considerations

- Asian clients may perceive the therapist as an authority figure or a person of knowledge and experience who is worthy of respect.
- A more directive, didactic approach than normally used is often appreciated by this group.
- At the beginning of therapy, it is helpful to focus on somatic symptoms, using a problem-solving approach. Talking about feelings and private thoughts may be very difficult for Asian clients. Sufficient time needs to be allowed for the development of rapport. Once established, it may be possible to start addressing the possibility of psychological effects.
- There is no direct translation of the concept of mental health for Asian people. They are generally unfamiliar with and cautious about the prospect of consulting a professional about mental health issues.
- There is stigma attached to psychological difficulties for Asian people. This may be spiritually based, such as the Buddhist concept that personal difficulties are the consequence of past transgressions of self, family, or ancestors.
- There may be a belief that nature should be allowed to take its course, as in the Taoist principle of passive coping. This includes a sense that it is important to endure and submit to the laws of nature.
- It is considered that people are responsible for resolving their own psychological difficulties through moderating and controlling their emotions and behaviour. Such control is highly valued in Asian culture and family members are encouraged to aspire to acquiring this ability to a high level, rather than seek assistance from someone outside the family.
- The imperative to control emotions may contribute to a higher likelihood of somatic symptoms being reported instead of psychological symptoms.
- Language may present a difficulty for recent migrants or people who have not acquired good English skills. The embarrassment of not being able to communicate adequately may prevent Asian people seeking assistance.

Clients with Disabilities

Considerations

- People with disabilities are at higher risk of all types of abuse. When working with a client with any form of disability, it is important that the therapist understands the implications of the disability by undertaking to seek information about the disability by asking the client directly, reading, workshops, and supervision.
- Check with the client about any special needs they may have and how these can be accommodated.
- Respect and acknowledge the particular culture of the deaf person.
- Consider whether assistive devices or an interpreter are needed when working with clients who have a hearing impairment.
- Take appropriate steps to assist with communication difficulties.

Additional considerations for people with intellectual difficulties

- This client group was described as having significant trust issues as a result of not being believed. Some of these clients have difficulty expressing themselves and they may not receive the assistance they need. For those in residential care, historically there has been a culture where their concerns are not taken as seriously as they need to be.
- People with intellectual difficulties are a vulnerable group and are at high risk of being sexually abused on an ongoing basis. They are also at risk of displaying inappropriate sexual behaviour. This may be expressed as sexualised behaviour. Such behaviour has been linked to the "*failure to learn more appropriate sexual expressions*".[1] Further, some may go on to sexually abuse others. It has been noted that people with intellectual disabilities are sometimes confused about their sexuality and their sexual preferences. People with intellectual disabilities with a history of sexual abuse often display self-harm behaviour and aggression towards other people.
- Mental health problems often remain undiagnosed, with difficult or unusual behaviours being ascribed to intellectual disability. Therefore, it is important to recognise mental health problems such as depression, anxiety, and PTSD among this group.
- Social attitudes towards this group of clients often make it difficult for them to receive the help and support they need. Because of social stigma regarding intellectual disability, the public often do not understand that sexual abuse happens to them, or the impact it has on their lives. As a group, clients with intellectual difficulties remain vulnerable and socially isolated.
- Legal proceedings may be difficult as the person may not be a reliable or accurate historian and may therefore be seen as an unreliable witness with a low possibility of a successful prosecution.

CHECK: IF THE CLIENT HAS AN INTELLECTUAL DIFFICULTY, HAS IT BEEN CONSIDERED THAT THEY:[1]		
Are part of a vulnerable population?	YES	NO
May have difficulty being heard or being believed?	YES	NO
Are often socially isolated?	YES	NO
Find it harder to get appropriate help?	YES	NO
May develop sexualised behaviour as a result of sexual abuse, leading to higher risk of re-abuse?	YES	NO

Children and Adolescents

Young people, especially children, are vulnerable to abuse and are reliant on adults to have their needs met. Additional considerations in working with children and adolescents include the following:[1,7]

- Some children live in a context where they are at risk of abuse due to unhealthy family processes and ongoing stressors. Family processes can also minimise or intensify the effects of abuse for children
- Relational interruptions are an important consequence of sexual abuse, such as disrupted attachment to relations with caregivers and future offspring, entering abusive adult relationships, and estrangement from members of the family of origin. Alienation can occur particularly with parents who are unavailable to the child due to their own unresolved issues. Disclosure of abuse can also alienate the child, who can be blamed for the stress and consequent changes in the family. Alternatively, the family can become silent and deny the abuse
- Reconnecting the child or adolescent with the family and other relationships can be an important part of therapy and was mentioned by many practitioners. Relevant and appropriate family members benefit from educational information about sexual abuse and its effects, and may need to have their fears and concerns addressed (such as the effects on the gender identity or future sexual behaviour of their child)
- Working with children and adolescents who have been sexually abused can often involve linking with other agencies such as Child, Youth and Family, foster care, courts, mental health services, and schools given their often complex circumstances
- Adolescents often attend therapy on a short-term basis, and therapy needs to be flexible while also meeting their needs. Attention needs to be given to developmentally-related effects such as the impacts of loss of virginity, the risk of pregnancy, sexually-transmitted infections, and gender identity.

Elderly Clients

Considerations

It has been found that older adults often think and talk about sexual abuse differently from younger people. Be aware of the following issues:

- Older adults abused as children may not consider the experience abusive
- Māori practitioners commented that older Māori women "*carry their sexual abuse history quite differently*"[1] from younger Māori women. They are more reticent, carry the shame and blame of being a victim, and have often never spoken of the abuse before
- Older women express more acceptance of the experience as "*part of life – you have to get on with it*"[1]
- Older adults often feel more need to "*keep the secret*".[1] It is too shameful to speak of, and it is their burden to carry
- How older people learned about sexuality may be quite different from the experiences of younger people, and this will shape their understanding of boundaries, sexual dynamics, and perhaps even their rights as an individual.

Practitioners who work with older adults commented that when a history of sexual abuse emerges it is likely to be told in the context of the person's life story, rather than being reported as a problem. Often the client has not been able to draw links between their difficulties and the experience of abuse. It has been noted that when

talking about the abuse, their emotional responses tend to be shown as a deep sense of sadness, loss, and shame. Anger is seldom expressed, which may be a more prevalent emotion shown in younger adults.

Male Clients

Additional considerations when working with men and boys who have been sexually abused include:

- Concerns about sexuality: "*Does it mean I'm gay that I was abused by a male?*"
- Shame associated with being a victim when men are "*supposed to be protectors of women and children*". "*Does it make me less of a man that I was abused*?"
- Not being taken seriously when the perpetrator was a woman. "*Lucky boy, wish it had been me…*"
- Shame because of normal male physiological responses to genital touch. "*I was sexually aroused by the abuse, so I must have wanted it or liked it… therefore it's my fault, isn't it?*"
- Men are less likely to disclose sexual abuse, less likely to seek assistance, and more likely to feel confused about their sexual orientation and gender identity than women. These factors increase their sense of shame about having been abused. According to social norms, men are expected to be strong, invulnerable, and protectors of women and children. If they become victims, they see themselves as weak, vulnerable, and unmanly
- Men who have been sexually abused can also experience difficulties with being a parent
- There is a lack of acceptance by society with respect to females as sexual abusers of males. As the incidence of women abusing boys is underestimated, questions are rarely asked about this possibility. Consequently, men and boys are then left to carry their abuse. They reported that there is still a dominant social belief, "*especially if they were abused anywhere around their adolescent years, 'well, good on yer mate… lucky you', meaning people just miss the abuse*"[1]
- For those males who have been abused and become abusers, there is a need to address the latter issue first. Their struggle with a desire to abuse is a priority because of safety issues. Practitioners advised referring these clients to a STOP programme before embarking on therapy for sexual abuse. This highlights the need to prioritise safety, both for the client and for potential victims.

Gay, Lesbian, Bisexual, and Transgendered People

There is no known causal relationship between transgender issues and sexual abuse, or sexual orientation and sexual abuse. However, there is a high incidence of CSA in the transgender community and a greater frequency of CSA in clients who are gay or lesbian than in the heterosexual community. As with any client-practitioner relationship, respect is emphasised as a vital ingredient to therapy with clients who are gay, lesbian, bisexual, or transgendered. This client group may well be far better informed about issues related to sexual orientation and gender dysphoria than the therapist they are consulting. Ideally, therapists who work with these clients are comfortable with their own sexuality and have an ability to be non-judgemental and respectful of alternative lifestyles.

Gay, lesbian, or bisexual clients

- These clients may wonder whether CSA has affected their sexual orientation. No causal relationship has been established between CSA and sexual orientation. However, there is a greater frequency of CSA in clients who are gay or lesbian.

- The higher risk of CSA or sexual assault during adolescence may be attributable to those with atypical sexual identity or orientation being a more vulnerable group who are more often targeted by sexual predators.[10]
- Sexual expression may be experienced as sexual assault and should be addressed in the same way as for heterosexual clients.
- A woman sexually abused by another woman will display similar symptoms to a woman sexually abused by a man. However, there may also be a greater sense of shame, betrayal, and disbelief and a less sympathetic response from friends and family.
- When providing counselling services for gay, lesbian, or bisexual people, therapists need to be aware of additional issues that may be interrelated with the trauma of the sexual assault. These may include societal homophobia and biphobia and the stigma of belonging to a marginalised community that may require hiding one's sexuality from family and friends.

Transgendered Clients

- Transgendered clients rarely present with issues of CSA or sexual assault. They are more concerned about gender or sexuality confusion.
- Some clients have an added layer of confusion related to the question: "*Am I this way because I was sexually abused?*". It is unlikely a definitive answer can be found for this question.
- If the client is in the early stages of hormone therapy, their presenting difficulties may be affected by hormones. It is recommended that therapists become informed about the effects of hormone therapy for transgendered people. Particularly in the early stages, these effects include emotional lability for those receiving oestrogen, and increased anger or aggression and hypersexuality for those receiving testosterone.
- It is recommended that therapists who work with these clients are mindful of their own internalised homophobia or transphobia.
- Transgendered clients prefer that therapists educate themselves about issues of transgendered identity in terms of the specific challenges, effects of hormone therapy, and resources available, and have an ability to network with other health professionals working in this field, such as endocrinologists, and relevant general practitioners.
- As with gay and lesbian clients, there is no causal relationship between CSA and transgendered identity. However, there is a high incidence of CSA in the transgender community. This may be due to being vulnerable as children, perhaps because they appear different, socially isolated, or unprotected.
- Transgendered children and adolescents are a vulnerable group and may be targeted by sexual predators.

5. Effects

Principle 5: Effects notes the vast array of emotional, behavioural, social, cognitive, physical, and environmental effects of sexual abuse for children, adolescents, and adults. There is a close interplay between effects and coping strategies which serve a function for the person, and effects are unique for each individual. There are also particular developmental considerations regarding the effects of sexual abuse.

The research team spent much time considering the complex issue of the effects of sexual abuse. In some ways, these seem very obvious. The effects are clearly negative and cause a great deal of emotional distress, therefore counselling services are made available to people who have experienced such abuse. However, there is a complex professional matter buried in the assumption that sexual abuse causes harm. ACC coverage of counselling for sexual abuse has required two conditions to be met: that the person has a "mental injury" and that the mental injury was most likely caused by the abusive event. These terms come from the legislation. Defining them in relation to professional practice is complex. If a past experience of sexual abuse has altered someone's self-esteem and led to depression then to relationship problems with their partner, which part of that scenario is "mental injury", which part was directly caused by the abuse, and which part should be the focus of therapy?

Most professionals answered that none of the above questions matters. The client has been sexually abused and they are in distress. They should be eligible for counselling services and the therapist will focus on those aspects of the distress that, in their judgement and in the opinion of the client, are the most important.

The difficulty is that the pathway or sequence of effects (such as low self-esteem, depression, or interpersonal conflict) is rarely simple or clear-cut. PTSD was one explanation for emerging effects. A group of well-respected clinicians and researchers has produced (similar) thoughtful and thorough conceptualisations of the long-term effects of severe and/or chronic CSA (eg, Briere, 1996, 1997, 2002; Courtois, 2000; Herman, 1992). These people agree that the diagnosis of PTSD does not adequately encompass the complexity, breadth, and intensity of effects often found in clients who have experienced severe abuse. Additionally, one of the diagnostic criteria for PTSD (that the individual was in fear of their life) may not necessarily be met by people who nevertheless report a bewildering array of distressing symptoms and self-destructive life patterns. For example, Christine Courtois (2000) describes the conceptualisation of complex PTSD as including symptoms currently included in criteria for dissociative disorders, PTSD, and borderline personality disorder. These complex PTSD conceptualisations provide a base on which individually-tailored, integrative therapies can be designed.

Although the framework of PTSD is useful, it should not replace a broad assessment of individual functioning.[9,11,12] A broad assessment should include a range of a client's behavioural, emotional, cognitive, and physical effects and their use of healthy and unhealthy coping strategies. Focusing assessment solely on PTSD is unlikely to determine sufficiently a client's level of functioning or help to tailor therapy to their individual needs.[9,11] A thorough understanding of the nature of effects and coping for the specific client has implications for assessment, goal-setting, therapy planning, monitoring, and self-evaluation.

Sexual Abuse Affects the Person Abused

It is useful to be aware of the nature and impact of sexual abuse for the client. The duration, frequency, and intensity of effects can vary depending on the person's developmental stage, past and current context, resources of resiliency and support, coping strategies, and personality.[1–3,9,11–13]

Effects and coping responses of people who have been sexually abused vary in a number of ways. Adequate coping strategies for dealing with abuse can lead to more adaptive functioning and fewer effects over the lifespan.

Children may show particular patterns as a result of sexual abuse, although adverse reactions to sexual abuse vary widely. International and New Zealand literature indicates that, as well as the initial effects of CSA, up to one-fifth of those who have experienced CSA show long-term effects in terms of impaired functioning and psychological problems during the lifecycle. However, there are also many individuals who do not show significantly problematic long-term effects.

Effects Differ for Each Individual

> *All these different things change the impact like there is the age, there is the relationship, there is the environment, if there is support, if there is not support, there's all the socioeconomic influences, there are cognitive influences, intellectual influences…*[1]

Age. Effects that develop later in life are likely to result from a disruption of the developmental stage of the child at the time of the abuse.[12,13] Researchers are divided on whether the age at onset of CSA is an indicator of the severity and nature of difficulty later in life. Some researchers believe that the older the child is at the time of abuse, the higher the level of mental health problems.[12] Others have found greater harm is experienced in adulthood when abuse occurs at a younger age. In studies of adults who have experienced CSA, the change made in therapy decreases with increasing age.

Development. When working with children and adolescents, it is important to understand the potential impacts of abuse experiences at different developmental stages.[12,13] Factors to consider include:

- The developmental stage of the child at the time of the abuse
- The chronicity of abuse (time span during which the abuse persisted)
- The presence of concurrent physical and emotional abuse
- Particular experiences that affect the child according to the needs at different developmental stages
- The onset of puberty (eg, for adolescents, onset of puberty is known to change the nature of effects and can trigger "sleeper" effects).

Nature of abuse. The presence of force or threats is likely to increase the possibility of mental health effects in adulthood.[12] Similarly, multiple types of maltreatment and abuse in childhood may result in increased adjustment problems in later years.

The severity of abuse has an effect on psychological functioning.[12] Attempted or completed intercourse including oral, anal, or vaginal penetration leads to more severe, long-term difficulties compared with non-contact abuse, such as exposure to pornographic material. The effectiveness of therapy in studies of children and adults where sexual abuse primarily involved penetration was typically lower than in studies of non-penetrative sexual abuse. However, both forms of abuse are associated with mental health difficulties.

Frequent sexual abuse over long periods of time is likely to lead to higher levels of difficulty in adulthood.[12] A direct relationship between multiple perpetrators and mental health effects in later life is likely, in that more severe effects are associated with multiple perpetrators.

Intra-familial abuse by a father figure (incestuous abuse) leads to difficulties later in life, particularly in areas such as relationships, trust, and self-esteem, as well as high levels of mental health problems in adulthood.[12]

The other thing too is the difference between a caretaker and a stranger. If you are violated by someone who is supposed to be taking care of you versus just a random person… Basic trust… it's so violated. And if it's out there then… this [home] is safe. Whereas if it's someone in here then nothing is safe.[1]

Differences in effects will be apparent between a child who was groomed for sexual abuse slowly over time and a child who experienced an unexpected, traumatic or stressful sexually abusive event.[12] Sexual abuse by one's own siblings where there is less than a five-year age gap is often aided by the use of force. This was shown to result in severe emotional disturbance in adulthood.

Response to disclosure. Sexual abuse is the least disclosed type of abuse in New Zealand and is more likely to be disclosed to a friend than family members or professionals.[12] Negative responses to disclosure can impact negatively or positively on psychological functioning. Practitioners identified that a key issue in disclosure is a deep sense of shame or feeling demeaned by not being believed. The most helpful response to disclosure is one that conveys belief as well as reassurance that blame lies with the perpetrator.

Family, social, and interpersonal factors can help to develop an understanding of the relationship between sexual abuse and effects for the client.[1,12] People who have experienced CSA often report a higher level of family dysfunction marked by conflict, low care and authoritarian parenting styles, and physical violence.

I have heard people say often that when they have lived in a generally abusive environment that the emotional abuse has actually done the most damage.[1]

For more information on how the person's context influences their reaction to sexual abuse, see 11: Context.

Māori Clients

Many of the effects identified by Māori practitioners were similar to all individuals regardless of ethnicity. Some of the more frequently mentioned effects included:[1]

Kaua e takahi te mana o te tangata. The feeling of being disrespected is an effect of abuse that may lead to whakamā, lack of trust, defensiveness, aggression, shame, shyness, self-blame, and issues of confidence, self-esteem, and self-identity. Mana was identified as the outward or external expression of authority.

Disrupted whakapapa (family breakdown). The consequences of abuse often lead to whānau support being blocked, as well as loss of cultural identity and connection. The client may choose isolation, or be alienated, disowned, and pathologised by some whānau members. The abused person may reject things they consider to be Māori, including their cultural identity and their people, which disrupts the life continuum involving whakapapa, whanaungatanga, kinship, and history.

… and the cycle is specifically one of loss of identity, and often within that the doorways of accessing tautoko (support), and I say tautoko that's both in terms of familial support and in terms of support by way of wairua (spiritual), in terms of building them up…[1]

Violations of tikanga. The appropriate behaviour, actions, values, worldviews, and Māori protocols come into direct conflict with the act of sexual abuse. The breaking of tikanga may lead to a lack of safety and mahi tukino.

Violations of tapu are a direct attack on Te Tapu o te Tangata, the sanctity of the person. This leads to areas sacred and revered being desecrated and tarnished. The consequences may include sexual difficulties, unsafe sexual practices, sexual health issues, physical health problems, and sleep and eating problems.

I think the greatest difference in terms of working with Māori as opposed to non-Māori is tapu. I think that, the issue for Māori clients is a sense of having lost culture.[1]

Violations of mauri affect the internal resources of the person, including the power and influence a person may hold, as well as self-esteem and self-confidence. This could be associated with a sense of powerlessness, fearfulness, and loss of control.

Flight of wairua as a result of unseen spiritual influences is an extreme reaction to sexual abuse analogous to dissociation that results in de-personalisation, de-realisation, out-of-body experiences, numbness, and disengagement in stressful situations.

Māori males share issues similar to those of Pākehā men in terms of difficulties in disclosure due to social attitudes to sexual abuse:

- Men tend to be more restrained from reporting sexual abuse because of social conventions about male behaviour. Males are portrayed as strong and aggressive, and reporting sexual abuse is often seen as a sign of weakness
- The fear of being seen as homosexual is also linked to difficulties disclosing sexual abuse
- 50% of New Zealand males with a history of sexual abuse used avoidant and self-harming strategies to deal with their feelings of shame and low self-worth, as opposed to impulsive or aggressive behaviour. Practitioners described anger as a strong effect for males, and often mentioned that males who had been sexually abused went on to perpetrate physical violence or sexual abuse.

> *I have found that at least 80%... become perpetrators themselves... I think it is the anger and this is where it all comes back to for them... it may be beating up people rather than becoming a perpetrator.*[1]

Māori females may use their reproductive abilities as a coping strategy to escape school and an abusive home environment. Other effects described were dissociation, detachment, withdrawal from whānau, and an inability to identify and break the abuse cycle with their own children.

One of the key differences in effects was between younger and older Māori women. Younger women were characterised as defensive and "staunch", with an attitude of "not giving a damn". These effects were seen by practitioners as a "survival-kit" that resulted in acting-out, aggressive behaviour, and violence. Older women, on the other hand, were portrayed by a sense of reticence, shyness, hesitance, and guilt.

> *... older ones are more, hold back, are very whakamā about what's happened to them and the shame and the blame of the victim, and they've held it sometimes for years, not being able to let, let it come away from them.*[1]

Whānau can be an important support for those who have been sexually abused. However, often those who experienced intra-familial abuse were faced with a dilemma when the perpetrator was a loved and respected family member. Other family members may not be aware of the abuse and shame that can occur for the whānau when incidents of abuse are revealed. With extra-familial abuse, the person can experience an indirect disconnection from the support of their whānau. Both types of abuse were reported to lead to the loss of tūrangawaewae or isolation and the loss of their roots resulting from the disconnection from whānau and hapū.

> *Whānau, I think, is the other aspect that is often really significant for Māori... often there are issues around tūrangawaewae, people's ability to feel confident about where they stand and to feel safe within those sort of relationships with whānau.*[1]

There is a sense of being unable to return to the marae to be part of where the person comes from, and ambivalence about returning home as pakeke (difficult) and contributing. A sense of loss and not knowing how to reconnect are strong factors for developing problems.

... in the extra-familial situation, I think the issue is one of huge loss, again in that when a taonga (treasure) is defiled then that affects every member of that whānau; particularly when unaware of the abuse, they have no context for why their taonga is behaving the way they are... the aroha (love) just gets shut down.[1]

Pasifika Clients

... I think there's a definite difference between Māori and Pacific Islanders, although some people would say there's not, but I think there is, and I think it's that whole shame base for Pacific Islanders. And it is that for Māori but it's the holding of it that's very different and the talking of it is very different and their understanding of it is very different.[1]

Many of the identified effects are similar for all individuals regardless of ethnicity. Effects mentioned most frequently were self-esteem problems, emotional disturbances, thought difficulties, loss of trust in men, and physical, emotional, and mental health problems. However, Tongan and Samoan clients often reported that the family was quite closed about the abuse.[1] Effects are also described as more diffuse amongst Pacific Island groups than they are for less collectively-oriented cultures. Culture, family, and community have powerful impacts on outcomes for the abused person. Practitioners commented on the need to develop new practice models for therapists that are sensitive to the needs of Pacific Island communities and incorporate elements that are culturally appropriate.

Shame is an important issue for people of Pasifika who experience sexual abuse. Violation of trust and the loss of important relationships often lead to confusion. Issues related to loss of virginity can arise for those who were not consensually sexually active before the abuse.

I've worked with... Pacific Island girls and they seem to have more shame around that affront on their body because I think the body is more sacred.[1]

Sexual abuse impacts on individuals, families, and communities. As family is central to Pacific Island identity, sexual abuse has a strong impact on almost every family member. Reporting abuse brings shame to oneself and everyone else in the family.

I was just thinking about Polynesian clients... one of the things that became obvious to me, is the difficulty in talking about it in the family and the whole fear of things getting spread throughout the community because it is such a close community and that happens around even selecting a therapist or counsellor, that often not wanting to go to people in their own cultural groups, not so much Māori, because everybody will know. Someone will tell someone else.[1]

Sexual abuse is frequently unreported as it is often difficult for Polynesian people to talk about sexual matters or disclose family abuse. To report family abuse means "*that also brings shame onto the family so... they hold back, it takes a long time for them to disclose or trust somebody else*".[1] The well-being of the family is seen as more important than that of the individual. Being forced to disclose may be very difficult for Pacific Island clients:

You know in our village where we grew up in Samoa we don't share about these things... we don't have the words even. If we say the words in Samoan it's a shame to say those words so we don't talk about it, we pray. I think we silently pray about it and it'll go away. But unfortunately we have to deal with it here.[1]

Asian Clients

People from Asian countries are more likely to report physical problems than mental health difficulties, and may be referred to therapists by medical doctors or specialists who believe that unexplained physical symptoms could have a psychological basis.

In some cultures, sexual assault is related to more shame and victim-blaming. People from Asian countries often do not acknowledge or talk about mental illness, with "*a lot more I'm okay, no problems, everything's fine*", but seek help later for physical problems.[14]

Coping Strategies and Effects Serve a Function

The client's coping strategies are often an attempt to relieve overwhelming negative emotion. Practitioners need to be able to distinguish between how the client copes with the effects of abuse (such as avoidant or risk-taking behaviour, self-harm, or substance abuse) and the effects themselves (such as anxiety, fear, shame, low self-esteem, and low arousal or problems with concentration and sleep). The interaction between coping strategies and the effects of sexual abuse influences the client's ability to function. What historically may have been an adaptive and useful coping strategy that helped the person survive can instead end up being a problem. An aim of therapy is to replace harmful coping strategies with helpful ones, although the therapist should first seek to strengthen and develop healthy strategies.[12,15] Coping through avoidance is related to elevated levels of negative effects and emotional distress.[9,12] Avoidance is a common coping strategy that provides temporary relief but does not avert long-term negative effects.

There is No Single Effect in Isolation

There is a range of effects that are interrelated depending on abuse-related and other variables. No single effect can be seen as a trustworthy indicator of sexual abuse. Since effects never occur in isolation, it is useful to consider them in terms of what effects are more likely to co-occur.

To identify effects of sexual abuse, the international literature and traditional diagnostic systems were thoroughly searched and researchers and practitioners across New Zealand consulted. This led to a large number of effects (initially more than 700) being identified and reviewed. The number of effects for children, adolescents, and adults were finally reduced to approximately 200. These identified effects were then written onto cards and reviewed by practitioners, researchers, and clients of sexual abuse services to identify overlaps and ensure that the wording was understandable to most people.[9]

The next aim included understanding what effects appear simultaneously (effect clusters) and how these clusters interrelate. Clients, lay people, practitioners, and researchers separately organised the different effects in multiple sorting tasks. The results were analysed using sophisticated multidimensional scaling techniques.[9,11] The results indicated that these different groups of people organised the effects into highly consistent, similar, and coherent patterns. People from different backgrounds and professions had highly comparable views on how these effects are connected and organised. Some of the results are presented in the following sections.

It is acknowledged that the emerging clusters and interrelationships from the New Zealand participants are somewhat different from traditional diagnostic systems. However, effects reflecting various disorders commonly reported to follow sexual abuse were included in the research. In the New Zealand sample, these traditionally organised effects were not considered to cluster.

Children and adolescents. The following list shows the range of effects and coping behaviours in children and adolescents that can follow sexual abuse. The examples for each type of effect demonstrate the variety

of behaviours that can be evident in children and adolescents. Some effects can occur on extreme ends of a behavioural continuum, such as acting-in or acting-out behaviour. The range of effects demonstrates why no single effect can be a trustworthy indicator of sexual abuse. New Zealand practitioners reported these illustrative behaviours as likely to co-occur. The list is not comprehensive but should serve as a guide to structure the often varied array of effects.

SUMMARY OF SOME OF THE EFFECTS AND COPING PATTERNS RELATED TO SEXUAL ABUSE (AND ILLUSTRATIVE BEHAVIOURS) FOR CHILDREN AND ADOLESCENTS[9]
Denial Insists everything is fine, refuses to be helped, avoids talking about own feelings
Regressive Starts wetting bed at night, wets clothes during the day, immature behaviour (eg, thumb-sucking), uses baby talk, difficulties calming down, refuses to go to bed
Hypervigilant Jumpy, easily frightened, bites fingernails, fearful about sleeping in the dark, clingy
Feeling threatened Feels threatened or afraid of others
Pessimistic Pessimistic about the future, negative about self and others
Self-blame and insecurity Worried about others' opinions, perfectionistic, constantly comparing themselves to others, feels guilty, blames themselves when things go wrong, overly protective of loved ones, fearful of losing loved others
Disobedient/Aggressive behaviour Constantly lies, gets into trouble at school, truant from school, bullies others, aggressive, tries to push the limits (eg, rebellious), disobedient, angry, quick-tempered, gets into dangerous situations, runs away from home, lacks empathy
Sexualised behaviour Places objects in rectum or genitals, preoccupied with sexual behaviour (eg, compulsive masturbation), exposes genitals, unusual level of sexual knowledge for age, preoccupied with sexual behaviour or pregnancy, confused about sexual identity
Dissociative behaviour Difficulties concentrating, muddled, lost in thought, passive, constantly daydreaming
Self-harm behaviour Harms self with objects (eg, cuts arms with blades), shows an intent to take own life, tries to commit suicide
Substance abuse Drinks alcohol, experiments with drugs, smokes cannabis
Eating difficulties Refuses to eat, eats too much, sudden changes in eating habits

Adults. The following list identifies groups of effects and behavioural examples for adults reported by practitioners and adult clients with a history of CSA.

SUMMARY OF SOME OF THE EFFECTS AND COPING PATTERNS RELATED TO SEXUAL ABUSE (AND ILLUSTRATIVE BEHAVIOURS) FOR ADULTS[9]
Avoidant Avoids socialising or mixing with other people, enjoys being alone, avoids certain places or activities, avoids talking about the past, has trouble trusting others (eg, friends, partner)
Impulsive/Risk-taking Drinks regularly, acts on the spur of the moment, drink-drives, is hot-tempered, engages in unsafe activities (eg, invites strangers into house, walks alone at night), has thoughts of hurting others
Self-harm behaviour Thoughts about suicide, hurts self on purpose (eg, cutting)
Shame/Low self-esteem Feels humiliated, afraid of what other people think, feels worthless, lonely, avoids intimacy
Arousal Trouble concentrating, lack of energy, easily frustrated, indecisive, trouble getting to sleep
Anxious/Fearful Frightened to be alone, on edge, trouble breathing, suddenly scared for no reason, nightmares or bad dreams, feeling unsafe
Pessimistic/Depressed Bad things continue to happen, pessimistic, feels worthless
Somatic complaints Irregular or severe menstrual periods, chronic pain (eg, arms, lower back), trouble breathing, irregular eating habits
Sexual difficulties Sexual problems (eg, no arousal), sexually unsatisfied, ashamed of sexual behaviour, embarrassed if others talk about sex, easily disgusted, engages in sexual activities to make things go own way

Sexual Abuse is a Complex Life Experience, Not a Diagnosis or Disorder

Understanding typical response patterns can be beneficial to clients and practitioners in therapy, as it allows practitioners to normalise their clients' experiences, individually tailor counselling, and monitor changes and progress over time in a way that is understood by the clients. Visual feedback on progress can then be given to clients.[9,11]

Clients with a history of sexual abuse reported on the effects and response patterns they experienced prior to seeking counselling. This gave valuable information about consistent and prevailing patterns of effects and their link to unhealthy coping strategies. These response patterns provide a general insight into the relationship of different effects and coping behaviours. Practitioners should not "make clients fit" into these patterns, and the patterns do not replace a comprehensive assessment. The following descriptions outline three main response patterns to CSA reported by adult clients in New Zealand.

Predominant female response patterns to CSA. Half of the sample of female clients reported high levels of anxiety. They also described depression and hopelessness, low self-esteem, and shame, as well as some characteristics of arousal (ie, problems with concentration and sleep, easily frustrated, indecisive). Although

only providing temporary relief, avoidant behaviour was the most frequently reported coping strategy by these women (ie, avoiding places or activities, enjoying being alone).[9,11] Other strategies such as self-harm or risk-taking behaviours were not reported. While somatic problems (eg, chronic pain, trouble breathing) were indicated by some women, sexual difficulties were generally not reported in this group.

Overall, avoidant strategies seemed to be mostly used when anxiety/arousal and depression/shame/low self-esteem were the main effects of sexual abuse.

Predominant male and overall response pattern to CSA. 50% of the sample of males and 22% of the sample of females reported a different pattern of sexual abuse effects and coping responses.[9,11] The main difference from the previous pattern is that there was no indication of fear and anxiety. However, high levels of depression, hopelessness, shame, low self-esteem, and arousal were again linked to coping through avoidance. An additional coping behaviour in this group was the use of self-harming strategies. This group also tended not to report physiological reactions such as sexual difficulties and somatic problems.

Overall, hopelessness, shame, and arousal seemed to be the effects linked to avoidant coping in both males and females. In comparison with males, females with a history of sexual abuse who reported high levels of anxiety also described avoidance of certain places, memories, and situations such as social interactions. However, males and females who were unaware of any anxiety frequently described relief from negative affect through self-harm.

Response pattern for females and males. Another response pattern was reported by a smaller number of males and females.[9,11] The pattern was characterised by heavy reliance on externalising or risk-taking coping behaviours such as substance abuse, aggression, and engaging in unsafe activities (eg, drink-driving, walking alone at night). There was no use of avoidance but high levels of impulsivity and risk of self-harm. Again, fear or anxiety as well as physiological difficulties (eg, sexual or somatic) were absent. Only moderate levels of shame and depression were reported.

It is important to note that the absence of anxiety and a high risk of self-harm occurred simultaneously across two otherwise different female and male response patterns. In addition, none of the clients reported the use of both externalising and internalising behaviours. Females and males always reported a high level of one type of behaviour (eg, avoidance) and the absence of the other type (eg, impulsivity/risk-taking). This emphasises the need to view effects and coping behaviours as interrelated rather than to gather information about the frequency or intensity of effects in isolation.

Effects can be Temporary and Discontinuous Across the Lifecycle

Children and adolescents. Effects of sexual abuse can be discontinuous in that they are likely to re-emerge in situations due to changes or stressors in the environment.[1,12] Such effects are also known as “sleeper” effects. For children and adolescents, the onset of puberty or the first intimate experiences are situations that can trigger sleeper effects. Long-term effects, however, are not inevitable. Involvement with legal procedures can exacerbate symptoms.

Adults. Variability in effects over time or the re-emergence of maladaptive functioning can be triggered by situations in which a person can feel vulnerable such as pregnancy, childbirth, beginning a new relationship, or seeing their own children arrive at the age that the client suffered their own abuse. Additional abusive episodes are also likely to lead to the re-emergence of effects or disruptions to healthy functioning. As for children and adolescents, involvement with legal procedures can exacerbate symptoms.

It is common for people who have been sexually abused to experience both CSA and sexual assault as an older youth or adult. In single events of adult sexual assault, although a reaction of shock and trauma is reported, the individual is seen as having had the opportunity over time to develop coping resources. When sexual abuse occurs over a period of time, effects are likely to become entrenched and the perception of self, world, and relationships can become severely distorted.

Resilience is common in children and adults. Try to understand protective factors known to decrease effects and use these to strengthen the client's resilience, such as working towards reconnecting with whānau and family, accessing social support and engaging in good-quality relationships, helping the client develop a positive self-concept, and replacing harmful coping with helpful and positive coping strategies.[1,7,12]

CONSIDER A VARIETY OF FACTORS IN THE CLIENT'S CURRENT FUNCTIONING:

What are the relevant developmental and environmental factors?

- Age and developmental stage?
- Nature of abuse (type, frequency, intensity, and chronicity)?
- Relationship to and number of perpetrators?
- Response to disclosure?
- Other life stressors?
- Resilience and support networks?
- Coping strategies?

Are there any culture-specific factors?

Has the client had an opportunity to discuss aspects of effects related to culture, age, gender, etc?

Is there a need for specialist supervision and advice?

Are there any language-specific factors?

Are there any developmental factors that might affect verbal ability?

Has there been sufficient explanation of the effects and the client's coping responses to these effects?

Have the client's existing coping strategies been identified (helpful and unhelpful)? Has the client been assisted to cope in new ways before being guided to remove old harmful strategies?

Are the client's changes in effects and coping being monitored?

How is the expression of effects and coping influenced by age, stage, and life events such as puberty, the onset of the first or a new intimate relationship, pregnancy, childbirth, divorce, loss, and/or the age and stage of their own children?

What protective factors are evident in the client's history and current functioning?

How can these factors be developed to strengthen the client's resilience?

What are the quality and effectiveness of the client's social support?

What are their relationships like?

How do they view themselves?

Sexual Assault is an Event, Not a Diagnosis or Disorder

Sexual assault is an horrific event, but not all who experience it are equally traumatised and require the same level of professional attention. Do not assume that long-term difficulties are inevitable.[1,15]

> *The commonest sort of acute presentation that we see is "stunned mullet" presentation. People are often just completely dissociated, numbed out, and often compliant, and just doing what they need to do to get through it. Their affect is quite flattened. That's a normal kind of acute trauma*

reaction. We don't know what they're going to look like a month or so down the track… we'll see the classics of a post-traumatic thing often presenting at that three month check up…[1]

The international research and the experience of New Zealand practitioners indicate that, when sexual assault is a single event in adulthood, the effects are very different compared with someone who experienced sexual abuse as a child. This is probably because adults who have experienced a single sexual assault had the opportunity to develop as a person prior to the event and have experienced trusting relationships. Since the sexually-abused child is still developing during and after abuse events, the development of important protective skills such as resilience is severely hindered.[1] There is an overrepresentation of sexual assault in vulnerable populations such as people with disabilities (eg, hearing impairment, intellectual disability), Māori, people with a history of sexual abuse or assault, those who speak English as a second language, and recent immigrants.[1]

It is useful to ask for a history of sexual abuse or assault when working with people who have recently experienced sexual assault. For clients with such a history, the most recent assault is likely to trigger many trauma-related reactions. Representatives from DSAC reported that women who have experienced chronic abuse frequently visit their general practitioner with medical problems such as chronic pain, particularly pelvic pain. They commented that some clients seem to exhibit a high level of resilience, seeming to "*put it behind them*" relatively quickly, while others struggle for long periods of time. A possible explanation provided was that women who recover more quickly have a greater sense of connection and family support. It may be that the resilient group is more likely to have experienced sexual assault as an adolescent or adult than chronic CSA. The following table outlines some of the common short- and long-term reactions to sexual assault:[1,15]

SHORT-TERM REACTIONS	
Emotional numbing	Loneliness
Disorientation	Anger
Disbelief or denial	Shame
Helplessness	Guilt
Vulnerability	Somatic complaints (eg, headaches)
Fear	Sleeping difficulties
Intrusive thoughts	Hyperarousal or hypervigilance

LONG-TERM RESPONSES	
Fear and anxiety	Depression and suicidality
Low self-esteem	Avoidance
Sexual problems	Social/Emotional isolation/avoidance
Nightmares	Altered body image/eating problems
Intrusive thoughts	Relationship difficulties/lack of trust
Hyperarousal or hypervigilance	Increased startle response
Irritability	Emotional numbing

Acute stress disorder and PTSD. There is a higher rate of PTSD after sexual assault than after any other type of trauma. However, without underestimating its devastating effects, it should not be assumed that long-term difficulties are inevitable.[1,15] The symptoms of post-traumatic stress can often be seen within three months of and immediately after the assault, although the latter is an acute reaction.[15] (Consult the appropriate literature for the criteria for these effects.)

TRAUMATIC EFFECTS RELATED TO SEXUAL ASSAULT AND ABUSE:		
Acute stress disorder: Did the effects occur within four weeks of the assault and resolve within that time period?	YES	NO
Acute PTSD: Were the effects consistent with PTSD but lasted less than three months?	YES	NO
Chronic PTSD: Did the effects last for three months or longer?	YES	NO
PTSD with delayed onset: Did the effects begin six months after the assault?	YES	NO
Complex PTSD: A complex range of symptoms which may follow severe and/or chronic CSA (includes symptoms currently included in the diagnostic criteria for dissociative disorders, PTSD, and borderline personality disorder).	YES	NO

The presence of avoidance after sexual assault is an indication of the increased possibility of the development of PTSD.[15] Despite the usefulness of the PTSD framework, practitioners should assess a variety of environmental and individual factors that interact with the person's experience of the assault and lead to individual differences in reactions.[15] Recovery from the experience of sexual assault is an individual, personal, and complex process.[15]

Reactions to sexual assault can dissipate rapidly or persist for a long period of time. It is not fully known why some people develop persistent problems while others do not. However, what is known is that a variety of factors prior to (eg, relationship to perpetrator, family functioning), during (eg, severity of assault) and subsequent to the event (eg, reaction to disclosure) may moderate the impact sexual assault has on a person's functioning.[15] Other factors influencing reactions to assault include family, culture, and society (see 11: Context).

Coping mechanisms are thought to relieve a client of negative affect experienced following the abuse. For some clients, adverse emotional and psychological reactions can decrease and disappear rapidly over time.[1,15] However, other people endure long-lasting consequences such as PTSD or complex PTSD.[15] Researchers have shown that, even 14 years after an assault, effects can still be present.[15] A gradual decrease in difficulties does not necessarily equate to recovery from sexual assault. Instead, effects can change as a consequence of time, the post-assault experience, or coping strategies used. An individual's effects are influenced by a variety of factors, as discussed below.

Relationship to the perpetrator. Sexual assault perpetrated by an acquaintance is as destructive as sexual assault by a stranger.[15] Contrary to common belief, those who experience sexual assault by an acquaintance are less likely to view the experience as an assault, and therefore less likely to report it and seek professional help.

Life stressors prior to sexual assault. People who experience CSA are more likely to be sexually assaulted.[1,15] The severity of earlier abuse is often related to an increase in the risk of experiencing sexual violence later in life. Those who experience multiple sexual abuse events are also at increased risk of developing severe and long-term difficulties.

Age. People of all ages are traumatised by sexual assault.[1,15] Younger people are likely to display trauma-related symptoms as a result of sexual assault.[15] However, elderly adults are also thought to be severely affected by sexual assault and may be more reluctant to disclose or seek professional help.[15] For those who do seek professional help, research indicates that the older the client is at the time of the assault, the better they respond to therapy.[6]

Culture. From a Māori perspective, the female genitalia (Te Whare Tangata) is viewed as tapu, as it brings together the divine and the human in the creation of life.[1,15] Sexual assault is therefore an attack on the mana and dignity of the birthplace.[15] Some may blame the assault on the victim, which can result in much shame and other disruptive effects.

Gender. While some effects of sexual assault are similar regardless of gender, research also indicates gender-specific difficulties for men following sexual assault.[1,15] Be aware that some men have a greater reluctance to seek help due to stigmatising social attitudes regarding homosexuality. As a result of sexual assault or sexual abuse, men tend to report difficulties with sexuality, sexual functioning, social isolation, intimacy, and self-harm.

Males are often portrayed as strong and aggressive. Reporting sexual assault or abuse is considered a portrayal of weakness. The responses by others to the person who was assaulted can have a greater traumatic effect than the abuse event itself.[1] People's beliefs and attitudes about male behaviour may involve a strong emotional reaction. Social attitudes are considered to work in favour of females reporting an assault. Many practitioners and clients felt that, in the same situation, males may be more restrained from reporting abuse by social conventions about male behaviour.

> *Oh I think it's more confusing because of the fact that there is so much out there that's saying "you should have enjoyed this, wow lucky you", you know if only it was me that kind of thing...*[1]

When a male is sexually assaulted by another male, a common question for them is whether it means they are homosexual.[1] Natural physiological responses to genital touch are often falsely interpreted as a sign of enjoyment and raise questions about sexual identity. Fear of homosexuality is another issue in reporting or recognising sexual abuse. Information needs to be given to clients informing them that physiological reactions are a natural response to sexual touch, but that this does not necessarily indicate homosexuality. Before seeking help males often experience a long process of personal insecurity, shame, grief, and denial. Furthermore, a male's perception of the sexual assault event can influence his functioning later in life.

> *I think the biggest thing for male survivors is the additional issue around homosexuality. One man that I have counselled was abused by males. And he had this great fear of people thinking he would be homosexual in fact he wondered himself if this made him a homosexual.*[1]

Drug-assisted sexual assault. Gaps in memory can occur through drug-assisted sexual assault (eg, drink-spiking or substance abuse), so that the person has little or no recollection of the event.[15] Alternatively, the client may have voluntarily ingested sufficient alcohol or drugs to become unsafe and vulnerable to being exposed to high-risk situations.

> *... when people don't have a memory their minds are often going crazy about what might have happened and might not have happened and fill the gaps with the worst case scenario.*[1]

Benzodiazepine flunitrazepam (Rohypnol) and the y-aminobutyric acid agonist y-hydroxybutyrate can result in a lack or complete loss of memory. Be aware that, despite not having detailed memory, clients show a similar behavioural pattern to those who have experienced non-drug-assisted sexual assault. Prophylactics for pregnancy and sexually-transmitted infection screening are difficult in cases of drug-assisted sexual assault because of the lack of memory of events. Make sure all prophylactic interventions are covered.

Sexual assault in the context of an intimate relationship. When sexual assault occurs within the context of an intimate relationship (in which it is expected there will be trust, respect, love, and emotional closeness), there are parallels with the effects of intra-familial CSA. A clear difference is the developmental stage of the person assaulted, as in the case of intimate partner sexual violence, in that the person is an adult. However, individuals may have quite different responses to this type of abuse, according to their backgrounds. Women who have grown up in families that imbued in them a sense of worth may quickly decide not to stay in an abusive relationship. However, when people have experienced childhood abuse or neglect (physical, emotional, and/or sexual), their sense of self may be too fragile to recognise clearly that sexual assault within their intimate relationship is abusive and destructive. Women who are regularly sexually assaulted by their partners may share many of the characteristics of "battered woman syndrome", feeling helpless to change their situation and not

considering that they deserve better. To date, most partner violence research has related to physical abuse, and more investigation needs to be carried out in relation to sexual abuse. While in New Zealand it is illegal for men to subject their partners to rape or other unwanted sexual activity, elsewhere debate has continued about whether the law should recognise marital rape.

There is research evidence to suggest that, compared with sexual assault by a non-intimate partner, sexual assault by an intimate partner is the strongest predictor of PTSD, stress, and dissociation.[19] Further, sexual abuse often co-occurs with physical abuse within a relationship. Women who are subjected to chronic physical abuse often report that their partners force them to engage in degrading and sadistic sexual practices.[20] A further issue of concern is that marital sexual assault survivors may be significantly more likely than acquaintance/stranger survivors to experience numerous assaults, many experiencing more than 10 assaults in a six-month period, and may also be less likely to seek help, from either Police or an agency.[21]

AREAS TO EVALUATE FOLLOWING SEXUAL ASSAULT:[1]		
Has there been a medical check? Has the client been screened for physical damage, sexually-transmitted infections, and the possibility of pregnancy?	YES	NO
Should prophylactic interventions be considered? Are pregnancy or sexually-transmitted infections an issue?	YES	NO
What educational information does the client have? Has practical information been given about issues such as sexually-transmitted infections and potential pregnancy, and local sexual assault counselling agencies?	YES	NO
Have appropriate lines of communication been established? Has communication been established with the general practitioner, client, therapist, and other relevant people?	YES	NO

6. Assessment

Principle 6: Assessment encourages the use of multiple assessment approaches and sources of information, as well as assessment as an ongoing process. The importance of considering lifespan development in assessment is highlighted.

> *I am doing an assessment process all the time mentally. I know the things that I need to know and I will be taking notes, and I say to them "I have learnt this about you" and let them know. I do an assessment process...*[1]

What is Assessment?

Assessment is the process of gathering information about the client to identify and prioritise their needs, with safety being paramount. A good assessment will help the therapist to understand the client in their context, identify their challenges and strengths, and develop an understanding of the client's difficulties. In creating this understanding, the practitioner brings together information from different sources that help them understand how and why the identified problems might have developed. This includes understanding what components of the client's environment, relationships, and personality traits impact on their current functioning. The understanding can be shared with the client and guides the development of a formulation and therapy plan which reflects the client's specific and unique therapeutic needs.

Assessment ideally draws information from a variety of sources, including the client's narrative, interview (asking the client specific questions), and information from significant others (where appropriate and consented to by the client) such as a partner or family member(s). This information may be further enriched by asking the client to complete pen-and-paper questionnaires which give information about the possible presence of difficulties like anxiety, depression, or PTSD. The advantage of using such questionnaires is that they help to gather a lot of information relatively quickly, and the client can complete them at various times throughout therapy in order to monitor progress.

Important areas to assess include safety, risk, and physical and emotional health, as well as broader areas such as relationships, family/whānau, identity, and self-esteem. It is also useful to ensure information is gathered from the client about lifespan development, personality traits, employment, education, their social support network, and their peer group.

Why Assess?

Intrinsic to assessment is gaining an understanding of what brought the client to the point of seeking help, how their needs may have been compromised, how the client has coped, and what their strengths and resources are, with a view to how best to proceed. Understanding why the client is experiencing difficulties provides the practitioner with information about how best to guide them to address the problems. When sufficient information has been gathered for the practitioner to develop a thorough understanding (a formulation), an important next step is sharing it with the client and asking whether it seems to make sense to them.

If necessary, alterations can then be made to better reflect the client's perspective. Clients often reported that they appreciated therapists who appeared to know what they were doing and could explain why they were doing it. This helped them to feel that therapy had been tailored to their unique needs, and that the therapist had a good understanding of them and was competent in finding ways to work with their specific sets of

difficulties. Clients also reported feeling safer knowing the direction of the therapy, and how the therapist intended addressing various issues of concern to them. This also involved discussing with and showing clients the amount of progress made using a variety of media, such as visual feedback. The international literature also attests to the fact that therapy which is tailored to each individual has better outcomes than therapy which is more general.

Collecting Information

> *Information on the effects of sexual abuse on a child can be gathered from the parents, the teacher... and... also the child.*[1]

Assessment involves gathering accurate information. Unfortunately, it is not always possible to gather information from one absolutely accurate source, so information should be accessed from a variety of sources. This approach increases the possibility of amassing information which will give an accurate overall picture of the client in a variety of environments and situations. For example, when gathering information about a child or adolescent, the therapist could talk with the child or adolescent, parent(s), caregiver(s), and teacher(s). If there are other health practitioners or relevant professionals involved with the child or adolescent, they would also be important sources of information.

Additionally, observations and questionnaires are valuable adjuncts to interviewing. When working with children, be aware that the accuracy of information received is dependent on the child's relationship with the practitioner, memory limitations, and the number of sources of information available. Likewise, with adults, interviews with the client and significant others, observations, and questionnaires are recommended as part of a thorough assessment. Interviews with others, of course, always depend on the needs and preferences of the client, and are only undertaken for the client's benefit and with the client's informed consent.

Another way to enhance accuracy is to include more than one location when carrying out an assessment, particularly when working with children.[6] For children, this may mean observations in the therapist's office as well as at school or home. This will provide a better picture of the child in their world. For adults, out-of-session tasks or daily diaries may provide valuable insights.

Ensuring the client's narrative and worldview are accurately understood is a good reason for checking information with the client. Meanings ascribed by a client can easily be misunderstood by the practitioner, and vice versa. A client's story must never be overshadowed by the therapist's interpretation of events. To ensure this, the client must be given space to tell their story. This needs to be balanced with pacing and guidance offered by the therapist. Supervision from senior professionals or cultural advisors is another recommended source of guidance.[1,2]

Practitioners are also mindful of their interaction with clients during the assessment process. The interaction, emotion, experiences, and content of conversation contribute valuable information about the client. Practitioners continually observe, reflect, listen and, when appropriate, ask. It is recommended that the therapist be able to collect information and tolerate what the client tells them. They should also be hopeful, honest, open to the client's worldview, accepting, gentle but firm, optimistic, positive, able to communicate with the client, respectful, challenging, and able to listen.[1,3]

Strategies for Assessment

> *I ask them about their peer group, how they get on with their teacher, what their family life is like, and for example, if they have any naughty friends and at the end of therapy they have some new friends, that's a cool measure. I also look at the symptoms, and I also look at the intensity*

and frequency, like have they stopped wetting their bed now, how many nightmares have they had, how many fights at school did they get in, those kinds of things. I look for behaviour change and mastery of… some of the practical things to change their behaviour… I sometimes consult with parents, how has his behaviour improved at home, how is he now, do they have any further concerns about the child.[16]

It is useful to employ a combination of both informal and formal approaches in assessment. Informal assessment methods include observations and interviews, while formal assessment includes the use of questionnaires, checklists, and structured interview measures (where a range of specific questions is asked in a specific order). Observation involves the therapist observing their own responses (this may provide useful information about how others respond to this client), as well as observing the client's verbal and non-verbal interactions and completion of tasks.

Using questionnaires at certain points in therapy helps the therapist and client to track progress. When the results of questionnaires indicate no progress is being made, further assessment is needed. This additional information can be used to further refine the understanding of the client, or perhaps to develop an alternative understanding of how the contributing elements work together. This is again reviewed by the therapist and client collaboratively in planning new therapy goals in an attempt to ensure therapy is progressing satisfactorily. Ideally, the therapist will not rely exclusively on either informal or formal assessment approaches, as neither approach is sufficient alone. Ongoing assessment and monitoring ensures that the therapist is maintaining external accountability (eg, where therapy is funded by a third party such as ACC) and is also necessary to ensure practice is safe and ethical.

Observation

Observation of behaviour is a useful assessment method with children, adolescents, and adults.

Children and adolescents. It is useful to observe children and adolescents in a variety of settings, including during therapy, at home, at school, with family, with peers, and with other adults. In the therapy setting drawings, sand trays, and sculpture are useful observation tools with children to help them describe and disclose when they do not have the necessary vocabulary. For example, children who have been sexually abused may draw pictures with sexual and emotional content.

Play therapy is another useful form of observation that gives the child a voice, assists their expression without requiring words, and may help them to connect with difficult feelings while in a safe place. This can assist the child to process trauma when it is necessary and safe for them to do so. Play therapy can be directive or non-directive, using media such as dolls, puppets, toys, board games, and stories. During play, the therapist should observe the child's mood, fears, and any emerging themes.

Observations in the home and school might include non-structured impressions, recordings of the frequency of behaviour, observation of communication and emotions, and observation of how the client engages in interactive tasks with others. Observation can help the therapist to evaluate the manifestation of effects, communication patterns, understanding and management of emotions, problem-solving, and relationships to others, including peers, siblings, and adults.

Adults. With adults therapists are encouraged to observe and monitor the client's interpersonal interactions during the session, including how the client relates to the therapist and their capacity for intimacy, ability to discuss particular topics, emotional state, and relationship skills.

Therapist observation. Therapists need to observe their own emotional, behavioural, and thought processes, as these provide valuable information about the client's emotions and interpersonal skills. This process helps to inform the therapist about how the client may be feeling and how others may respond to them.

Interview

Interviews are semi-structured interactions that are often conducted in a specific location, are purposeful, and are guided and directed, while also being flexible and responsive to the needs of the client and practitioner. The purpose of the interview is for the practitioner to start to develop a therapeutic relationship with the client and to gather information about the nature of the client's difficulties in order to plan therapy.

Children and adolescents. A valuable source of information is the client's own account. Interviews are used not only to obtain this information, but to observe behaviour such as how a child and caregiver respond to the therapist and to one another. This form of assessment with children is recommended when their more basic needs for safety, food, shelter, and security have been met. In addition, interviewers need to have the necessary knowledge to conduct interviews with children and adolescents, the child needs to feel their therapist cares and can be trusted, and the child needs to be developmentally able to participate in the interview (given the difficulties in using standard interviewing methods when assessing pre-verbal children or children with limited verbal abilities).

Interviews elicit information about safety, developmental and family history, physical and mental health, education, and other information the child or adolescent is able to provide. Information on parental history can also be obtained from the parent(s), including their personal history of trauma and abuse, family of origin, substance abuse, and physical, mental, and relationship problems. This information helps the therapist to contextualise clients and their responses. The use of genograms, lifeline drawings, and timelines is helpful in tracking difficulties in the context of the client's history.

Interviews can be conducted with appropriate family members and other extra-familial sources. In addition to interviewing families, it is worthwhile to interview other informants such as teachers, social workers, day-care workers, and former therapists.

Adults. Interviews are used to obtain information and understand the dynamic and interactional process of how a client responds.[16] The most common form of assessment is questioning and observing clients in an interview setting. It is useful to involve process techniques related to pacing, timing, and rapport-building, coupled with reliable information-gathering. A competent practitioner pays close attention to the interview process and uses a variety of techniques to ensure the process is as comfortable as possible.

Pen-and-Paper Questionnaires

An exclusive reliance on practitioner opinions and clinical experience is sometimes inadequate. Therefore, the use of client self-report as the only means of monitoring change is often insufficient. A multi-modal approach with a range of formal and informal tools is recommended to assess a client's progress. Assessment with standardised and validated formal assessment measures is particularly recommended when practitioners seek information about clients' current and past functioning. The use of pen-and-paper questionnaires is also recommended as a useful part of therapy to gain an understanding of clients' perspectives of their needs and responses. Practitioners who use formal assessments as part of their practice reported that this information provided a useful way to talk with clients about their progress in therapy. Clients are often greatly encouraged by noting how the intensity of their symptoms has reduced according to the outcomes recorded on monitoring

questionnaires over time. This is particularly helpful when a specific effect is still a part of a client's life yet they have difficulty recognising change over time.

Considerations. Not all questionnaires are useful for all clients or situations. When selecting questionnaires that will complement practice, consider the following:

FACTORS TO CONSIDER WHEN SELECTING QUESTIONNAIRES:
1. Relevance to client and sensitivity to change Is the questionnaire sensitive to change (ie, will it give information about whether the client is improving over time)? Is it relevant to the client (i.e, will it make sense and seem logical)? Is it appropriate for the client's age and culture? Does it measure the effects of sexual abuse or assault? Does it measure level of functioning?
2. Easily understood and completed Can the instructions be followed easily? How much time does it take to complete?
3. Use of objective referents Does it assess here-and-now issues in a tangible way? Does it describe behaviour, thoughts, and emotions in ways that assist the client to complete the form and the therapist to benefit from the information?
4. Use of multiple respondents (eg, self and practitioner reports) Can it be used with a number of sources? For example, can the client and their caregiver or teacher use it?
5. Therapeutic process information Will it enhance the therapeutic process? Will it provide valuable encouragement and feedback to clients? Is it relevant to human experience? Can it account for changes in functioning?
6. Psychometric properties Is it reliable and consistent? Does it assess what it purports to? How accurate is it? Is it appropriate for New Zealand clients?
7. Accessibility Is it difficult to access? Is it restricted to specialist practitioners?
8. Cost Is it affordable?
9. Understanding by non-professionals Will it be understood by the client? Does it require a high degree of literacy?
10. Interpretation and feedback Can the therapist give the client uncomplicated feedback from this questionnaire? Is it too complicated? Does it make sense?
11. Practical use How useful will it be in informing decision-making? Is it going to add value to the therapist's understanding of the client?
12. Necessity Is it necessary? Is it going to add to a positive outcome?
13. Compatibility and suitability Is it compatible with the therapist's theoretical orientation and practice? Is it suitable for the client?

Useful pen-and-paper questionnaires or measures. A review of relevant international measures was carried out, and the following outline is recommended as a guide for formalising an assessment approach.[8,16,17] Measures appropriate to the individual client should be selected.

SCREENING OR OUTCOME MEASURES	TOP CORE-SYSTEM OHIO SCALES: CHILD AND ADOLESCENT	ADULT	GENERAL	Observation, interview, collateral data when available, file review, and other historical information
PRIMARY MEASURES ACCESSIBLE TO ALL PRACTITIONERS [COUNSELLING OR HEALTH-RELATED QUALIFICATION]	CBCL CRTIR SDQ TSCC TSCYC	BSI IES SPTSS	GAS Likert scales QOLI VPS and other client satisfaction scales	
	CAPA CAPS-CA	CAPS		
SECONDARY SPECIALIST MEASURES (EXAMPLES) [RESTRICTED TO PSYCHOLOGISTS]	BYI CDI MASC	BDI-II		
	Measures of cognitive and adaptive functioning Measures of non-trauma-related difficulties			

BDI-II	Beck Depression Inventory (Second Edition; Beck, Steer, & Brown, 1996)
BSI	Brief Symptom Inventory (Derogatis, 1993)
BYI	Beck Youth Inventories of Emotional and Social Impairment (Beck, Beck, & Jolly, 2001)
CAPA	Child and Adolescent Psychiatric Assessment – Child version (Angold & Costello, 2000)
CAPS	Clinician-Administered PTSD Scale (Blake et al, 1995, 1998)
CAPS-CA	Clinician-Administered PTSD Scale for Children and Adolescents (Nader et al, 1998, 2002; Newman & Ribbe, 1996)
CBCL	ASEBA Child Behavior Checklist (1–5 years, 6–18 years, and Teacher Report Form; Achenbach, 2001)
CDI	Children's Depression Inventory (Kovacs, 1992)
CORE-System	Clinical Outcomes in Routine Evaluation (CORE-OM; Evans et al, 2002)
CRTIR	Child Report of Treatment Issue Resolution – Revised (Nelson-Gardell, 1997)
GAS	Goal Attainment Scaling (Kiresuk & Sherman, 1968)
IES	Impact of Events Scale – Revised (Weiss & Marmar, 1996)
Likert scales	Likert scales (Likert, 1932)
MASC	Multi-dimensional Anxiety Scale for Children (March, 1997)
Ohio Scales	Ohio Mental Health Consumer Outcomes System (Ohio Adult Scale, 2001; Ohio Department of Mental Health, 2005; www.mh.state.oh.us)
QOLI	Quality of Life Inventory (Frisch, 1988; Frisch et al, 1992, 2005)
SDQ	Strengths and Difficulties Questionnaire (Goodman, 1997, 2001)
SPTSS	Screen for Post-Traumatic Stress Scale (Carlson, 2001)
TOP	Treatment Outcome Package (Kraus, Seligman, & Jordan, 2005)
TSCYC	Trauma Symptom Checklist for Young Children (Briere et al, 2001)
TSCC	Trauma Symptom Checklist for Children (Briere 1996; Lanktree & Briere, 1995)
VPS	Visit-Specific Satisfaction Survey (Peck et al, 2001; Ware & Hays, 1988)

Note: See Technical Report 9 for the references for these materials.

What Information is Needed?

Many aspects of information gathered during an assessment have been discussed earlier. Competent practitioners ensure they have a sound grasp of their clients' safety and risk to self or others. An understanding of the effects that a client is experiencing as a result of sexual abuse is important. The process of therapy, goal-setting, rapport and relationship, and the client's culture are useful sources of information. In addition, gather information about why the client has sought therapy, their history, including abuse history, the client's current context including relationships, family/whānau, social, community, and the involvement of other agencies. Information gathered should be clear and reliable and identify specific problem areas that can be markers of change. When conducting assessments, practitioners should be aware of the purpose of the referral, pre-abuse functioning, current context, and historical information.[1]

Purpose of the referral

RELEVANT FACTORS TO CONSIDER INCLUDE:
What are the reasons given by the client and caregiver(s) for the referral? Why is the client seeking therapy? What do they (and others) consider to be the issues? Do these problems relate to sexual abuse? How does the client understand what has happened to them? If the client is a child, what does the child's caregiver(s) say are the reasons for counselling?
Understanding therapy This involves explaining the process of therapy. What is the client's understanding of and expectations for therapy?
What are the client's difficulties and effects? What is a problem for them? What does the client want to change?
Why now? This includes information about what triggers effects and what may be the purpose of the difficulties.
What are the consequences of effects? How is the client coping? Relevant information includes how others respond to the client as a result of their difficulties.
Safety and risk Does the client have complex circumstances? What is their attitude to sexual conduct and sexual safety? See 1: Safety.

Pre-abuse functioning

Therapists who carry out assessments with children and adolescents need to have a sound knowledge of child and adolescent development. Assessment needs to take into account the developmental level of the child or adolescent in relation to their age and developmental stage.[1,13] Difficulties may arise when assessing pre-verbal children or children with limited verbal abilities. Understanding significant life stages is also important when undertaking assessment with adults. For instance, because effects may emerge at particular times such as life transitions, relationship stages, or developmental crises, readiness for therapy may occur in "chunks" over time.

CONSIDER THE FOLLOWING FACTORS:
How did the client function before the sexual abuse? This includes checking their previous behaviour, learning, and social functioning as well as whether there has been a history of mental health problems.
What are the effects of abuse? How does the client cope? Check the effects described earlier.
What were the changes as a result of abuse? Check for noticeable behavioural, emotional, cognitive, and relational changes. How did preferred activities, hobbies, and interests change? When did behaviour change?
Were there any other influences for change? Other influences that trigger and maintain change include significant variations in the person's circumstances, school, and developmental stage or lifespan. It is important to learn what the triggers or precipitating factors were that led to the current difficulties.
What is the client's developmental level? With children and adolescents, it is important to check their developmental functioning. What is the client's chronological age, developmental level, and language ability?
How does the client compare with their peers? Comparison with same-age peers is important with children and adolescents. Where does the child differ in behaviour, thoughts, knowledge, boundaries, and emotions from their peers? Do they have advanced sexual knowledge, reactions to seemingly innocuous objects, and attachments to others?

Current context

Information about the client's context informs the therapist about issues such as safety, cultural and religious practices and beliefs, how current difficulties are perpetuated, what might act as future triggers, quality of life, functional ability, coping strategies, social skills, adaptive behaviour, attitudes, education, workplace issues, and social and agency support (see 11: Context).

CONSIDER THE FOLLOWING:

FAMILY AND WHĀNAU

Children and adolescents

How does the child or adolescent view themselves? How do they view themselves in relation to family? What are their attachment patterns? Who are their key attachment figures? Is the perpetrator a family member? Are the non-abusive family members protective? What are the attitudes of the family towards the child? How available is the caregiver to supporting the child in therapy? How complex is the life of the family? Are there any health or mental health issues?

Adults

Who is in the family? What is the cultural identity of the family? What are their relationship patterns? What is the quality of key relationships? What was the response to the abuse and disclosure? Do they have children? What are their parenting skills like? What are the family circumstances?

SOCIAL AND COMMUNITY CONTEXT (SCHOOL, WORK, COLLEAGUES, PEERS)

Children and adolescents

How does the client behave at school with peers and teachers? How do others perceive them? What is the role of cultural and societal attitudes to sexual abuse?

Adults

What is the educational and occupational history of the client? How is the client coping at work? What are their activities and social supports? Are other health professionals involved? Is the client involved in any sporting or cultural activities? Do they have any spiritual or religious affiliations? Should family be involved (eg, partner)? If so, has the client given consent to contact others?

Interagency

What other services have been or are currently involved? Do these services meet regularly? What other therapeutic approaches have been previously used? What worked and did not work? Why? What other professional expertise is needed for the client? Is a medical assessment or other health care involvement needed? Are any agencies involved with other family members (eg, Police, court)? Should other agencies be involved? If so, has the client given consent for contact?

History of abuse

Gaining an understanding of the client's history provides information about predisposing factors that may have led to the current difficulties, such as genetic or environmental predispositions, past coping patterns, safeguards for the client, and familial patterns.

CONSIDER THE FOLLOWING:

Previous experience of abuse

Does the client have a previous experience of sexual abuse? What were the frequency and duration of past abuse experiences? What was the nature of the abuse (eg, relationship to perpetrator, type of abuse, age of onset)?

Disclosure

What was the client's experience of disclosure? If the client is a child, have they undergone an evidential interview? Has the child made a disclosure to anyone else? Was the client supported in their disclosure (especially maternal support) or was the perpetrator supported? Was there family resistance to the disclosure?

Family history

Conducting an assessment of full developmental history from birth through timelines or genograms is useful. History can reveal patterns related to education, training, life experiences, family history, emotions, coping, relationships, and memories. Useful information is gathered when observing how the client reflects on their history. How was the client raised? How did they view their caregiver(s)? What is the parental and familial history of trauma and abuse? What are the physical, mental, and relationship problems in the family of origin and/or the family that raised them? Do caregivers or parents have any mental health issues?

Patterns of behaviour

Obtaining a full developmental history identifies prior patterns of behaviour, such as coping patterns when under stress. History provides indicators of significant times when the client may be more vulnerable or unsafe.

Formulation and Therapy Planning

As noted above, assessment guides the development of a formulation and therapy plan which reflects the client's specific and unique therapeutic needs. Formulation and therapy planning are essential to the provision of therapy that targets the most important issues for each client. When a thorough assessment is undertaken, the practitioner has a breadth and depth of information about their client that helps them to understand the client in the context of their individual environment. This information includes safety issues (see 1: Safety), cultural impacts (see 4: Culture – Identity and Diversity), effects for the client (see 5: Effects), and context, including their living situation, personal attributes, relationships, and developmental stage (see 11: Context). As the practitioner reflects on the information they now have about their client, they will begin to form ideas about what makes this client "work" the way they do, what strengths and vulnerabilities they bring with them to therapy that need to be emphasised or worked around, and what the environmental or personality factors are that may present opportunities or challenges during the therapeutic journey.

A useful way to structure the development of a formulation is to consider the following points:

- What are the **specific problems** that led this client to seek assistance at this time (eg, relationship difficulties, alcohol and drug problems, depression, anxiety, symptoms of post-traumatic stress, or physical ill-health)?
- What **historical or genetic factors** may have led to a greater vulnerability for this client (eg, CSA, maternal neglect, chaotic family dynamics, family history of depression or anxiety, or other mental health issues)?

- What are the **individual personality characteristics** of this client that may have led to the development of their particular set of effects (eg, anxious and fearful, angry and aggressive, or impulsive and risk-taking)?
- Has something recently happened in the client's life that has **triggered** more intense symptoms of distress (eg, birth of first child, child reaching the age at which the parent was abused, beginning or ending of an intimate or sexual relationship, or discovering other family members have been abused)?
- What factors in the client's life seem to be **maintaining** the problems (eg, currently in an abusive relationship, social isolation due to difficulty in trusting others, misuse of alcohol or drugs, chaotic lifestyle, or continuing impact of destructive family dynamics)?
- What **strengths** does this client have that will help them to attain improved life satisfaction and a sense of stability (eg, client identifies as a "survivor" rather than a "victim", a strong support network of whānau/partner/friends, able to maintain paid employment, or a sense of hope for the future)?

A sound formulation can only be developed with the benefit of an effective assessment. Once the formulation has been developed by the practitioner, it is shared in an open and collaborative manner with the client. For example:

> *I've been reflecting on all of the things we've been talking about over the past few weeks and I've come up with some ideas that might help to explain why you're experiencing these problems at this time. I'd like to share them with you to see what you think. After all, you are the expert on you and will be able to tell me whether I'm on track with my thinking.*

If the client agrees with the formulation, the process of developing an individualised therapy plan can begin. If not, further information is needed so that the practitioner and client can agree that they have together identified the factors which explain what is happening and why it is occurring now, the factors that may help or hinder effective therapy, and the shared goals (see 7: Goals). Some examples of formulation and therapy planning are provided in Appendices 5 and 6.

Assessment Checklist for Young Children (Less than Five Years)

ASSESSMENT AREAS		
Safety and risk	YES	NO
Nature of abuse	YES	NO
Protective factors	YES	NO
Medical or forensic examination	YES	NO
Therapeutic needs	YES	NO
Parenting and attachment	YES	NO
Maternal or family support	YES	NO
Complex needs	YES	NO
Language	YES	NO
Legal status	YES	NO
NATURE OF ASSESSMENT – SEE PAGE 114 FOR AN EXPLANATION OF INITIALS		
Other report (eg, parent, caregiver, other professional, file, CBCL, TSCYC)	YES	NO
Observation (eg, play, drawings, social interactions)	YES	NO
BARRIERS TO ASSESSMENT		
Limited measures (mostly parent report)	YES	NO
Difficult to assess mental injury as children often do not meet full symptom criteria	YES	NO
Effects are often hidden	YES	NO
Influenced by current developmental stage	YES	NO
Suggestibility	YES	NO
Culture match	YES	NO
Practitioner training and experience	YES	NO

Assessment Checklist for Children (5–12 Years)

ASSESSMENT AREAS		
Safety and risk	YES	NO
Nature of abuse	YES	NO
Protective factors	YES	NO
Medical or forensic examination	YES	NO
Developmental stage	YES	NO
Mental health difficulties	YES	NO
Parenting and attachment	YES	NO
School and teacher relationships	YES	NO
School behaviour	YES	NO
Peer and social relationships	YES	NO
Gender differentiation	YES	NO
Complex needs	YES	NO
Language	YES	NO
Legal status	YES	NO
NATURE OF ASSESSMENT – SEE PAGE 114 FOR AN EXPLANATION OF INITIALS		
Parent or other report (eg, teacher, other professionals, CBCL, SDQ)	YES	NO
Self-report measures (eg, TSCC, CBCL, BYI, MASC)	YES	NO
Interview (eg, structured: ADIS, CAPS-CA, SCID; unstructured)	YES	NO
Observation (eg, play, drawings)	YES	NO
BARRIERS TO ASSESSMENT		
Adult reports tend to focus on observable behaviour	YES	NO
Difficult to assess mental injury as children often do not meet full symptom criteria	YES	NO
Effects are often hidden, especially internalising effects	YES	NO
Influenced by current developmental stage	YES	NO
May not reveal information to protect self and others	YES	NO
Culture match	YES	NO
Practitioner training and experience	YES	NO

Assessment Checklist for Adolescents (13–18 Years)

ASSESSMENT AREAS		
Safety and risk	YES	NO
Nature of abuse	YES	NO
Interview with parent and adolescent	YES	NO
Self-report	YES	NO
Gender issues	YES	NO
Identity, sexuality, and sexual safety	YES	NO
Lifestyle choices	YES	NO
Substance use and abuse	YES	NO
Mental health difficulties	YES	NO
Family and whānau (confidentiality and consent)	YES	NO
Peer relationships and school behaviour	YES	NO
Complex needs	YES	NO
Legal or forensic status	YES	NO
Willingness to engage in assessment	YES	NO
NATURE OF ASSESSMENT – SEE PAGE 114 FOR AN EXPLANATION OF INITIALS		
Interview (eg, ADIS, CAPA, CAPS-CA, SCID)	YES	NO
Parent or other report (eg, teacher, professionals; CBCL, SDQ)	YES	NO
Self-report measures (eg, CBCL, TSCC, BYI, CDI, MASC)	YES	NO
Observation (eg, with family members)	YES	NO
BARRIERS TO ASSESSMENT		
Premature ending	YES	NO
Problems engaging in therapy	YES	NO
Reluctance to disclose sensitive information	YES	NO
Reluctance to seek help	YES	NO
Culture match	YES	NO
Practitioner training and experience	YES	NO

Assessment Checklist for Adults (Over 19 Years)

ASSESSMENT AREAS		
Safety and risk	YES	NO
Nature of abuse	YES	NO
Protective factors	YES	NO
Medical or forensic examination	YES	NO
Mental health difficulties	YES	NO
Education and occupation	YES	NO
Family and social relationships	YES	NO
Complex needs	YES	NO
Gender identity	YES	NO
Legal status	YES	NO
NATURE OF ASSESSMENT – SEE PAGE 114 FOR AN EXPLANATION OF INITIALS		
Self-report measures (eg, IES, SPTSS, BSI)	YES	NO
Other report (eg, partner, professionals)	YES	NO
Interview	YES	NO
Observation (eg, drawings)	YES	NO
BARRIERS TO ASSESSMENT		
Culture match	YES	NO
Low social support	YES	NO
Practitioner training and experience	YES	NO
Cost and transport	YES	NO

7. Goals

Principle 7: Goals outlines collaborative goal-setting as an essential component of effective therapy.

There is a particular conundrum with respect to formulating the goals of therapy. On the one hand, it is important to establish with the client fairly clear, well-specified, and tangible goals for therapy. On the other hand, there are likely to be subtle differences between the client's implicit goals and the types of goal that are generally in the therapist's mind, as exemplified by the following quote:

> *People will come in and say "I want to get out of my sexual abuse"... or "I want to be able to enjoy sex"... something like that. They're immediate [goals]. Whereas... what I want for my clients is much broader and it's more than that, it's a dream... a vision of the possible and to enable clients to get to the point that they can envisage the possible rather than just deal with somehow controlling the chaos within me right now.*[1]

On a session-to-session basis, however, establishing agreed-upon short-term goals is an essential element for effective outcomes. Giving some definition and clarity to the broader, more holistic goals, seems to also be necessary. It is recommended that immediate goals be established collaboratively early in the counselling process and re-evaluated with clients on a regular basis. It is advisable to decide on and prioritise goals according to what is important to clients, even if they are immediate or limited in scope. Once clients succeed in accomplishing the goals that they see as important, they are likely to be more open to working towards goals that the counsellor may view as useful but which they had not previously considered.

It is possible to give some broad, general goals for particular client groups, remembering that generalisations always need to be checked out for their relevance to a specific individual.

For Māori clients, for example, the goal of re-connection with personal and cultural identity may be relevant. Re-establishing connection with whakapapa and whānau has been described as a double-edged sword. It provides togetherness but can also lead to concerns about confidentiality and, in some cases, can be an unhelpful and unsafe environment for someone who has been sexually abused. For this reason, re-establishing connection is a delicate process that should only be undertaken when conditions related to appropriate timing, client-readiness, expertise, and safety are satisfied.

For Pasifika clients, important goals may include forgiveness (of the perpetrator), strengthening cultural identity, and strengthening family connections to enhance the ability to protect and take care of the child.

With adolescents, as they often attend therapy briefly, it is advisable to set short-term goals with a view to anticipating that the client will return in the future. Ensuring the adolescent's encounter with the therapist is productive, non-threatening, and involves psycho-educational approaches is a valuable method to increase the likelihood of return at a later time.

KEY GOAL ISSUES TO CONSIDER INCLUDE:		
Have goals been established with the client for the current session and the intermediate term?	YES	NO
Are the goals specific, targeted to problems, and achievable?	YES	NO
Are they the client's or therapist's goals? Are they goals that the client is motivated to accomplish?	YES	NO
Do the goals account for what may be important in the particular cultural context of the client?	YES	NO

8. Rationale and Process

Principle 8: Rationale and Process notes the importance of explaining to clients the process and rationale of therapy. Preparing clients for therapy and providing them with information about what to expect can help them to engage in counselling and increase their sense of safety. Clients benefit from shared information in therapy, which can further guide issues of timing and pacing.

Rationale

> *... giving them an idea of what to expect and I think that alleviates a lot of anxiety...*[1]

Providing a rationale for clients means discussing with them the justification, reasoning, and logic for pursuing a particular direction in therapy. In providing a rationale, the client is being given an opportunity to consider whether the therapy plan fits with their own goals and ways of working. Clients reported feeling more secure when they knew what to expect in therapy and had the therapeutic process explained to them. Clients noted that they felt most comfortable with practitioners "*who knew what they were doing*" and were able to provide a sensible explanation of why they were doing it.

A sound rationale for therapy is derived from a careful explanation about how therapy is most likely to be successful, and is based on the practitioner's knowledge and experience. It also takes into consideration client needs, preferred ways of working, factors that may contribute to and maintain difficulties, historical factors, and protective factors. Protective factors include strengths inherent in clients and their context that foster resilience, provide support, and act as buffers against harmful pressures. A well-thought-out rationale is the basis for prioritising which issues are targeted and when. It underpins how therapy is conducted and promotes the development of collaborative therapeutic goals. Therapeutic goals are then likely to be meaningful to the client, well timed, and lead to the tailoring of therapy to suit the needs, difficulties, strengths, and values of the client.

Providing the client with information about sexual abuse and its consequences helps them to understand their own reactions both currently and historically. Sharing and checking with the client that their particular range of difficulties is being understood in light of their experience of abuse will ensure that their difficulties are understood accurately (or will let the therapist know they are on the wrong track). It also assists the client to understand their situation and gain a sense of collaboration in the counselling process.

Process

Process was described by practitioners as a powerful and moving aspect of therapy. Process was referred to as both the dynamics of the therapeutic experience and the progression of insights and stages of progress reached by clients throughout therapy. Clients appreciate explanation about the process of therapy and the rationale behind learning self-care before focusing deeply on traumatic material. Remind them that although they may have braced themselves and were able to endure the abuse, the healing process is different. The aim is not endurance but self-care.

Therapeutic Dynamics

> *It's more in the moment looking at the dynamics, that interpersonal stuff that is going on in the room...*[1]

The dynamics of therapy refer to the in-the-moment processes that occur in the encounter between practitioners and clients. Processes include specific relationship interactions, such as the concepts of transference and counter-transference, and the notion of parallel processes. Because counselling for sexual abuse often takes longer than a brief therapy model (six to ten sessions) and because attachment issues are common, it is likely that the dynamics of the counsellor-client relationship will be affected by the internal personal responses of each person. This may lead to particular issues arising in the therapeutic context. It is important to be alert to this possibility as it can be helpful to the process of therapy when well managed, but may undermine therapy or even become destructive when the process remains unattended to by the practitioner.

This is an important reason for regular and adequate supervision. Parallel processes occur when interactions between the client and practitioner parallel other relationships. For example, a client who reacts angrily within the therapeutic relationship (eg, to perceived insults) is likely to respond similarly in other relationships. In both situations, it is advisable for the practitioner to monitor and reflect on their own responses to the client. It is useful to wonder whether particular feelings about or responses to the client are indicative of how others may be responding to them. It is also essential to assess whether responses are beneficial to the client's progress. Ideally, the therapeutic relationship should model for the client a healthy relationship in which both parties are able to express feelings, including negative feelings, and still feel accepted and respected.

Particularly in work with children, it is evident that the inclusion of non-abusive family members in treatment can be advantageous. This helps with self-soothing skills, interpersonal boundaries, and structure to be reinforced outside the therapy room in the child's daily life.

Progress

> *I always feel enormously relieved when people get to the grief and loss stage because that to me is much more healing...*[1]

An understanding of client progress informs the timing and prioritisation of therapy strategies, as well as being useful for monitoring the success of therapy. It could be counterproductive, for example, to undertake sex therapy before the client has resolved the trauma of a sexual assault. The pace at which the client progresses varies and depends on factors such as developmental stage, the nature of the abuse, and the particular issue being addressed in therapy. The development of trust, for example, may only occur near the end of therapy.

Interview Process

Skilful interviewing involves process techniques related to pacing, timing, and rapport-building, coupled with reliable information-gathering. Pay close attention to the interview process and use a variety of techniques to ensure the process is as comfortable as possible for the client.

- The purpose of the interview needs to be explained to the client. Understanding what to expect improves the therapeutic alliance.
- Children and adults prefer consistency of structure for each session. This makes it predictable, safe, and less anxiety-provoking.

- Skilled questioning includes appropriate tone and timing, and a balance between open and closed questions. It is also necessary to strike a healthy balance between not rushing the client and getting the information needed.
- Practitioners need to be aware of any avoidance by the client of particular topics, emotions, thoughts, and images.
- Attention needs to be paid to the interaction between the client and the interviewer.
- Emphasise honesty and confidentiality for both practitioner and client.
- It is useful to normalise the client's feelings. Clients may also benefit when strengths are emphasised.
- The practitioner is advised to regulate and monitor their own responses to their client. This can shed light on what the client may be feeling or how others may respond to them.
- The boundaries of both client and practitioner should be respected. Allow adolescents some degee of autonomy and control during discussions on sensitive topics.
- An understanding of the child's or adolescent's developmental level is essential in the interview process. This will inform the nature of the relationship and the anticipated level of progress.
- For children, attention span may be a process issue. Keep topics brief and use a multi-modal approach, including play therapy and visual and tactile techniques (sand therapy, art materials, dolls, and collage).

Cautions

> *... depending on how it impacts on the young person, often in adolescence they will present again, if they have had early sexual abuse issues because they are dealing with developmental stage issues, adolescence and issues around... sexual relating and... individuating from their families and that can be really scary for people who have been abused because they can often be in a really powerless position and to actually take steps to separate from family can be... quite a step for them... so sometimes young people will re-present and they will be advised to have further sexual abuse [counselling] or to start sexual abuse counselling...*[1]

Be aware that, for some clients, paying too much attention to the emotional process can result in avoidance of therapy. For example, adolescent clients (particularly males) may only attend a few sessions, perhaps because they want to avoid experiencing negative emotion. To address this, some practitioners recommend a more psycho-educational approach for teenagers. The rationale is to normalise the client's response while giving the adolescent client enough information to enable them to seek further help in adulthood if needed. Furthermore, with such a narrow window of opportunity, it is critical to demonstrate an attitude that is professional, competent, knowledgeable, and skilful. It is important to model desirable attitudes, competencies, knowledge, and skills. Should the client return at a later date, their experience and expectations of therapy will have been enhanced.

It is recommended that particular care be taken with any techniques that may generate overwhelming traumatic content. The effectiveness of the early introduction of physical techniques, regressing clients to childhood and re-birthing-type techniques has not been demonstrated and may be contraindicated for some clients. Furthermore, the early introduction of action methods by inexperienced practitioners is also contraindicated.

Although practitioners commonly agree that rapport is essential, it is usually something that happens as a result of a good therapeutic alliance rather than being an issue discussed with clients. Of course, where trust is an issue for the client, rapport may develop at a slower pace. It may be useful to identify that and reassure the client that trust develops over time when it is earned. While the New Zealand research data and the international

literature consistently (and accurately) stress the pivotal importance of the therapeutic relationship in maximising a positive therapeutic outcome, it is not sufficient without the addition of agreed therapeutic goals and a sound and well-explained therapeutic approach.

KEY RATIONALE AND PROCESS ISSUES TO CONSIDER:		
Is there a clear and plausible rationale to guide the therapeutic approach with the client?	YES	NO
Has therapy been individualised to the client based on a sound rationale and in line with the agreed goals?	YES	NO
Have the process and rationale of therapy been explained and have they been accepted by the client?	YES	NO
Are the therapist's responses to the client being monitored and evaluated? What is the basis for the reactions? Are the therapist's needs getting in the way of responsible therapy? Is the therapist responding to the client in similar (unhelpful) ways as others in their life?	YES	NO
Is there a balance of process issues such as pacing, timing, rapport-building, reliable information-gathering, and structured or semi-structured therapy elements?	YES	NO

9. Monitor and Feedback

Principle 9: Monitor and Feedback encourages regular, collaborative monitoring of progress throughout therapy that can be used to provide feedback to clients.

> *I might notice things are becoming easier, the client feels more comfortable talking about things, might even challenge me on things that I say and they don't agree with so then I would give them feedback on that, that I notice certain things, I might notice the way they talk, they sit, what they report, what they've been doing in day to day life, and I would offer feedback on what I notice that would fit into the box of improvement...*[16]

Monitoring

Therapy is evaluated according to the extent that it benefits the client according to the client themselves, parents, family, community, other agencies, ACC requirements, and the practitioner. Therefore, evaluations of outcomes should be consistent and should accurately reflect the overall status of the client. Practitioners felt monitoring provides information to feed back to clients, assists in decision-making, guides therapy, and assists with finishing therapy. Clients felt feedback gave them a feeling of moving forward, as well as providing benchmarks of recognisable progress. Therefore, monitoring of clients' progress is considered a vital aspect of therapy.

Combinations of monitoring approaches were often reported by practitioners and clients as useful indicators of progress.[16] Two forms of monitoring included:

1. **Informal** monitoring of progress during the course of therapy (typically carried out by the therapist to gauge the progress being made with the client). Informal approaches include unstructured client feedback, client behaviour during and between sessions, and professional impressions.
2. **Formal** monitoring of the client's status at different stages of therapy, especially at the finish of therapy and any follow-up sessions. Formal monitoring methods include structured and semi-structured observations, surveys, and questionnaires.

Different levels of monitoring have been used to gauge client improvement. Two of these levels are:

1. **Change on individual and personal levels**. This includes reductions in the negative effects of sexual abuse, changes in emotion, attitudes, and perspectives, and improvements in self-esteem and coping strategies.
2. **Engagement with the environment**. Therapists reported that changes in how a client engaged with life were a useful monitoring measure, such as changes in family functioning, school or work performance, and relationships, as well as specific accomplishments such as returning to their marae.

Safety and limits of practice. It is crucial that the level of client risk to self and others is monitored throughout therapy. It is important that practitioners are aware of the limitations of their practice and, where appropriate, consult with and refer to relevant professionals in accordance with the needs of clients.

Monitoring is a dynamic and collaborative feedback process. Progress needs to be consistently checked against goals that have been set and organised collaboratively between the client and practitioner. As one client stated, "*[we] jointly made a plan that would help. Small topics, session by session, built towards larger goals.*"[3] Goals frequently mentioned by clients and practitioners included client self-report of behavioural change, relief from the effects of abuse, goal attainment, or other indication of change. Monitoring includes direct feedback from

the client, observation, what the client does during and outside therapy, goal attainment, changes in coping, and reduction in effects.

Monitoring is based on a combination of approaches. The determination of outcomes needs to be based on more than one criterion, and each criterion can be accompanied by a robust standard of accomplishment rather than an impression about degrees of improvement or change.

> *I use non-standardised measures particularly goal attainment and look for indicators of change and healing from what is communicated to me by client both consciously and unconsciously. I use supervision to test my sense of what is monitored and to look for blind spots. I use art expression to provide indicators of change and outcome.*[1,8]

Practitioners are encouraged to use a combination of approaches to determine progress, such as:

- Review of goals
- Subjective therapist impressions from a review of notes
- Changes in client appearance
- Improvements in the therapist-client relationship
- Changes in outcomes on questionnaires
- Outcomes on negotiated out-of-session tasks
- Therapist observation of changes in behaviour in and out of the therapy setting and interactions with family members and significant others
- Changes in drawings with children and writing with adults (although care needs to be taken in the interpretation of such material)
- The use of corroborating information and obtaining feedback from significant others, especially those working with child and adolescent clients
- Formal monitoring tools that validate a client's subjective report. Practitioners and clients felt they are an objective means of assessing client progress and change in emotional state.

Monitoring can guide direction. Therapeutic services need to be assessed in terms of the extent to which they are benefiting the client. A positive outcome means no further need for services. This can be defined in terms of factors such as reduction in effects, improved quality of life, improved family functioning, improved school functioning, better integration with peers, positive coping strategies, and enhanced resilience.

Monitoring is regular. Practitioners are encouraged to monitor client progress regularly during therapy, across sessions, and according to set goals and reliable indicators of change such as behaviour and questionnaires.

> *My counsellor used to take notes all the time, and would refer back to issues needing to be clarified from week to week, and noting progress by comparing comments made at different times.*[3]

Feedback

> *This one gives feedback… actively making comments or statements or suggestions – not just saying "oh, ummm, oh".*[3]

Feedback to clients is encouraged. This enables clients and therapists to reflect on and evaluate progress. Practitioners often used evidence of progress to encourage and motivate clients. Feedback detailing a client's

progress was found to be very helpful. Some clients felt monitoring provided an honest account of events in their lives and objective evidence of change. Feedback can be given through visual media (eg, charts detailing change across time, spatial indicators such as the distance between hands or walking across a room to indicate degree of change), verbal (eg, discussion of noticeable changes), or can be experiential (eg, the client does a task that they had been unable to do).

Feedback by clients. Where possible, it is important to allow the client to give feedback on their therapeutic progress. Verification from clients about progress can validate as well as challenge practice. Recommended avenues of feedback include client self-report of behavioural change and relief from effects, goal attainment, and other indications of change.

> *Checking with the interviewee if it is OK to move on or do we want to stay there at this stage...*[3]

Feedback by others. For children and adolescent clients, it is important to determine outcomes in terms of family variables such as family cohesion and whether the family fosters a positive attitude toward the child. The family should also be involved in providing feedback on the child's outcome through formal and informal indicators of improvement. Where possible, it is useful to obtain corroboration from other family members.

Other useful sources of feedback include peers, teachers, and other professionals. Involvement of family members and close friends was considered helpful in contextualising counselling. However, caution is needed regarding who should be invited to participate in this way, and the client's rights should not be compromised through breaches of confidentiality or safety.

Feedback is empowering. Feedback is a good opportunity for therapists to convey their belief in clients' abilities to progress. A therapist's belief in their client's ability to improve was reported to be an essential key in enhancing outcomes. Clients also felt empowered when their progress was visually presented.

10. Opportunities and Challenges

Principle 10: Opportunities and Challenges outlines the unique situation in Aotearoa New Zealand with regard to working with people who have been sexually abused, and some of the associated opportunities and challenges.

Training

Therapists who carry out assessments with children and adolescents should be appropriately trained in assessment strategies and have a sound knowledge of child and adolescent development, because assessment needs to take into account the developmental level of the child or adolescent.[1] Therapists should know the boundaries of skill and experience when working with particular populations such as transgendered clients and recent immigrants. Difficulties may arise when assessing children with special needs or disabilities. For example, standard interviewing may be less suitable for a child who is at a pre-verbal developmental stage.

Interprofessional Cooperation

It is always useful to establish open and respectful communication with other professionals who are working with the client. For some clients with complex needs, no one person can provide the range of resources needed. In such cases, practitioners strive to foster a collaborative approach in the best interests of the clients. Communication between the general practitioner, client, therapist, and other relevant professionals is useful and is established whenever possible (with the client's consent). This is particularly relevant when the client is involved with mental health services, in which case therapists should also be in regular contact with relevant mental health professionals.[1] Other agencies likely to be of central importance are Child, Youth and Family, and Group Special Education (Ministry of Education).

Social supports are important for clients and need to be activated when issues such as safety arise. Referral is essential when issues arise that are outside the therapist's expertise, such as medical checks and screens for physical damage, sexually-transmitted infections, the possibility of pregnancy, sex therapy, and complex mental health difficulties.

Challenges to Change

When sexual difficulties are affecting progress, the practitioner can help the client (and their partner) to consider how they will deal with the possibility of sexual activity decreasing or stopping while the partner who has been abused has individual therapy. Sex therapy is not appropriate until the trauma of sexual abuse or assault has been addressed. It is important to normalise difficulties with sexual function and encourage greater confidence in discussing sexual issues. Consider referral to an experienced sex therapist. ACC can approve funding for clients to receive sex therapy when sexual difficulties are impacting on the client and their intimate relationship. Clients are encouraged to bring their sexual partners to therapy, particularly if there is a relationship issue. The development of capacity for intimacy is the underlying philosophy of sex therapy,

and involves the client recognising and finding ways of dealing with abuse-related triggers, and their partner avoiding sexual practices which are aversive and trigger negative reactions or dissociation. It was noted that "*pressure (to be sexual) is the greatest killer of arousal and taps into some of the abuse dynamics*".[1] Therefore, the client who has been sexually abused is likely to benefit from patience, open communication, and sensitivity from their partner.

Cultural Issues

Because of the shortage of counsellors and other therapists from all ethnic groups in New Zealand, it is likely that a client may be a member of one of the many ethnic groups in New Zealand and the therapist will be a European New Zealander or native-born New Zealander. It is important for therapists to recognise the importance of cultural differences, starting quite simply with language, and "*Using our own protocols, our own language, and our own ways of working with our families...*"[1] was seen as important to building rapport. For clients who are not native English speakers, there may be embarrassment about not being able to communicate adequately.

In some cultural groups, there is additional stigma associated with receiving mental health services. For example, if the client is a relatively recent immigrant from an Asian country, they may be cautious about the prospect of consulting a professional about mental health issues. This may be spiritually based (eg, the Buddhist concept that personal difficulties are the consequence of past transgressions of self, family, or ancestors). There may be a belief that nature should be allowed to take its course. This includes a sense that it is important to endure and submit to the laws of nature. The imperative to control emotions may contribute to a higher likelihood of somatic problems being reported rather than psychological difficulties.

CHECKLIST FOR OPPORTUNITIES AND CHALLENGES:		
Are any other agencies involved with the client or with other family members (eg, Police, mental health services, court)?	YES	NO
Who are the professionals who the client has given permission to contact if necessary? What is their involvement?		
Are there any current legal proceedings?	YES	NO
Is there a need for medical assessment or other health care involvement? Do any medical issues need to be addressed?	YES	NO

11. Context

Principle 11: Context notes the importance of considering the client in their social, physical, and cultural context and the impact of the environment and development on effects following sexual abuse.

Assessment and Context

Adults

Clients live within a social and physical context. It is important for practitioners to consider the person within the context of their lives and relationships and to monitor their functioning in each of these areas (also see 6: Assessment).[1,3,7,12,13] In order to gather sufficient contextual information about the client, a thorough assessment is essential. Although assessment is typically understood to occur at the beginning of therapy, as noted earlier it is an ongoing process which continues throughout therapy. Practitioners have different models for accessing the information that assists planning therapy for each unique client. Making a careful assessment of the following contextual areas will assist therapists to plan appropriate, focused, and effective therapy:

GATHER INFORMATION ABOUT THE FOLLOWING AREAS:[1]
Living situation
Where is the client living? Who are they living with? How are their relationships with others in the house?
Do others in the house know the client is attending counselling?
If so, what is their reaction? If not, why?
What is the client's financial situation? Can they manage financially or is their situation threatened by poverty or difficulty with budgeting?
Relationships
Does the client have an intimate partner? If so, what is the quality of the relationship?
Does the client retain contact with their family of origin? If so, how are these relationships experienced by the client? If not, why?
What have been the attachment patterns in the client's family of origin and intimate relationships?
If the client is employed, how functional are their work relationships?
Individual attributes
Does the client have particular personality traits that impact on different spheres of their life, such as sensitivity or resilience? Do they tend to become angry and aggressive, or depressed and withdrawn when under stress?
Does the client have particular belief systems that impact on how they view themselves, others, the world, the future? Do they hold a view that the world is a dangerous place and people are not to be trusted? Are they able to embrace a belief that there is hope their situation will improve with time and therapy?

Cultural identity may influence the effects of sexual abuse experienced by the client or their ability to disclose abuse.[1] In gathering contextual information about the client, find out about their ethnic or cultural affiliations (also see 4: Culture – Identity and Diversity). Cultural groups include those associated with ethnicity, disability, gender, religion, sexual orientation, gender identity, and specific social codes. Be sure to view each client as an individual and not assume they adhere to particular cultural codes or ethnic or religious traditions just because they identify with a certain group.

Be aware of any change in reported effects and how they may relate to the client's environment.[1,7]

WHEN NEW EFFECTS EMERGE, OR EXISTING EFFECTS APPEAR TO WORSEN, CHECK THE FOLLOWING:		
Is there a change in the client's living or working situation?	YES	NO
Have there been recent changes in relationship status, such as the end of an existing relationship or the beginning of a new one?	YES	NO
Is the client feeling increased vulnerability or lack of safety? If so, what has triggered this feeling?		

Developmental stage and lifespan events can intensify or trigger the effects of sexual abuse.[1] When first meeting a new client, seek information that helps an understanding of their developmental stage. While chronological age is a guide to some developmental stages such as puberty, further information is needed to ascertain the client's level of emotional maturity and the lifespan events they have experienced. Developmental stage and particular lifespan events are likely to affect people's experience of the effects of sexual abuse.

PRACTITIONERS NEED TO KNOW THE FOLLOWING:		
Is the client currently in an intimate or sexual relationship?	YES	NO
What is their history of intimate relationships?		
Is the client a parent? If so, what impact did the birth of their child(ren) have? What are the ages of any children, and at what age did the client experience sexual abuse?		

Ongoing assessment ensures changing contexts are recognised and taken into consideration by the practitioner.[8,16] Practitioners need to be alert to their clients' changing circumstances and anticipate any challenges that those changes may trigger (also see 1: Safety, 2: Client Focus, and 9: Monitor and Feedback).

Assessment and ongoing monitoring of the environmental context of children and adolescents require particular diligence.[8,16] This issue is addressed in the following section which is devoted to the needs of children and adolescents.

Societal views of sexual abuse impact on the client in their context.[18] The way that sexual abuse is talked about in society and portrayed in the media can affect the client and their family/whānau, and can serve to perpetuate shame and disrepute for the client. Particular attitudes and myths regarding sexual abuse contribute to the social stigma associated with abuse.

Children and Adolescents

Children and adolescents live within a social and physical context.[1,7,9,13] Children who have been sexually abused are particularly vulnerable. They are reliant on adults to make responsible and safe choices for them. Practitioners who work with children are aware of the need to be particularly alert to the environment in which the child lives and the physical and emotional safety of that environment. Adolescents are also vulnerable. While they may be able to access support or choose to change their living situation, they also present challenges to caregivers or others who seek to keep them safe. They may engage in risk-taking behaviours that put them at risk of further abuse (such as involvement with drugs, alcohol, or the law), and it is often difficult to protect them from the acting-out or self-destructive behaviours which may be the result of sexual abuse. Issues noted above regarding societal views of sexual abuse also apply to children and adolescents.

Interrupted attachment. When assessing the quality of relationships in the lives of children or adolescent clients, the issue of attachment patterns is particularly important. Carefully assess the attachment relationships

of the client with other family members or caregivers, and be aware that having emotionally unavailable caregivers increases a child's vulnerability to further abuse.[1,7,13]

Intergenerational abuse. Make sure information is gathered about the extended family and any history of sexual, emotional, or physical abuse. A parent or caregiver who has been sexually abused may lack the ability to protect their child(ren) adequately.[1,7,12,13]

Cultural identity may influence the effects of sexual abuse experienced by the client or their ability to disclose abuse. When gathering information from children and adolescents, be mindful that it is likely to be very difficult for them to find the words to describe what has happened to them. They may be fearful of the consequences of telling, particularly if they have heard threats about bad things happening to them or their families from the perpetrator of the abuse. This is the case regardless of the client's ethnicity, although Māori and Pasifika practitioners noted that there are additional difficulties for children from these cultural groups.[1] Māori children and adolescents may find it almost impossible to disclose that an elder of their whānau, hapū, or iwi has sexually abused them. Their fears of not being believed may be heightened by the knowledge that the abuser is held in high esteem within the iwi. For children of Pasifika families, there are no words to describe what has happened to them without using language that is considered shameful and taboo.[1]

Children and adolescents often express their distress through physical or somatic complaints, such as a stomach ache, headache, or fatigue, and through acting-out behaviour. Alternatively, they may become quiet and withdrawn and their schoolwork may deteriorate.[9,13] Some children will try to cope by over-focusing on schoolwork and therefore appear to be doing well. If schoolwork is their sole focus with no social interaction or recreation to balance their studies, this should be noticed and considered by caregivers and practitioners.

Be aware of any change in reported effects and how they may relate to the client's environment.[1] When new effects emerge in young clients, carefully re-check their living, school, and social situations and re-assess their safety. Try to discover whether any changes in their environment may be impacting on them, and take action to ensure safety where necessary.

Developmental stage and lifespan events can intensify or trigger effects of sexual abuse.[1,7] An escalation of existing effects or the emergence of new ones may be related to the client reaching the next developmental milestone. This might include the onset of puberty, the first sexual relationship, the death of a parent or close family member, or starting a new school.

Ongoing assessment ensures that changing contexts are recognised and taken into consideration by the practitioner.[8,16] This applies as above for adults.

Assessment and ongoing monitoring of the environmental context of children and adolescents requires particular diligence.[8,16] When the above recommendations are followed carefully, the result will be a diligent approach to ensuring the ongoing safety of the client.

ADDITIONAL CONSIDERATIONS WHEN WORKING WITH CHILDREN AND ADOLESCENTS INCLUDE:
Who is the child or adolescent living with?
Who are their caregivers and who is in the family or whānau?
Who do they identify as key attachment figures and what is the quality of those relationships?
What was the response to the disclosure of sexual abuse?
What is the quality of relationships with siblings and peers?
Are the parents supporting the child or adolescent?
What are the family circumstances or stressors?

Therapy and Context

Adults

To maximise the potential for therapeutic success, it is essential that each client is considered within their social and environmental context. Although clients may present with similar stories or reported effects of sexual abuse, each will have their own unique response, mediated by factors such as whānau and family support, resilience, and individual personality traits. An experience of sexual abuse that is debilitating for one client may present passing challenges for another. A carefully developed therapy plan will take this into consideration, ensuring that each client receives what they need to enable them to function successfully within their environment (also see 2: Client Focus).

When the client's relationships, living conditions, financial situation, and social support system are considered, therapists can be responsive to the range of stressors in their lives and can ensure therapy is planned appropriately. In planning therapy for the client, consider the following:

- **Relationship to the perpetrator**. Where the abuser was a whānau or family member, the issues are more complex. The client may be confused by their feelings of both loving and hating the abuser, especially a father or father figure
- **Confidentiality**. It is important that confidentiality is maintained. This issue becomes especially complex when working in group situations or with families and whānau
- **A belief they could or should have stopped the abuse**. It is very common for people who have been sexually abused to believe that they could have stopped the abuse if they had really tried, and the fact they did not leads to intense shame. Shame needs to be shifted to where it belongs, which is with the perpetrator. Children are never responsible for abuse
- **A belief that they asked for or enjoyed the abuse**. In some families, the only attention or affection the child has received has been of a sexually abusive nature. Some children experience sexual arousal (as well as fear and confusion) when they are sexually abused. Alternatively, they may have enjoyed having special attention. They need to know that this does not mean they are responsible for the abuse or that they are flawed in some way
- **For Māori, the whānau is usually the central focus**. There may be a strong sense of shame and consequent disconnection. Isolation from the whānau can devastate a sense of belonging and strongly affect the person's sense of identity. Therefore, encourage the client to work towards reconnecting with their whānau, where this is safe and appropriate: "*... I also see clients who have a lot of mamae (hurt), a lot of grief in terms of the disconnection that has taken place within the whānau.*"[1] (Also see 4: Culture – Identity and Diversity)
- **Relationship to non-abusive caregiver**. There may be a disruption of attachment to the non-abusive caregiver where it is perceived (rightly or wrongly) that they were not protected from the abuser: "*... but that also brings in attachment issues, you know, you often have... a client that felt... that their mother abandoned them and so a lot of the work is around that...*"[1,7]
- **There may be unresolved issues of mistrust, abandonment, non-belief, or alienation**. These issues are very likely to impact on the client's ability to develop and maintain intimate relationships
- **Relationship to siblings**. Sibling relationships may be affected by the abuse because the client has made themselves available to the perpetrator to protect younger siblings. This is commonly reported by clients, who are then devastated if they discover that young siblings were also abused, in spite of their self-sacrifice. Siblings may also be traumatised by witnessing the abuse of their brothers or sisters

- **Relationship to children**. Adults who have been sexually abused as children may display inconsistent or insufficient parenting skills. They may be over-protective with their children, seem oblivious to the presence of potential danger, and struggle to achieve healthy attachment relationships with their children. Consideration of parent-child relationships may prevent children's vulnerability to abuse and avoid intergenerational abuse. However, it is important to note that these difficulties affect some parents, but certainly not all: "*... difficulty bonding with a girl baby infant right through toddlerhood has been a really distressing thing to witness as well. Just an avoidance of bonding and on some occasions they just cannot, they identify too strongly*"[1,7]
- **Intimate relationships**. Partners of people who have been sexually abused may also influence how well they engage with therapy. It is not unusual for a client to experience heightened distress in the early stages of therapy or for them to become disinterested in, or frightened of, closeness and sexual intimacy. Additionally, effects are often experienced more intensely as people transition into new relationships. Lack of understanding about the process and pervasiveness of problems can lead to difficulties between the couple and pose barriers to therapy
- **Life events may trigger the emergence of effects of CSA**. Key situations in which a client may struggle with emerging or re-emerging effects are pregnancy, childbirth, new relationships, marriage, divorce, bereavement or loss, or having children in the same age group in which the client's abuse occurred. Being exposed to another abusive situation, such as sexual harassment in the workplace, can also trigger effects (also see 5: Effects).

Be aware of the above considerations, and ensure each area is checked. Use a psycho-educational approach where information is provided which lets the client know that their responses are normal or typical responses to an abnormal situation and that they can build skills and resilience which will enable them to move on from the effects of abuse. In particular, help the client to:

- Recognise and name their experience as abuse (where this is the case)
- Shift any sense of shame and blame to the perpetrator
- Accept that children are not able to prevent themselves being abused by adults, especially when the abuser is a family member
- Understand that a sexual response to genital stimulation does not mean they wanted or enjoyed the abuse
- Process their feelings about family members who either were abusive or failed to protect them
- Process their feelings about not having been able to prevent the abuse of siblings
- Understand that issues of trust, difficulty in maintaining functional boundaries, and general relationship difficulties may be related to their experience of sexual abuse and can be addressed in therapy
- Understand that some self-destructive or risk-taking behaviours such as substance abuse, unsafe sexual practices, and self-harming behaviours may be the result of their experience of abuse and can be addressed
- Develop the ability to recognise links between their current responses to particular situations and their past experience of sexual abuse, and to make increasingly better choices
- Build resilience. Key components of resilience include self-enhancement, social and family support, positive or adaptive coping strategies, and positive emotion
- Encourage reconnection. One of the key variables to resilience in dealing with abuse is the relationship with the non-abusive caregiver

- Encourage social engagement. Resilience is based on behaviours that decrease social alienation and therefore increase social support.

Education for family or partners should address the following issues:

- Effects commonly related to sexual abuse. Certain ways of behaving may be more related to sexual abuse than perceived personality flaws
- Shame belongs to the perpetrator, not the abused person. Care must be taken to avoid any inference that the abused person could or should have done something to prevent it
- The abused person may need repeated reassurance that it was not their fault and that they have the support of the family
- Importance of boundaries. The family and partner may need to learn to respect the person's need to rebuild functional boundaries. This may be experienced initially by family members as being pushed away
- How to respond in ways that are helpful rather than ways that exacerbate the problems of the person
- Therapy may temporarily increase the frequency and intensity of problems, and family members may conclude from this that therapy makes it worse
- Partners need to be aware that those who have experienced sexual abuse may not want sexual contact as they process issues related to the abuse, and that an understanding response is most helpful
- Partners should be educated about difficulties with parenting.

Children and Adolescents

> *It's not the event – it's the absence of any caring or affective attachment, plus abuse. That is what creates a toxic environment that is where you get severity (of effects)... coupled with that is also the sense of entrapment of not being able to escape a situation...*[1]

As a therapist, be aware of the environment in which the young client lives, including family functioning before, during, and after the abuse. Understand the client as a person in context rather than focusing solely on the events of abuse. Sexual abuse does not occur in isolation, but is likely to occur in environments that are also emotionally and/or physically abusive or neglectful (also see the earlier section for adults as much of that information also applies here). In planning therapy, consider the following:

- Emotionally unavailable caregivers and interrupted attachments are likely to increase a child's vulnerability to abuse in general
- Disrupted environment. Emotional and physical abuse and impoverished lifestyles are often reported to be concurrent with the event of sexual abuse
- Divided loyalties in families can sometimes be an issue when a family member such as an older sibling is the perpetrator of the abuse
- There is a risk of generational perpetuation of abuse.

Therapeutic interventions will therefore include:

- Working with the family whenever this is practical and safe for the child or adolescent. Particular attention should be paid to attachment patterns, including maximising the potential to achieve a secure attachment between the child and non-abusive caregiver
- Where financial or family stressors contribute to the family struggling to protect children, addressing these issues where possible. This may include referral for budgeting assistance, finding a support person to help

the family to access benefits or financial entitlements, and helping the family to access extra childcare or time to allow exhausted or stressed parents the opportunity to recover. Parents may also benefit from attending a parenting skills course

- If the non-abusive caregiver discloses CSA, encouraging them to access counselling for their own abuse issues. This will help prevent the continuation of the intergenerational cycle of abuse. Wherever possible, perpetrators should be encouraged to seek therapy for their abusive behaviour and, if applicable, for their own experiences of CSA.

Cautions

While it is valuable to work with the family of a child or adolescent who has been sexually abused and the partners of adults, practitioners must take into account whether this is safe and appropriate for each client. Clearly, there are situations where involving family members or an intimate partner may present the possibility of re-traumatising the client. Carefully assess the situation before proceeding.

Additionally, while supportive families and partners can maximise the potential for a successful outcome in therapy, other families may (perhaps unintentionally) undermine the possibility of positive change. This may be the result of the family or partner feeling threatened by therapy (eg, are they talking about me? Will my partner become more confident and not need me any more?) or because they notice at the beginning of therapy that their family member seems worse instead of better. They may therefore encourage the client to withdraw from therapy as it is not helping. In situations where families or partners are undermining therapy because of concern for the client, an educational session to explain the process may alleviate their worries.

A CHECKLIST OF THINGS TO REMEMBER:		
Is the client safe?	YES	NO
Has appropriate psycho-education been provided for the client and/or their family?	YES	NO
Are there any cultural or other needs of the client?	YES	NO
Where is the client living?		
Who lives in the house?		
What is the quality of relationships?		
Is the client coping at school or work?	YES	NO
Does the client have a social support network?	YES	NO
Have alcohol and drug issues been addressed?	YES	NO
Are there any other self-destructive or high-risk behaviours that need attention?	YES	NO
Is poverty an issue for the client?	YES	NO
Are there any legal issues?	YES	NO

12. Therapy Completion

Principle 12: Therapy Completion encourages practitioners to plan for the end of therapy early on in collaboration with the client. Finishing therapy also involves helping clients to anticipate and plan for setbacks in their progress, and recognising the emotional significance of the therapeutic relationship.

> *I think that the process of finishing therapy is a really big issue, just as much as initiating the relationship... I tend to be quite particular about that...*[1]

It is useful to consider the end-point of therapy at the beginning of therapy. This can occur when discussing with clients the number of sessions that are anticipated and the goals that will be worked on during therapy. Practitioners emphasised a difficulty "*in finishing in a way that feels right for both people*". An awareness that therapy will inevitably be time-limited allows therapists and clients to create positive expectations regarding the scope of therapy.

Many practitioners perceived one of the long-term goals of therapy as empowering the client.[1] Implicit in this idea is the recognition that, at some point in time, the client will be managing well without the support of a therapist. Therefore, concluding therapy is a special event and indicates that the client is on a new pathway.

Time Limits

It is often possible for professionals to see the need for services and there is a temptation to consider therapy as lengthy in duration rather than time-limited. With clients who have been sexually assaulted, short-term therapy is usually more beneficial. For adult clients who have experienced CSA, medium-term lengths of therapy have been reported to be effective. Children have been noted to benefit from a slower pace of therapy over a longer period of time. Therefore, there is no set period of time that can be recommended and the most appropriate length of time depends on the specific client. However, a general conclusion is that therapy that continues for lengthy periods needs to be re-evaluated in terms of its effectiveness.

Practitioners can base their sense of readiness to finish therapy on client feedback, the behaviour of the client during and outside sessions, some level of goal attainment, evidence of increased coping behaviour, and a reduction in the client's distress and difficulties. If these indicators are identified early in therapy and negotiated with the client, it will mean that closure will be based on an explicit rationale and understanding of the purpose of therapy.

Special Relationship Needs

Most therapeutic relationships involve a close, meaningful, and connected relationship between practitioner and client. Because individuals who have been sexually abused may have a history of serious disruption to close, trusting relationships, these disturbances in attachment experiences often result in difficulties for clients in managing emotionally-involved and intimate relationships, such as the therapeutic alliance. As a result, the end of therapy may have particular emotional significance. There is a greater likelihood of clients feeling abandoned or that the end of therapy is a separation of a relationship that is reminiscent of past experiences or presents a threatening situation. Many clients who have been abused have not left past relationships on good terms. Some may have escaped abuse, been isolated by family, or been removed for safety reasons. It is therefore important to be aware of these issues for clients.

Anticipate Setbacks

A potentially useful strategy is to prepare clients for future challenges, known commonly as relapse prevention. This term originally came from the treatment of clients with alcoholism and other addictions in which a relapse during abstinence was likely, but which should not then have communicated failure to the client. Relapse prevention strategies prepare the client for the possibility that there will be setbacks in their progress so that when they occur, the effects are not devastating for the client. Situations influencing setbacks can include the following:

- A crisis within the family or whānau can present a disruption of the counselling process for the client
- Problematic environments are disruptive for adults as well as children and adolescents
- Practical issues such as transport, childcare, and finances were noted as difficulties for the individual. For example, those who live in rural locations may need to travel long distances to get to therapy.

Since the concept of relapse prevention was first developed, the term has been quite widely used and applied to other areas. For example, in the treatment of sex offenders, a relapse prevention plan focuses on what the client can do to reduce the likelihood of relapse by having a plan in place to avoid temptation and other high-risk situations. In the context of the treatment of clients who have been sexually abused, the term "relapse" is not necessarily a helpful one, although the general idea is useful and there is evidence of its value. The major components in sexual abuse work would include:

- Reassuring clients that occasional setbacks are common and do not indicate that things will never improve
- Helping clients to recognise the kinds of situation that are high risk for them and helping them to develop clear plans to avoid such situations
- Encouraging clients to recognise warning signs of relapse in terms of their own feelings and to seek reassurance or short-term help, or revisit therapy before a crisis situation develops.

Consider Staggering Therapy

It may be beneficial for practitioners to organise a graduated end to sessions by staggering the length of time between sessions and allowing clients to have an increasing amount of autonomy and mastery over their lives outside sessions. Some therapists use booster sessions in which particular areas in need of further work are addressed at a later date when clients have gained some experience of coping without regular therapy support.

> *... it's a bit like the teenager leaving home, isn't it? And they need to be able to check back in and just say,"hey, things are OK", or "I need a top-up" or whatever, you know, and go away feeling that much stronger.*[1]

Client-Initiated Ending

Some clients find that they are not responding to their therapists and would like to leave therapy or find alternative therapists. However, they may not implement this for a number of reasons, including concerns over upsetting their therapists. Effective therapeutic relationships are ones in which both therapist and client feel comfortable with the possibility that there is a mismatch in the professional relationship. As stated earlier, it is not considered constructive by clients for therapists to over-analyse the nature of the mismatch by excessive dwelling on process issues. In cases of a mismatch between counsellor and client, an honest and open discussion was preferred by clients to be able to continue with counselling. It is important for therapists to

know of other professionals to whom they might refer a client when it appears that there is a mismatch with the present arrangement. The rights of the client are also relevant here.

Children

Most of the above applies equally to children, except that the anticipated duration of therapy needs to be negotiated with the caregiver who is bringing the child to therapy. Younger children will have a less clear understanding of the concept of time limits and expected duration of therapy.

Children often mark the end of a significant experience with an event such as a party, celebration, or performance. It may be useful, especially with younger children, to plan for a similar event marking the end of therapy. The therapist could present the child with some token of the conclusion of the work, such as a scrapbook of ideas and issues that have arisen during therapy.

The idea of preventing relapse is especially important for children in that it may be less obvious to children what their areas of vulnerability are and what situations are likely to continue to present difficulties for them. This is because of the dramatic changes in developmental tasks for children. For example, thoughts and memories of abusive sexual experiences as a young child may have little significance until the child becomes an adolescent and begins to engage in appropriate sexual exploration and activities with peers. Children and their families can be informed of likely areas of future difficulty without setting up the expectation that they will inevitably happen.

CHECKLIST FOR THERAPY COMPLETION:		
Is there a plan which (given the number of sessions available) prioritises the goals and needs that might be managed by the client after the conclusion of therapy?	YES	NO
Has there been discussion with the client about the likely duration of therapy and the realistic expectations regarding the types of gain that can be made?	YES	NO
Is the therapist systematically looking for signs that therapeutic gains have plateaued and that it might be useful to move towards ending therapy?	YES	NO
Has the therapist examined the degree to which the therapeutic relationship is intertwined with relationship threats (such as disrupted attachment) that the client may have experienced in the past?	YES	NO
Has the therapist anticipated how the gaps created by the end of the formal therapy can be filled by individuals and experiences in the client's environment and community?	YES	NO
Has the client been prepared for possible setbacks so that, when they occur, they do not lose confidence?	YES	NO
Have hazards or situations that are likely to cause the client special challenges been identified?	YES	NO
Has the therapist worked with the client to devise a plan to cope with threatening situations that might arise in the future?	YES	NO

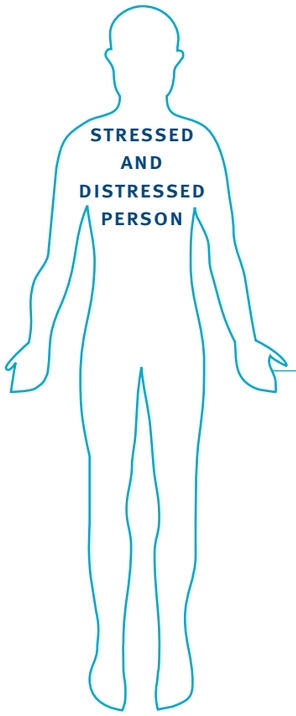
Appendix 1: Project Reports

Technical Report 1	An annotated bibliography of New Zealand (Working Paper 2) literature on sexual abuse Ruth Mortimer
Technical Report 2a	Archival file analysis: Report for a random sample of archived sensitive claims that received counselling Anita Darrah, Lynn Jenner, Joanne Taylor, Shane Harvey, and Cheryl Woolley
Technical Report 2b	Archival file analysis: Report for files with a large number of counselling hours Lynn Jenner, Joanne Taylor, and Shane Harvey
Technical Report 3	Consumer focus group and key informant interviews (pilot report) Lynn Jenner, Cheryl Woolley, and Ruth Mortimer
Technical Report 4a	Mapping the hypothesised effects of childhood sexual abuse: A coherent framework from childhood to adulthood Pia Pechtel, Shane Harvey, and Ian Evans
Technical Report 4b	Profiling: Patterns of effects following childhood sexual abuse in adulthood Pia Pechtel, Shane Harvey, and Ian Evans
Technical Report 5a	Three waves of childhood sexual abuse research: (Literature Review 1) Effects and assessment in adulthood Pia Pechtel, Cheryl Woolley, and Ian Evans
Technical Report 5b	Sexual assault in adulthood: Effects, assessment (Literature Review 2) and treatment Pia Pechtel, Anne Ryan, and Cheryl Woolley
Technical Report 5c	The nature, assessment, and treatment of the (Literature Review 3) psycho-social consequences of sexual abuse for children and adolescents: A critical review of the literature Ruth Mortimer, Ian Evans, Rebekah Jourdain, Rebecca Cargill, and Cheryl Woolley
Technical Report 5d	Treatment of adult survivors of childhood sexual (Literature Review 4) abuse Ruth Mortimer, Jan Dickson, and Cheryl Woolley
Technical Report 6	Effects of therapy with people who have been sexually abused: A meta-analysis Shane Harvey and Joanne Taylor
Technical Report 7	Practitioner focus group and key informant interviews Ruth Mortimer, Lynn Jenner, Judith Campbell, Anne Ryan, Jan Dickson, Cheryl Woolley, and Averil Herbert
Technical Report 8	Practitioner survey: Respondent profile Joanne Taylor and Shane Harvey
	Practitioner Survey: Section B and Section D Ruth Mortimer, Judith Campbell, and Cheryl Woolley
Technical Report 9	A review of progress and outcome measures: Use with sensitive claims clients in Aotearoa/New Zealand John Fitzgerald, Andrea Hodgetts, Juanita Ryan, Jan Brassington, John Collier, and Tracey Augustine

Technical Report 10	A qualitative study investigating the views of ACC sensitive claim practitioners about monitoring therapy progress and outcome Juanita Ryan, Andrea Hodgetts, John Fitzgerald, Jan Brassington, John Collier, and Tracey Augustine
Technical Report 11	Measuring outcome: A survey of ACC sensitive claim practitioners Andrea Hodgetts, John Fitzgerald, Jan Brassington, Juanita Ryan, John Collier, and Tracey Augustine
Technical Report 12	Sexual abuse and the media Karen Frewin, Keith Tuffin, and Rachael Pond

Appendix 2:
Diagram of a Notional Client's Therapeutic Journey

A consumer's therapeutic journey



STRESS BUILDING? STRESS CHRONIC?

- Who will look after the kids?
- Can I get there?
- Where are the rooms?
- Can I wait?
- There's a waiting list
- Can I find a counsellor at all?
- How do I find a good counsellor?
- How would I pay?

WHAT'S OUT THERE TO HELP ME? ACC?

Ability to name problems

Public education

Awareness of problems

Can't face dealing with problems at present

No treatment

Self-harm, self-medication, etc

I'VE FOUND A COUNSELLOR. WHAT IF...

- S/he doesn't believe me?
- I can't talk about it?
- S/he doesn't like me?
- S/he says it's my fault?
- S/he doesn't understand my life?
- I don't know what to do when I go there?
- S/he doesn't care?
- S/he's crazy, weird, too fringey, too straight?
- S/he makes me do stuff I don't want to do?
- S/he bosses me around?
- S/he won't work with me when s/he finds out what I'm like?
- S/he makes me do stuff that makes me worse?
- S/he freaks out when I tell what happened?
- I can't pay?
- Paying will cause hardship?
- S/he makes me talk about it?
- S/he doesn't make me talk about it?
- S/he calls my flat/home/work and everyone finds out?

AT THE FIRST MEETING THERE ARE SIGNS...

- Do I feel comfortable with her/him?
- Do I feel comfortable here?
- How does the room feel?
- Is s/he like me?
- What can I tell from his/her clothes?
- What does s/he look like?
- How does s/he greet or welcome me?
- What's the waiting area like?
- Are there other people looking at me?
- What's the entrance like?
- Will everyone know why I'm here?
- Who'll see me going in?
- What's the building like?

OK. WE'RE STARTING WORK...

- If I phone her/him, will s/he call back?
- What if I need to see her/him before the next session?
- Is this the right time in my life to be doing this?
- Can I cope in my own life with this being stirred up?
- What sort of shape am I in when I leave the sessions?
- Can I say if it's not working?
- Can I disagree with her/him?
- Is it all about money for her/him?
- Is it just a job for her/him?
- Does s/he let me see her/him as a person?
- Does s/he make me do stuff I don't want to do?
- Does s/he say things that build me up?
- Does s/he tell me when I make progress?
- Is s/he giving me small manageable things to work on?
- Are we talking about what matters to me?
- Does s/he help me to tell her/him things?
- Does s/he seem together as a person?
- Does s/he think I'm crazy?
- Does s/he like me?
- Does s/he blame me for what happened?
- Does s/he seem shocked?
- What does her/his face say when I tell her/ him things?
- Does s/he seem to know what s/he's doing?
- Am I getting choices about the goals?
- Is s/he going too fast or too slow?
- Does s/he remember things I've said?
- Does s/he ease into the session?
- Does s/he help me re-connect with her/ him in each session?
- Does s/he notice how I am on different days?
- Does s/he notice how I am when I get there?
- Does s/he care what happens to me?
- Does s/he think I'll ever get better?
- Does s/he explain how the counselling works?

AFTER A WHILE... DIFFERENT THINGS MATTER

- Can we prepare for telling some family members what happened and maybe confront them?
- Does s/he know about other stuff eg, how prosecutions work, court processes?
- Does s/he know about other ACC stuff eg, other claims procedures, lump sums, compensation, work issues, reading matter, knowledge of entitlements?
- Does s/he put me onto other resources or services eg, other social services?
- Are we working on what matters to me?
- Am I handling my relationships any better?
- Am I feeling less guilty and less ashamed?
- Am I starting to understand myself better?
- Can I keep up with paying for this?
- Is s/he making me go over and over the abuse event/s?
- Is s/he making me cover the same ground too often?
- Is s/he dumping her personal issues on me?
- Are we keeping on doing stuff that isn't working?
- Is this going somewhere?
- Is s/he giving me practical ways to handle things?
- I'm still having ups and downs. Am I going to get better?

LOOKING BACK ON COUNSELLING SOME PEOPLE SAY

- They now accept that the abuse was not their fault.
- They have improved relationships and more closeness.
- They are better parents – more loving and more protective.
- They understand more why they behave(d) in certain ways.
- They are closer to some family members.
- They can forgive some people eg, their mother.
- They are more able to have friends.
- They believe they are good people.
- They are not as emotionally up and down.
- They are not so hard on themselves.
- They can help some others (in the family?) to stop abuse and get counselling.

Appendix 3: References

1 Technical Report 7

2 Technical Report 8

3 Technical Report 3

4 Technical Report 2b

5 Technical Report 2a

6 Technical Report 6

7 Morrison LJ. *A grounded theory of the role of family in recovery and healing from child sexual abuse* 2006; Master's thesis, Massey University, Palmerston North, New Zealand.

8 Technical Report 11

9 Technical Report 4

10 Cassese J. *Gay men and childhood sexual trauma: Integrating the shattered self* 2000; Binghamton, New York, The Haworth Press.

11 Technical Report 4b

12 Technical Report 5a (Literature Review 1)

13 Technical Report 5c (Literature Review 3)

14 Kim SSK, Atkinson DR, Umemoto D. Asian cultural values and the counseling process: Current knowledge and directions for future research. *The Counseling Psychologist* 2001; 29: 570–603.

15 Technical Report 5b (Literature Review 2)

16 Technical Report 10

17 Technical Report 9

18 Technical Report 12

19 Temple JR, Weston R, et al. Differing effects of partner and non-partner sexual assault on women's mental health. *Violence Against Women* 2007; 13(3): 285–297.

20 Roberts AR, Roberts BS. *Ending intimate abuse: Practical guidance and survival strategies* 2005; New York, Oxford University Press.

21 Mahoney P. High rape chronicity and low rates of help seeking among wife rape survivors in a nonclinical sample. *Violence Against Women* 1999; 5(9): 993–1016.

Appendix 4: Glossary of Māori Words

Aroha	Love in the broadest sense. Compassion. Affectionate regard.
Atuatanga	God or supernatural being/entity. Atuatanga may mean a belief in the existence and/or influence of Atua on terrestrial activities.
Hapū	Sub-tribe.
Iwi	Tribe.
Karakia	Incantation (prayer) or recitation of a chant over a being.
Kaupapa Māori	Māori-oriented agenda and/or aspiration. Māori-driven schema.
Mahi tukino	Undesirable work/conduct.
Mamae	Pain or affliction. To feel pain or distress of the body or mind.
Mana	Authority, control, influence, prestige, endorsed power.
Mauri	Life essence/force/principle of humankind. Sometimes thought of as the source of emotions.
Pakeke	Difficult.
Taonga	Precious artefact and/or something highly prized/valued.
Tautoko	Support.
Tikanga	Protocols, customs, ethical conduct.
Tūrangawaewae	Literally a place to stand.
Wairua	Spirit.
Whakamā	Shame, abasement, shy.
Whākapapa	Genealogy.
Whanaungatanga	Relative/Blood relative. The process of whanaungatanga may broadly be defined as interrelationships, creating and/or maintaining connections to those who are regarded as family in the broadest sense.
Whānau	Family, to be born.

Appendix 5: Case Formulation for an Adult Client

Note: The examples of case formulation provided in **Appendices 5** and **6** are based on a composite of client cases. Identifying information has been removed and the cases are partly adapted from information collected in the practitioner survey.

Referral Information

Joy was referred for sensitive claims counselling by her keyworker at the local community mental health service. She had recently been discharged from the psychiatric ward after a serious suicide attempt (overdose of prescribed medication). She is a 34-year-old woman who prior to admission had been living alone, working 70–80 hours a week, and appeared to be living a full and fulfilling life. This was her first psychiatric admission and first contact with any mental health service.

Background Information

Joy is the elder of two daughters. Her parents separated when she was nine years old. Her father was physically and emotionally abusive to his wife and children. Joy's mother, believing she was doing the "right thing", acceded to her ex-husband's demands that he have unsupervised access to his children. During her visits to her father, Joy was subjected to sexual, physical, and mental abuse. She described the verbal (mental/emotional) abuse as being the most destructive. Her father regularly humiliated her in public, inviting others to notice how "fat and ugly" she was, and drawing attention to different parts of her body.

Joy formed an attachment to her young stepmother, who tried to protect her from her father's emotional abuse. Later, after separating from Joy's father, the stepmother reported his repeated pattern of raping and sexually abusing her. This resulted in charges being laid, with a subsequent court case. Joy (as a young adult) supported her stepmother through this ordeal, witnessing her being subjected to humiliating questions and allegations in court. Her father was sentenced to a custodial sentence for this sexual abuse. He has served other terms of imprisonment for sadistic and predatory sexual behaviours.

Joy's only long-term intimate relationship began in her teens with a man who was much older, controlling, and abusive. To her credit, over time she recognised she deserved better and was able to extricate herself from this relationship.

Early in Joy's working life, she became very successful in her chosen profession and was from time to time "head hunted" by other employers seeking her combination of hard work, integrity, and an ability to "get the job done". She enjoyed an active social life with a variety of friends and seemed to all her friends and family to be doing well.

Eighteen months before her suicide attempt, Joy was raped and abused by two men in her own home. She later reported that their verbal abuse (calling her "a fat, ugly slag") had caused her more damage than the sexual assault, which was prolonged and severe. Joy reported "feeling like shit, filthy, and disgusting". Joy did not report the rape to the Police for several reasons:

1. She felt responsible because she had allowed one of the men access to her home (he provided access to his accomplice after restraining Joy with ropes).
2. She was deeply humiliated and shamed by the things they did to her and did not want to even say the words to describe them.
3. Her feelings of worthlessness and being "shit" were strongly reactivated so it seemed unlikely anyone would care about what had happened to her.
4. She had witnessed the ordeal her stepmother faced when she appeared in court to give evidence against her father. She believed (no doubt realistically) that her whole life, including its sordid elements, would be laid out for the audience (perhaps through the media as well as those in court) to see and make judgement on.

Over the months prior to her hospital admission, Joy experienced difficulties in her workplace and was quickly re-employed, only to face further trouble (financial problems of the employer, which were not personally related to Joy or her competence). She began to feel more and more afraid and "useless", and started to avoid her friends and family. She continued to "feel like shit", and began having a vivid repeating dream that she awoke from sleep to find she had excrement spewing from her mouth, covering her and her immediate environment in filth. She reported hiding in the house so no-one would know she was home as she could not face keeping up her bright and happy persona, which she felt sure her friends expected from her. Over time she became more distressed and felt worthless, ugly, and hopeless about the future. She felt increasingly out of control and unable to manage her increasingly distressing emotions. She could not talk to anyone about how she felt (others were accustomed to Joy being the person who helped them), and ultimately she decided suicide was the only option.

Case Formulation

Joy is a 34-year-old woman referred for counselling after a serious suicide attempt and subsequent inpatient psychiatric admission. She was recently the victim of rape and sexual assault by two men in her own home. She has firmly asserted she is not currently suicidal and would not consider suicide again, citing the damage it would cause family and friends. However, she continues to experience severe symptoms of depression, anxiety, and post-traumatic stress disorder.

Referral information and further assessment by the practitioner reveal the following:

Specific problems

Joy reports numerous symptoms of depression, phobic anxiety, and PTSD. For example, her mood is consistently very low, she is tearful much of the time, she feels hopeless about the future, feels worthless and guilty, has no energy or motivation, cannot concentrate, has had to give up her employment, and what sleep she does have is disturbed by distressing, repeating nightmares. She is finding it very difficult to leave the house, is anxious about people visiting her at home, and feels "stalked" when friends try to contact her to invite her out or check how she is doing (misperceiving well-meant concern as evidence that people are trying to gain entry to her home in order to abuse her in some way). She is afraid to sleep in her bed, has flashbacks to the rape, and has become petrified that the men who raped her will find and assault her again (even though she has shifted to another address, has a confidential phone number, and the men were not previously known to her). After

a period of time, Joy gradually acknowledged an array of problems she initially felt too ashamed to disclose. These included "sleep-eating" and other sleep-related activities, skin picking, and dissociated periods of "self-gouging" after the shower.

Historical factors

Joy's experience of childhood trauma, including sexual, physical, and emotional abuse, has increased her risk of further sexual abuse as an adult. This increased vulnerability is likely to stem from an impaired ability to set functional boundaries (being naïve about potentially dangerous situations and unsafe people), as well as a tendency to be overly compliant (both long-term effects of childhood sexual abuse). Additionally, her mother, while being caring and loving to her daughter, was unable to protect her adequately from her father's abuse, thereby modelling compliant behaviour rather than assertive self-care.

Individual characteristics

Over the years of childhood, adolescence, and adulthood, Joy developed a personal style which demonstrated to the world she was confident, competent, and happy. However, this persona disguised Joy's internal sense of emptiness and worthlessness. She achieved a measure of self-esteem by always looking for opportunities to do kind things for others and by working exceptionally hard for her employers. As a result, she was seen as "strong and together" which made it feel impossible for her to confide in others about the rape, her previous history of childhood trauma, and her worsening symptoms of panic, phobic anxiety, and depression. It also led to her over-working to the point of collapse.

Triggers

The rape triggered many memories of abuse from Joy's past. The verbal abuse of the two men was uncannily similar in tone to the things her father said to humiliate and distress her (perhaps because these are things abusive men say to vulnerable women they set out to intimidate and humiliate). The nightmares have intensified her "feeling like shit", leading her to avoid friends and family as she feels unclean, worthless, and "a waste of space". Her inability to protect herself from her father's abuse as a child (protection should have been by caregivers) left her convinced she should have been able to stop it. This has triggered feelings of guilt and responsibility for the rape. She is convinced she deserved it because she allowed one of the men into her home. Difficulties in her employment situation deprived her of an important source of self-esteem, leading to a deepening sense of worthlessness.

Maintaining factors

Joy's commitment to working a huge number of hours per week was an effective avoidance strategy. Having virtually no free time (except for sleeping) meant that she did not have time to reflect on the things that had happened to her and what her feelings were. Over time, however, this overwork led to "burnout", thereby decreasing instead of increasing Joy's ability to cope. Being the strong and kind person in her social network led to her feeling unable to "dump" on her friends by telling them her own troubles. This deprived her of the ability to gain emotional support, have her feelings and reactions normalised, or have her friends or family realise Joy needed extra support and assistance. As her mental health deteriorated, she used increasingly complex avoidance strategies to avoid seeing friends and family. She stopped answering her phone and emails, kept the curtains closed and windows shut in her home, and parked her car a few streets away from home so that no-one would know she was home if they came to visit. Her decision not to report the rape to the Police was based on

the ordeal she saw her stepmother having to endure during a court case. She was fearful of the consequences of reporting. She thought she would be publicly revealed as being "shit", and that she would become "visible" and therefore vulnerable to further abuse. However, this decision (an attempt at self-care) led to intense feelings of guilt. She was convinced that because she did not have the courage to expose herself to public humiliation, her "selfish" decision meant that these two men could continue to sexually assault and rape other victims. She saw herself as personally responsible for any further rapes which might take place, even though the details of these would be unknown to her.

Strengths

Joy's ability to find meaning and pleasure in life prior to the rape, despite her experience of childhood trauma, indicates she is very likely to achieve this again. She has the ability to manage and sustain a heavy workload, including the ability to take responsibility and "make things happen". Joy has a circle of friends and family who care very much for her, particularly as they have often been on the receiving end of her kind and generous gestures.

Summary

While Joy is currently facing an array of distressing psychological and physical symptoms, she is not currently suicidal and is committed to working towards a return to good health. She has the ability to engage in a therapeutic relationship in which she can gradually learn to trust the therapist. She has the support of friends and family. There are clear links between her current symptoms, which can be understood as being primarily symptoms of post-traumatic stress disorder. There are also links evident between Joy's history of childhood trauma and her vulnerability to sexual assault as an adult. The ways in which she was socialised as a child (compliant mother, abusive father) led to her developing a style of pleasing others rather than considering her own needs and safety. This in turn prevented her seeking assistance as she became aware she was no longer coping with her escalating emotional symptoms, and instead choosing to avoid through over-work and "hiding away".

In essence, Joy's current situation can be described as a result of the following:

- Reduced ability for self-care and a pattern of putting others' needs first
- Low self-esteem and feeling worthless ("like shit")
- Emotional and physical exhaustion, leading to an array of medical illnesses as well as psychological symptoms
- A belief that she must always be the "strong" one, therefore cannot tell others her troubles or ask for assistance.

Developing a Therapy Plan

Based on the above formulation (after consulting Joy about its merit), the following therapy plan might be developed in collaboration with Joy:

- Continue regular monitoring of safety in terms of both suicide risk and sense of safety from potential abusers. Develop a safety plan to address any potential increase in risk. (*In Part One, see Principle 1: Safety and Appendix 4: Safety Decision Tree*)

- Establish a strong therapeutic alliance, so Joy can trust her therapist enough to believe in their ability to help her attain a sense of safety in the world and recover the ability to participate fully in society. (*In Part One, see Principle 3: Therapeutic Relationship*)
- Help Joy develop self-soothing skills, including grounding, controlled breathing techniques, emotion regulation, and distress tolerance. This will be necessary to ensure that she is not overwhelmed by therapy. (*In Part One, see Principle 2: Client Focus. Also see Technical Reports 5b and 5d for reference lists of useful texts related to therapy for CSA and adult sexual assault. Technical Report 1 provides an annotated bibliography for all New Zealand-sourced works related to working with clients who have been sexually abused as children or adults*)
- Address the most distressing symptoms first and prioritise these collaboratively with Joy. For example, improve Joy's ability to leave the house, increase her confidence in having trusted friends and family visit at home, ensure that physical health issues are being adequately addressed, improve Joy's mood through decreasing social isolation, expand her social support, re-establish previously enjoyed activities, improve her ability to sleep in her bed, and decrease the intrusive experiences (nightmares and flashbacks). (*See Technical Reports 5b and 5d for lists of references to assist with the "how to" component of therapy for clients who have been sexually abused.*)
- When stability is established, begin to process traumatic memories, first of the recent rape, then of abuse that occurred in Joy's childhood. Processing trauma memories needs to be done in a careful and titrated manner, with close regard to what this individual client can tolerate. John Briere's concept of the "therapeutic window" is a useful reminder to neither "undershoot" nor "overshoot" what Joy is able to tolerate. *For further information, refer to texts by (among others) John Briere (1996, 1997, 2000), Lucy Berliner (1988, 1996, 1997, 2002), Christine Courtois (1988, 1994, 2000), David Finkelhor (1985), Edna Foa (1991), Judith Herman (1992a, 1992b), Patricia Resick (1993), and David Wolfe (1986, 2003, 2006). Texts useful for working specifically with male survivors of sexual abuse include those by Gartner (1999), Harker (1997), King (2000), Lisak (1994, 2001), Pescosolido (1989), Pierce (1987), and Romano and DeLuca (2005). New Zealand texts related to working with sexual abuse survivors include those by Kathy MacDonald, Ian Lambie, and Les Simmonds (1995) and Kim McGregor (1994, 2007). See also the resource reference list in the section in Part One on References: Decision Trees*
- Include reminders to regularly monitor how Joy is doing with therapy (eg, is she making progress in her life outside the therapy room, or is she too often overwhelmed?). This information will guide re-formulating and adjusting the therapy plan
- Be mindful that it is not uncommon for clients to defer reporting to their therapist symptoms or details they initially consider too shameful to share. They may deny or minimise their use of alcohol and/or drugs, self-harming behaviours (eg, cutting), or unsafe sexual practices until they feel confident that revealing their secrets will not lead to the therapist being disgusted in, or rejecting, them
- Think ahead to the time when therapy is completed and how this will best be managed for this particular client. (*In Part One, see Principle 12: Therapy Completion.*)

Appendix 6: Case Formulation for a Child Client

Referral Information

Desiree, aged six, was referred for sensitive claims counselling by her family general practitioner after her mother (Deb) talked to the doctor about the concerns she and the school had about Desiree's behaviour. Desiree's parents, Deb and John, had been married for 10 years and were expecting a second baby in four months' time. The principal of Desiree's school had contacted the family to express concern about Desiree's sexualised behaviour at school. She advised Deb and John that, unless Desiree's behaviour could be managed, the school might need to consider excluding her because of the risk she posed to other children. Deb and John were experiencing similar problems at home when Desiree had friends visit her at home, and were anxious to do what they could to help their daughter.

Background Information

Desiree is the only child in her family, but a sibling is expected in four months' time. When Desiree was a preschooler (aged three-five years), her parents left her with a babysitter who was the daughter of a friend while they worked full-time. The first inkling they had that all was not well was when Desiree showed an unusual interest in her mother's genital area when they were taking a shower. She was keen to touch and smell and invited her mother to reciprocate, making comments such as "It tickles doesn't it Mum, nice tickles". Deb gently questioned her daughter and discovered that the babysitter, an 18-year-old girl, had been sexually abusing Desiree for some time. The abuse included genital touching of Desiree and coaching Desiree to touch the babysitter's genitals. It seemed that this had become a regular occurrence on an almost daily basis while Desiree was in the babysitter's care.

Initially, Deb and John felt that they could manage the situation alone. Deb gave up work so she could stay at home with her daughter. The family shifted to a different town to distance themselves from the sexually abusive babysitter and her family. The disclosure of the abuse had irreparably fractured the relationship between the two families, as the babysitter's family was unwilling to accept that their daughter had been sexually abusive, and the babysitter herself denied doing anything more than taking an occasional shower with Desiree. Unfortunately the problem did not resolve, but instead became worse when the family shifted and Desiree started at a new school.

Deb found that when Desiree had friends or cousins over to the house to play, she had to supervise the play constantly to stop Desiree initiating sexual play with the other children. The school was experiencing similar problems and also reported that Desiree was spending a lot of time "with her hand down her pants", masturbating during class. The teacher reported that Desiree seemed almost unaware of what she was doing and that the masturbation seemed to be a form of self-soothing behaviour for her. Deb and John conceded

that they had also noticed Desiree "fiddling with herself" at home, but thought it was a phase that would pass if they ignored it. They were also concerned about Desiree's need to sleep in their bed every night. This often meant that John had to leave the marital bed to sleep elsewhere (putting a strain on their relationship). They were concerned about the possibility that Desiree would still want to sleep with her parents when the new baby arrived, which they could see was not going to be tenable.

Case Formulation

Specific problems

Desiree is initiating sexualised play with other children, both at home and at school, and is also engaging in masturbation as a form of self-soothing in both of these contexts. She is only able to sleep when in her parents' bed, which often leads to her father having to sleep elsewhere. Her parents have concerns about the effect of these problems on a new baby. There is also potential risk to the baby from Desiree's sexualised behaviour, as well as practical concerns about managing a new baby and a child who sleeps in the marital bed. An additional concern is the effect on Desiree of the arrival of a new sibling in her life after six years as an only child, which might intensify the existing difficulties.

Historical factors

Desiree spent two years primarily in the care of a teenage girl who regularly sexually abused her. She had come to accept that sexual behaviour was an everyday part of a relationship with others, and had learned that she could use masturbation as a way of calming herself down or making herself "feel nice".

Individual characteristics

Desiree's developmental stage is an important factor in developing a formulation to assist with therapy planning. She has learned to use sexualised behaviour as a way of interacting with others and soothing herself, at an age when most children are learning to trust others in the context of a nurturing and supportive relationship with caregivers. While other preschoolers were learning to play well with other children, including developing their ability to share and to take turns, Desiree was learning to give and receive "nice tickles".

Triggers

Having other children to play with has become a signal for Desiree to engage in sexualised play as a way of interacting and enjoying the company of others. Masturbatory behaviour is triggered by anxiety or boredom, and has become a somewhat dissociated self-soothing strategy. Being away from her parents, particularly her mother, increases Desiree's anxiety, leading to inappropriate self-soothing and an inability to sleep in her own bed at night.

Maintaining factors

Masturbatory behaviour is reinforced because it "feels nice" and soothes Desiree when she is anxious or upset. While sexualised play is no longer necessarily rewarding (it has begun to lead to difficulties at school and at home), for a long period of time it was rewarded by her babysitter's special attention during incidents of sexual activity.

Desiree's parents initially decided that her need to sleep in their bed was understandable. They felt guilty that their daughter had been sexually abused by a babysitter who was chosen and trusted by them. Therefore,

they felt they should do all they could to re-establish a safe environment in which Desiree could trust others. Consequently, Desiree has been reinforced by seeking the physical reassurance of her parents and maintaining a close proximity to them. Desiree is now unable to get to sleep, or stay asleep, unless she is sleeping in a bed with her mother.

Strengths

Desiree has parents who love her and want the best for her. They accept that her sexualised behaviour is not her fault, but is nevertheless unacceptable and needs to be addressed. They are committed to doing whatever is needed to help their daughter develop more appropriate self-soothing strategies and the ability to play with other children without engaging in sexualised play. They acknowledge that currently Desiree's sexualised play is a risk to other children and that she needs to be closely supervised when in the presence of other children. Desiree understands that her parents love her and she has a strong attachment to them, particularly to her mother.

The school, while appropriately adamant that the sexualised behaviour needs to stop, is nevertheless willing to help in any way possible. It has expressed a preference to assist Desiree to reduce or eliminate these inappropriate behaviours, rather than exclude her from school. However, it is also firm in its view that, if the sexualised behaviour continues to be a risk to other children, this may be its only option.

Summary

Desiree is a six-year-old girl, with loving parents, who has developed a pattern of sexualised play following two years of sexual abuse by a female adolescent babysitter. Her sexualised play is causing problems at both school and home and it is vital that this is addressed as quickly as possible, to avoid possible exclusion from school and loss of playmates out of school. Desiree also exhibits some anxiety, as she finds it difficult to sleep alone, creating a concern about her response when a new sibling joins the family in a few months' time. She also uses masturbation as a self-soothing strategy and this seems to be a somewhat dissociated activity for her (she is unaware of what she is doing and the inappropriateness of this behaviour in public). Desiree has already faced significant changes in her life, including having her mother stay home to look after her (she may miss her babysitter who, although sexually abusive, was not unkind to Desiree), moving to an area away from previous friends, and starting a new school. Soon she will have a new sibling, an event which may well be challenging for a six-year-old who has become accustomed to being the centre of her parents' attention.

In essence, the following issues need attention:

- Sexualised behaviour
- Inability to sleep in own bed
- Adjustment to a new home, new friends, and new school
- Preparation for becoming a "big sister" instead of an only child.

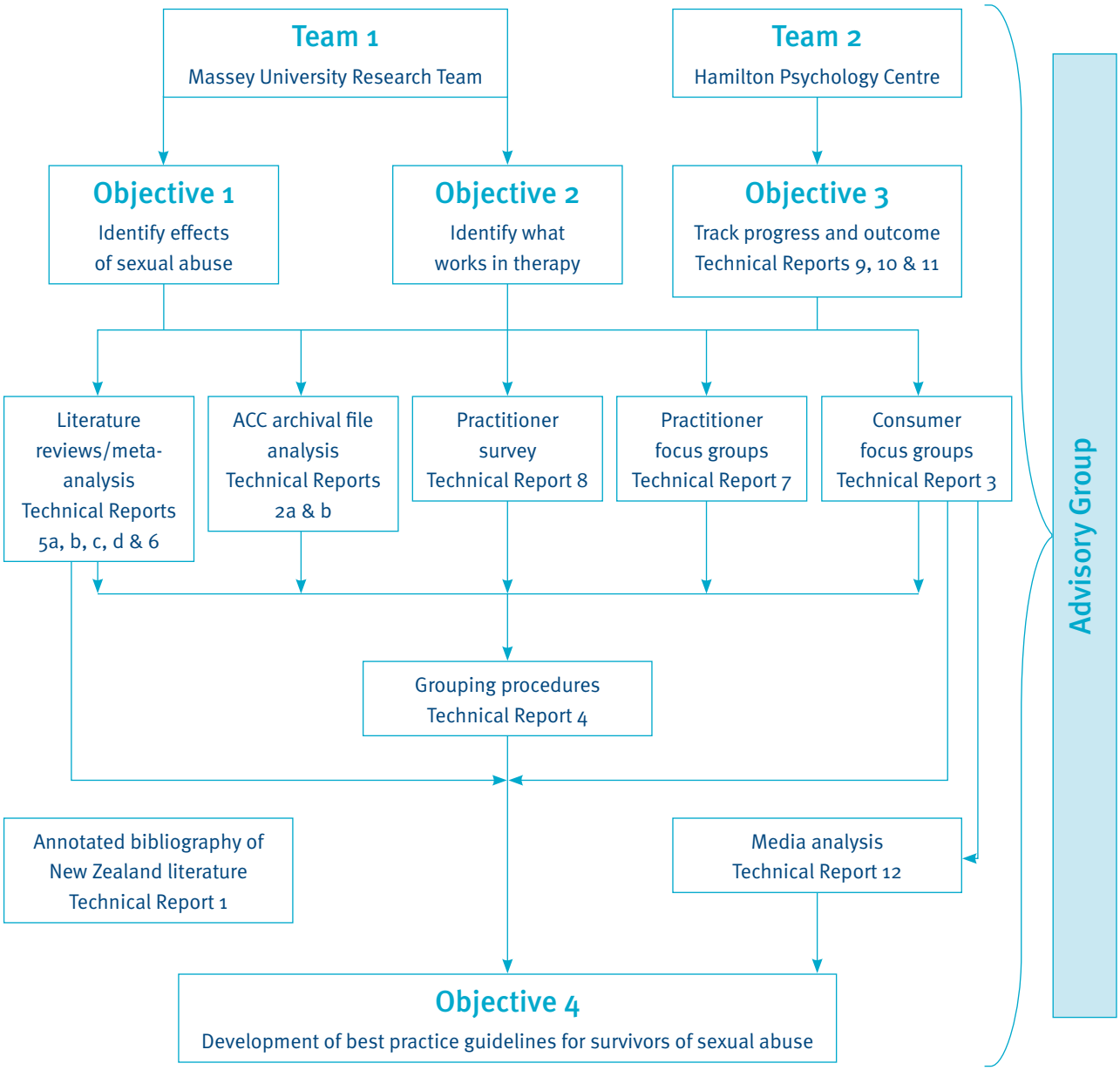
Developing a therapy plan

After a thorough assessment has been undertaken, a discussion with Desiree's parents about the formulation should be conducted. It is important to reach a jointly agreed formulation of the child's problem areas, individual characteristics, and strengths, and some ideas about how to proceed. The following therapy plan is an example of how a therapist might proceed with this case:

- Address safety issues first. In Desiree's case, this means that the sexualised behaviour must be a priority for therapeutic attention. Sexualised behaviour puts Desiree at risk of further sexual abuse and poses a threat to other children, including the new baby who will soon join the family. (*In Part One, see Principle 1: Safety*)
- Take as much time as necessary to establish rapport with Desiree. This will include finding out about her interests (eg, favourite superhero, television programme, movies, or games) and including elements of these in therapy sessions. (*In Part One, see Principle 3: Therapeutic Relationship*)
- Ensure a collaborative "team" approach with Desiree's parents so that they feel involved and instrumental in working towards the development and achievement of goals. (*In Part One, see Principle 2: Client Focus, and Principle 5: Effects*)
- Talk with Desiree's parents about the importance of including the school (particularly Desiree's classroom teacher) in the "team" to ensure a consistent and collaborative approach. Ask the parents to sign a consent form giving permission for contact with the school (ensuring agreement regarding the limits of information shared). (*In Part One, see Principle 11: Context*)
- If possible, meet with Desiree's school principal and classroom teacher to gain a good understanding of her behaviour at school, both in and out of the classroom. Ideally, a school observation should be carried out by a person unknown to Desiree. At the very least, have a telephone conversation with the principal of the school and Desiree's classroom teacher. (*In Part One, see Principle 6: Assessment, and Principle 11: Context*)
- In conjunction with Desiree's parents and the school, develop a set of achievable, measurable goals (these might include the initial reduction and subsequent elimination of sexualised behaviour, learning new ways to play and have fun with others, learning new ways to self-soothe, and learning to sleep in her own bed). (*In Part One, see Principle 7: Goals*)
- Follow good behavioural principles in designing a therapy programme for Desiree (ie, always try positive reinforcement first, or rewarding behaviour which is different from the behaviour to be eliminated). Star charts or other reward systems can be used for this both at home and at school. Try to catch Desiree playing appropriately with others and give praise for this, specifically noting what she is doing right (eg, "It's great to see you having such a nice time colouring in with Jane. You two look like good friends"). (*In Part One, see Principle 8: Rationale and Process*)
- Use social stories to help Desiree understand that sexual play is not acceptable, and that it might frighten and upset other children. Social stories can also be used to help Desiree to learn alternative ways of playing and interacting with other children
- Provide alternative methods for self-soothing. A special soft toy, doll, or cuddle rug may provide an appropriate interim distraction for the purposes of self-soothing. Praise Desiree when she uses the alternative method and gently remind her of her new method when she is inappropriately self-soothing (masturbatory behaviour)
- When the first goal is achieved, a similar approach could be used to address other salient issues, such as sleeping in her own bed
- Social stories will also be useful in helping Desiree to adjust to her new school, make and keep new friends, and prepare to be a "big sister" when her new sibling arrives. The therapist and her parents could use role-play to help Desiree to develop new ways of interacting with others. In the therapy playroom, dolls, puppets, drawing, or other child-friendly methods could be used for the same purpose
- Ensure that there is an effective system for monitoring and measuring change and outcomes (eg, observational data from school and home, parent and teacher reports, or forms detailing the frequency of target behaviours). (*In Part One, see Principle 9: Monitor and Feedback*)

- Prepare for the end of therapy. Build in a relapse prevention plan, including an expectation that in times of stress Desiree may revert to former behaviours, ways of noticing evidence of such relapse, and a plan to avert or respond appropriately to this
- Build in a follow-up plan, which could be either a session scheduled to check how things are in three, six, and/or twelve months, or planned follow-up phone calls to ensure that therapeutic gains are being maintained and to offer further assistance if they are not.

Appendix 7: Overview of the Project



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