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Effects of Childhood Sexual Abuse in Adult Women: An examination of
mediating factors and current counselling approaches to prevent repetition

by

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A Thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfilment of the requirements for the degree of
Master of Social Work

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Abstract

This study examines the relationship between mediating factors and repetition of sexual abuse, such as resiliency, post-traumatic stress symptoms, dissociation, alcohol and substance abuse, and poverty. An essential part of this study is the understanding that repetition is both psychological and social in nature. Thirteen (13) interviews were conducted and information was gathered from the literature to identify mediating factors and various therapeutic strategies that are currently used in the prevention of repetition. This study found that long-term individual counselling is needed with a focus on relational trust. Also, counsellors should be trained in object relations therapy and resiliency theory, which have both been identified as theories that can be the foundation of an eclectic approach to the prevention of repetition. Furthermore, that there is a need for culturally sensitive programs for marginalized women. An outline of a psycho-social prevention program is presented which incorporates the findings.

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TABLE OF CONTENTS

Chapter 1: Introduction.....	5
<i>i. Introduction to the Problem.....</i>	<i>5</i>
<i>ii. Relevance and Importance of the Study.....</i>	<i>6</i>
<i>ii. Research Question.....</i>	<i>7</i>
<i>iii. Definition of Terms.....</i>	<i>8</i>
Chapter 2: Theoretical Framework.....	11
<i>i. Introduction.....</i>	<i>11</i>
<i>ii. Contributing Theories.....</i>	<i>12</i>
➤ <i>Attachment Theory.....</i>	<i>12</i>
➤ <i>Object Relations Theory.....</i>	<i>14</i>
➤ <i>A Social-Narrative Model.....</i>	<i>15</i>
➤ <i>An Ecological Approach to Understanding Repetition: Linking Personal Interpersonal and Sociocultural Factors and Processes.....</i>	<i>18</i>
<i>iii. Mediating Factors and Prevention.....</i>	<i>21</i>
Chapter 3: Literature Review.....	23
<i>i. Introduction.....</i>	<i>23</i>
<i>ii. Mediating Factors.....</i>	<i>26</i>
➤ <i>Resiliency.....</i>	<i>27</i>
➤ <i>Post Traumatic Stress Disorder.....</i>	<i>29</i>
➤ <i>Dissociation.....</i>	<i>32</i>
➤ <i>Alcohol and Substance Abuse.....</i>	<i>33</i>
➤ <i>Shame.....</i>	<i>34</i>
➤ <i>Severity of Abuse.....</i>	<i>35</i>
<i>iii. Prevention and Treatment Implications.....</i>	<i>38</i>
<i>iv. Strengths and Weaknesses of the Literature.....</i>	<i>41</i>
Chapter 4: Research Methodology.....	45
<i>i. Introduction.....</i>	<i>45</i>
<i>ii. Data Collection and Analysis.....</i>	<i>46</i>
➤ <i>Recruitment of Participants.....</i>	<i>46</i>
➤ <i>Interviews.....</i>	<i>46</i>
<i>iii. Sample.....</i>	<i>48</i>
<i>iv. Method of Analysis.....</i>	<i>49</i>
➤ <i>Grounded Theory.....</i>	<i>50</i>
<i>Methodological Limitations.....</i>	<i>51</i>

Chapter 5: Results.....	53
<i>i. Introduction.....</i>	<i>53</i>
<i>ii. Categories and Nodes.....</i>	<i>56</i>
➤ <i>Repetition.....</i>	<i>56</i>
➤ <i>Mediating Factors.....</i>	<i>56</i>
➤ <i>Presenting Issues.....</i>	<i>60</i>
➤ <i>Therapeutic Approach – Techniques.....</i>	<i>61</i>
➤ <i>Therapeutic Approach – Theories.....</i>	<i>63</i>
➤ <i>Prevention.....</i>	<i>65</i>
➤ <i>Gaps and Unmet Needs.....</i>	<i>71</i>
➤ <i>Summary of Categories and Nodes.....</i>	<i>74</i>
<i>iii. Conclusion.....</i>	<i>79</i>
Chapter 6: Analysis.....	80
<i>i. Introduction.....</i>	<i>80</i>
<i>ii. Prevalence of Repetition and Social Incoherence.....</i>	<i>81</i>
<i>iii. Psycho-Social Mediating Factors.....</i>	<i>85</i>
<i>iv. Prevention and Treatment of Repetition.....</i>	<i>95</i>
<i>v. Gaps and Unmet Needs in our Current System</i>	<i>100</i>
<i>vi. Conclusion.....</i>	<i>107</i>
Chapter 7: Outline of Prevention Program.....	108
<i>i. Introduction.....</i>	<i>108</i>
<i>ii. A Psycho-Social Prevention Program Model: A Workshop for Counsellors.....</i>	<i>110</i>
➤ <i>Section I: The Psycho-Social Nature of Repetition.....</i>	<i>110</i>
➤ <i>Section II.....</i>	<i>111</i>
○ <i>Mental Health Effects of Repetition.....</i>	<i>111</i>
○ <i>The Many Levels of Repetition of Sexual Abuse.....</i>	<i>115</i>
➤ <i>Section III: Theoretical Foundations in an Eclectic Approach.....</i>	<i>119</i>
○ <i>Object Relations Theory.....</i>	<i>120</i>
○ <i>Resiliency Theory.....</i>	<i>121</i>
➤ <i>Section IV: Treatment Implications.....</i>	<i>122</i>
<i>iii. Conclusion.....</i>	<i>124</i>
Chapter 8: Conclusion.....	127
<i>Recommendations for Further Research and Practice.....</i>	<i>130</i>
<i>Role of this Study in the Literature.....</i>	<i>131</i>

Appendices.....133

Appendix A.....133

Appendix B.....134

Appendix C.....150

Bibliography.....152

Chapter 1: Introduction

i. Introduction to the Problem

Sexual abuse is a social problem that affects many women and girls. Draucker (1998) reports that 20 percent of adult women, 15 percent of college women, and 12 percent of adolescent girls will be sexually abused or sexually assaulted during their lifetimes. In their review of the literature, Doll, Koenig, and Purcell (2004) found that a wide range of girls experience some form of childhood sexual abuse. In this same article, Doll et al. refer to the rate of prevalence in girls who are sexually abused, which is reported to be three to five times higher than that attributable to the cases found in boys. The incidence of sexual abuse has been found to be much higher in women and girls; this fact underscores the importance for research that is focused specifically on violence against women and girls (Draucker, 1998).

For most women, trauma from childhood sexual abuse does not end with the event. The abuse has complex ramifications for women, many of which they carry through their adolescence and/or adulthood. Draucker (1998:162) asserts that the

Initial effects of sexual assault may include shock, numbness, withdrawal and denial, and long-term effects may include depression, substance abuse, sexual dysfunction, anxiety disorder, and chronic post-traumatic stress symptomatology.

Moreover, Miller, Cardona, and Hardin (2006:7) state that “women survivors of childhood sexual abuse report cognitive distortions occurring around five principles: safety, trust, power, self-esteem, and intimacy.” Research studies have indicated that women who were sexually abused during their childhood are two to three times more likely to be sexually abused either in their adolescence or during adulthood. Draucker

(1998:162) explains that “in reality, many women who are sexually assaulted as adults have been sexually abused as children or exposed to other forms of violence.” This phenomenon is called repetition of sexual abuse (Rich, Cindy L. et al., 2004; Casey, Erin A. et al., 2005).

ii. Relevance and Importance of the Study

My interest in this research topic began to form when I started working as a sexual abuse counsellor five years ago. A commonality among the women with whom I have worked became apparent: many women who were sexually abused in their childhood were subject to abuse during their adolescence and/or adulthood. Similarly, I have observed that the traumatized clients tend to re-experience situations reminiscent of the original trauma. Other forms of non-sexual abuse and abusive relationships are also overrepresented in these women’s lives.

As I began to review the literature about trauma, sexual abuse, and repetition, I noticed that a large part of this literature confirmed the prevalence of repetition among women who were sexually abused during their childhood. However, there is limited literature hypothesising the reason for the occurrence of repetition, and there are even fewer sources that incorporate these theories into finding strategies for the prevention of reoccurrence. This gap in the literature compelled me to explore factors that mediate childhood sexual abuse and repetition, such as, a woman’s resiliency, post-traumatic stress symptoms, disassociation, alcohol and substance abuse, shame, and the severity of the original abuse. I was confounded by the following reality: if the occurrence of repetition is clear, why have researchers not produced more studies aimed at uncovering

the core of this phenomenon, and why are there no established unified societal foci aimed at preventing it? On the contrary, some programs that have been developed to help women deal with the aftermath of the abuse can cause further trauma to the woman.

I have observed that many counsellors seem to refrain from talking openly about repetition of sexual abuse as a psycho-social phenomenon, due to what seems to be a fear that they will take on a 'blame the victim' mentality. This fear had caused a silence among counsellors which prevents their clients from understanding what has contributed to their experiences of repetition and from feeling empowered to make changes. When counsellors only focus on repetition as a social problem, they fail to take into account the psychological effects of childhood sexual abuse which can become disempowering for women. For example, a counsellor could make gender inequalities the focal point of her counselling interventions, while failing to include the role of mental health effects resulting from childhood trauma. In my own work, I did not understand the complex factors that contribute to the perpetuation of repetition and I have noticed this lack of comprehension among other counsellors in the community. I think that if we can begin to understand repetition as a psycho-social phenomenon, then we can begin to break the silence and address all the factors involved in women experiences of repetition.

iii. Research Question

An essential part of this study is the understanding that repetition of sexual abuse is both psychological and social in nature. This aspect demonstrates the difference between this study and most mainstream perspectives, this study does not view repetition strictly as a pathology that rests on the woman's individual bio-psychological make up, or

simply as a result of societal forces. This study sought to make a contribution to the literature that is currently available on the topic of the relationship between mediating factors and repetition of sexual abuse. In addition, the information gathered from the literature and the interviews that were conducted have been incorporated in such a way as to become the cornerstone for a psycho-social prevention program, the goal of which would be to serve in practice.

The benefits of this project are twofold:

1. The identification of factors that mediate between childhood sexual abuse and repetition have been clearly established and
2. The acknowledgement of potential psycho-social prevention strategies has been discussed.

Furthermore, through semi-structured interviews, counsellors¹ were questioned on what they identify as mediating factors. They were asked to identify the various therapeutic strategies that are currently used in the prevention of further repetition of sexual abuse.

Moreover, an outline of a psycho-social prevention program has been developed. This program possesses a variety of therapeutic strategies aiming to address the unique needs of women who have experienced, or are at risk of experiencing, repetition of sexual abuse. Much of the literature on the topic of repetition identifies a need for the design of prevention programs; however, this design concept remains largely underdeveloped. Through the identification of mediating factors and prevention strategies, counsellors will have a new outline for a psycho-social prevention program available for working with this specific group of women.

¹ In this study 'counsellors' will include: counselling, therapist and social work professionals.

*iv. Definition of Terms*Repetition

Repetition of sexual abuse is more commonly known as revictimization. It is this researcher's personal choice to use the term repetition, instead of revictimization, in this thesis because it describes the woman's experience more accurately. Repetition of sexual abuse is more significant when related to repeated experiences of sexual abuse. In addition, the term re-victimization can be disempowering to women as it identifies them as victims; using this term implies a lack of control or lack of ability to change the pattern of abuse in one's life. The following definitions will be used to identify repetition of sexual abuse throughout this research:

- [Repetition of sexual abuse] is the recurring experience of sexual abuse later in life or the participation in a relationship that re-enacts the physical, sexual or emotional abuse that was suffered in childhood (Kessler, et al., 1999: 335).
- "[Repetition of sexual abuse] was defined as having experienced childhood sexual abuse and a separated incident of adolescent/adult victimization." (Arata, 2000: 28)

Mediating Factors²

- This term refers to the psychological and social dynamics that intercede between childhood sexual abuse and the repeated abuse in one's adolescence and/or adulthood. Some examples include resiliency, post-traumatic stress symptoms,

² In the literature, the term mediating variables is also used.

dissociation, alcohol and substance abuse, shame, and the severity of the original abuse.

Grounded Theory

- Grounded theory is a qualitative method of deriving theory from data. Hallberg (2006:143) explains that “the systemic abstractions and the conceptualization of empirical data constitute the theory-generating process.” Data analysis using grounded theory begins with working hypothesis, and moves to conceptual ordering and then to theorizing (Walker and Myrick, 2006).

NVivo

- NVivo research software helps access, manage, shape and analyze detailed textual information; this software also offers tools for classifying, sorting, and arranging information.

Chapter 2: Theoretical Framework

i. Introduction

The analytical framework used in this study is grounded in a social constructionist perspective. From this standpoint, four theories – attachment theory, object relations theory, the social narrative model, and the ecological approach to understating repetition – have been discussed to allow a comprehension of various life situations, that women, who were sexually abused in their childhood, may experience. These include:

- multiple experiences of sexual violence, and;
- increased vulnerability to sexual abuse and its relation to mediating factors.

Through a review of the various current theories that explain repetition, it is remarked that no single theory provides a thorough explanation of this phenomenon. Sexual abuse and repetition result from many complex factors. It therefore becomes imperative that this framework embody a variety of theories so that a multi-faceted more comprehensive theoretical lens is created.

There is a shortage of literary sources that integrate empirical studies into a theoretical understanding of repetition (Grauerholz, 2000); therefore, the following theories have been used to achieve a comprehension of this phenomenon: attachment theory (Van der Kolk, 1984; Holmes, 2001; Haskell, 2003), object relations theory (Cashdan, 1988; Carey, 1997), a social-narrative model (Tromp et al. 1995; Foe et al. 1994; Foe et al. 1995; Amir et al. 1998; Lynn et al., 2004) and an ecological approach (Bronfenbrenner, 1977, 1979; Heise, 1998; Grauerholz, 2000). In order to adequately

integrate these theories into this larger theoretical framework, a brief literature review is presented.

ii. Contributing Theories

Attachment Theory

The environment in which a child is raised has a great deal of influence on the psychological write-up of her adolescence and/or adulthood, as well as in the social experiences she encounters. Similarly, a child's primary caregiver has a greater influence on the child's development process than any other person involved in her life. Attachment theory provides some insight into the reasons why a woman who has experienced sexual abuse during her childhood might encounter the repetition of this experience in her adolescence and/or adulthood. Using attachment theory in an analysis of repetition of sexual abuse provides insight into potential patterns that could develop later in life. For example, in the case of a child who has experienced sexual abuse, a secure attachment to her primary caregivers, or lack thereof, can often predict how she might react to a similar trauma later in life. If a child has an insecure attachment to her primary caregiver, attachment theory provides an explanation for why, as an adult woman, this individual is unable to establish healthy relationships. In contrast, if sexual abuse was perpetrated against a child who has a secure attachment with her primary caregiver, she may, in adulthood, develop resiliency and cope with trauma in much healthier ways. An adult woman, who had an insecure attachment with her primary caregiver during her childhood, can begin to work on changing this internal working

model in therapy so that she can begin to develop secure attachments and a healthy social network.

Attachment theory sheds light on the primary caregiver's crucial role: that of providing a child with love, affection, safety and security, in order permit that child to develop a secure attachment and explore the world with a sense of security. Van der Kolk (1989) stresses the crucial role that a secure attachment plays in a normal social and biological development. The author explains that as children mature the:

...ever-expanding cognitive schemas decrease their reliance on the environment for soothing and increase their own capacity to modulate physiologic arousal in the face of threat (p. 4).

Haskell (2003) states that secure attachment develops when primary caregivers respond sensitively to the child's emotional needs and signals. She elaborates by explaining that the adjusted relationship with the primary caregiver permits the immature and developing child to expand her capacity to process emotions appropriately. The author emphasizes the necessity for the primary caregiver to provide the child with this type of security on an ongoing basis if the child is to have the ability to develop further secure attachments.

When the primary caregiver fails to provide this ongoing security, the child will develop insecure attachments when attempting to relate to other people. Holmes (2001) explains that attachment theory finds its origin in the adult's manifestation of her power within the fulfilment of her responsibility pertaining to the protection and provision of security for her children. When a caregiver abuses the child, the fundamental biosocial contract is shattered by the caregiver's use of her power for personal gain, rather than the use of power for the protection and nurturing of the child (Holmes, 2001:96). In order to

maintain a sense of security, children often blame themselves for the abuse rather than by risking their relationship with the primary caregiver. Van der Kolk (1989) explains that children become “fearfully and hungrily attached and anxiously obedient.” The development of insecure attachments becomes a pattern which flows into adulthood, and it has been speculated that this pattern puts women at risk of repetition and re-experiencing trauma (Van der Kolk, 1989; Carey, 1997). It is, therefore, a useful theory to apply when investigating a woman’s experience with sexual abuse.

Object Relations Theory

Carey (1997) recommends treatment using the psychodynamic theory *Object Relation Theory* which assume that people are “interpersonally motivated, using interpersonal defences to protect attachment with significant others.” The author explains that children develop their most significant attachment through “object relatedness,” which signifies self-other patterns. According to Carey, children seek to protect this attachment. Consequently, in a situation where they become victims of sexual abuse, the child-victim internalizes the abuse and begins to blame herself. Carey argues that this situation causes an “object relation disturbance,” which in turn brings about maladaptive interpersonal behaviours and perceptions in the child’s life. Ultimately, this can be the root of the child’s behaviour which can cause the child to carry similar distorted beliefs into adulthood. Carey asserts that this can lead to repetition and re-enactment.

When implementing this theoretical perspective in treatment, Carey stresses the importance of considering and facilitating three main propositions during counselling sessions. Initially, the author explains the need for the counsellor to facilitate the

development of a healthy therapeutic attachment which includes an emphasis on empathy, respect, and collaboration. Carey (1997) puts the emphasis on the dynamics of re-enactment, and how the counsellor should consider this aspect both inside and outside of the counselling relationship. In the process of such re-enactment, the counsellor should set clear boundaries with the woman and be observant of signs indicative of a self-destructive relationship. The author explains that it is necessary that the counsellor facilitate interpersonal awareness through the preferred means of emphasizing attachments more than confronting interpersonal awareness. He also underlines that it is the counsellor's responsibility to facilitate gradual recognition of interpersonal defences.

A Social-Narrative Model

It is important to begin with the following understanding: repetition of sexual abuse would not exist if we lived in a society that did not perpetuate violence against women and children. Because we do live in such a society, it is important to make children aware of such dangers by explaining to them that childhood sexual abuse is a fundamental violation that should never occur. Unfortunately, this rarely occurs in the life of a child who has been sexually abused; on the contrary, her experiences often lead to guilt, shame, self-blame, and a variety of other psychological and social mediating factors, which are all precursors of repetition.

The inclusion of a social-narrative model in this analysis is important because it sheds light on the impact mainstream values has on women with childhood sexual abuse experiences and the way these principles contribute to the occurrence of repetition. In addition, incorporating a social-narrative model allows the researcher to analyze

repetition in both the individual and through social perspectives. Furthermore, this model is conducive to the comprehension of mediating factors; they do not all result from individual pathologies, but are largely influenced by social factors. The inclusion of a social-narrative model in this theoretical framework will provide a psycho-social perspective on the development of a prevention program model which can, in turn, be more empowering for women.

Lynn, Pintar, Fite, Ecklund, and Staffor (2004) developed a social-narrative model of dissociation which provides a further understanding of repetition. The authors explain that dissociation has been labelled a functional defence mechanism that outlives its usefulness and becomes a persisting dysfunctional symptom of abuse (p. 170). Lynn et al., argue that dissociation “arises as a result of the social conditions in which victims live and are abused, and as a reflection of unbearably conflicted social relations” (p. 170). The authors identify the conflicting or dissociative social relations as the central focus of this model. They further explain that this model focuses on contradictory or dissociated social relations, rather than being centered on locating dysfunctional dissociation in the individual – which is the case for most other theories.

Lynn et al. makes clear that there are contradictions between the explanation of the personal experience of a sexually abused child, and the other meaning associated with the dominant social narrative. Essentially, traumatic interpersonal violence is a contradiction of cultural norms as expressed in shared social narratives (p. 170). One example, speaks to the absence of socially abnormal, secretive events of childhood sexual abuse in children’s books, cartoons and that these events are not being mirrored in the experiences of other children in their neighbourhood or at school. The authors further

elaborate by portraying this extreme discrepancy between personal narratives and a shared social narrative as “social incoherence.” According to the authors, this is not a situation in which the problem stems from a woman’s cognitive expectations. They describe the issue as one which society’s expectations do not match those attributable to women who have experienced sexual abuse. Therefore, the woman is limited in her ability to recover if the dissociated social conditions remain.

According to these authors, in some cases of women who are subjected to childhood sexual abuse, repetition is “dysfunctionally functional,” because it lessens the contradiction between their personal experience and the social expectation. The authors state that repetition has a communicative component. The explanation that they provide is that repetition:

...sometimes operates as a kind of performance, a way of narrating past abuse for others to see, not by telling the story in words but by enacting it, again and again, until somebody sees, somebody understands, somebody finally steps in and helps the victim to experience a different ending this time (p.174).

Lynn et al. assert that repetition is an attempt to alter the social relations which exist in the present, rather than attempting to gain a mastery of past experiences. The authors explain that even though a woman might have control over some aspects of repetition in her life, there are other factors within society over which she has no control. The authors state that the woman’s fear is not imaginary or irrational. Lynn et al. propose that repetition will occur more often in cases of women who continue to have dissociated personal and social worlds. It seems essential to include a social narrative model in this examination of repetition of sexual abuse because of the unique view that the dissociation

of personal and social worlds is a contributing factor to a woman's potential multiple experiences of sexual abuse.

An Ecological Approach to Understanding Repetition: Linking Personal Interpersonal and Sociocultural Factors and Processes

The ecological approach to the study of repetition of sexual abuse embodies a psycho-social approach to understanding this phenomenon and theorizes that repetition occurs as a result of the following four categories: the ontogenic development, microsystem, exosystem and macrosystem. These categories provide the potential for a more thorough analysis on the role society plays in a woman's experiences of repetition. In addition, this theory acknowledges the many power differences contained within a woman's immediate environment and in society at large. Sexual abuse is ultimately about the perpetrator's attempt to gain and hold power and control over an individual. Therefore, it is imperative that the dynamics of power be included in an analysis of repetition. As an important contribution to the present theoretical framework, this theory clearly identifies the presence of mediating factors that may predict or impede repetition. Within the scope of theories, this is the only one that emphasizes mediating factors and their complex roles in repetition.

Grauerholz (2000) uses an ecological approach in order to speculate about repetition of sexual abuse. This theory presupposes that a woman's experience with repetition can only be understood by considering factors at three levels. These three levels are the individual, interpersonal, and sociocultural levels. According to the author, this theory is multifaceted in nature and avoids focusing solely individual's actions that might put herself at risk of repetition. There are four levels of analysis in this framework

(See ‘Diagram 1’ below for a visual representation of the four levels of this ecological approach to repetition):

- the ontogenic development;
- the microsystem;
- the exosystem; and
- the macrosystem.

Diagram 1: An Ecological Approach to Understanding Repetition – Linking Personal Interpersonal and Sociocultural Factors and Processes

(Grauerholz, 2000: 6)

The ontogenic development, as Grauerholz explains, is associated with the woman's personal history and her subjective participation in the current relationship; these two components will have an impact on her current behaviour or will serve to shape it. According to the author, the most critical ontogenic factor is the initial victimization; it shapes the woman's personality and thus affects her interactions with others in a manner which makes repetition more likely. Grauerholz emphasizes that another essential ontogenic factor is developed through the early family experiences. These have been

established by the author to represent an important factor used to determine the level of a woman's psychological distress in adulthood.

According to Grauerholz, the microsystem explains the immediate context of the abuse which usually involves a family member or an intimate relationship. The author explains that prior sexual abuse can cause vulnerability to repetition of abuse in two ways (p. 10):

- factors that may lead to increased contact with potential perpetrators such as increased sexual activity in adulthood, impaired ability to judge risky situations or people, dissociative disorder, stigmatization, and low self-esteem; and
- factors that increase the likelihood that perpetrators will choose to act aggressively. The author suggests that perpetrators are skilled at identifying indications of women's vulnerabilities; he states also that certain factors may contribute to the decrease of the woman's ability to respond assertively and effectively.

Grauerholz defines the exosystem as the "formal and informal social structures such as work, neighbourhood and social networks" (p. 6). The author explains that in order to understand the exosystem, one must take into consideration the way that social power is developed, and how a woman's lack of power can contribute to her susceptibility to repetition. The researcher explains that the exosystem focuses on the ways in which a woman's socioeconomic status, isolation, and support system may contribute to her lack of power in society and, in turn, put her at a higher risk of repetition.

Finally, Grauerholz defines the macrosystem as representing “cultural values and beliefs that foster their influence on the other three systems” (p.6). The author identifies two main cultural beliefs that put women at a higher risk of repetition. They are:

- the blame put onto the woman; and
- the social construction of the good girl/bad girl.

Grauerholz stresses that these cultural tendencies have profound repercussions on a woman’s life: whether it is where her recovery is concerned, or in the context of her being liable for her exposure to possible repetition of the abuse.

iii. Mediating Factors and Prevention

Empirical evidence has been documented regarding factors that mediate between childhood sexual abuse and repetition of abuse. These mediating factors are resiliency, post-traumatic stress symptoms, dissociation, alcohol and drug abuse, shame, and the severity of the original abuse, which all play a role in repetition of sexual abuse (Banyard et al., 1996; Sandberg et al., 1999; Kessler et al., 1999; Merrill et al., 1999; Arata, 2000; Noll et al., 2000; Messman-Moore et al., 2002; Noll et al., 2003; Rich et al., 2004; Casey et al., 2005). It is important that these factors be addressed within the scope of prevention programs. This will be the premise of a thorough analysis of mediating factors and prevention strategies and will prove that there is a direct link between mediating factors and prevention. First, it is critical that mediating factors be examined because these factors can trigger or impede repetition. In other words, mediating factors can predispose or protect women from repetition. The information originating from the knowledge and understanding of mediating factors can be used in the development of a

psycho-social prevention program model and training of counsellors. For example, if it is found that shame is a factor that mediates childhood sexual abuse and repetition, ways in which a woman can dispel shame can be included in the prevention program. Similarly, if a woman displays resiliency and the ability to recover from the abuse, these factors can be included in the prevention program model so that other women may learn of these aspects and potentially use them to their benefit through their own efforts to prevent repetition. Finally, when examining mediating factors, it is important to be aware of both the social and subjective participation that recreates patterns of violence – in a sense, one can view society and the individual as co-authors of the script.

These four theories, as presented in this chapter – attachment theory, object relations theory, a social-narrative model, and an ecological approach – provide the foundation of the theoretical framework that is being used in the current study. *Attachment theory* provides insight into the integral role played by the development of a child's early relationship with her primary caregiver – regardless of whether the primary caregiver is the abuser – when considering the child's vulnerability to repetition of sexual abuse. From this position, *Object relations theory* provides a way for counsellors to begin working relationally with women who have childhood sexual abuse experiences. A *social-narrative* model provides the type of information that will offer insight into how repetition is the product of dissociated or conflicting social relations that do not mirror one's personal experience. An *ecological approach* to understanding repetition of sexual abuse provides a psycho-social perspective that places and emphasis on the importance of understanding that repetition can result from both the individual and societal problems,

which also includes an analysis of power relations. In the next chapter, literature on mediating factors and current prevention programs will be reviewed.

Chapter 3: Literature Review

i. Introduction

For many women who have experienced sexual abuse during childhood, the nightmare does not end with the abuse. Studies have shown that girls who have been subjected to sexual abuse, on average, are two to three times more likely to experience repetition during adolescence and/or adulthood (Rich et al., 2004; Casey et al., 2005). Although there is extensive literature on repetition, a core definition is rarely provided. Despite the failure of literature to use a universal definition for repetition, the writings have one commonality, which is the recurrence of abuse at various times in a woman's life. In written documentation, repetition is more commonly identified as re-victimization. The term repetition has been chosen for this review because it more accurately identifies what takes place: it is synonymous with repeated experiences of sexual abuse³.

This review of the literature will begin with a definition of repetition, and will briefly examine the social construction of this phenomenon. The analysis will continue by encompassing an overview of the various factors that mediate between childhood sexual abuse and violence experienced in adulthood. The chapter's final component will include an examination of prevention programs covered in the literature, as well as their theoretical underpinnings.

In the scope of this review, few concrete definitions were found. First, Arata (2000: 28) stated that repetition is "having experienced child sexual abuse and a separate incident of adolescent/adult victimization." In another article, Kessler and Bieschke

³ As discussed in the Introduction, the term re-victimization can be disempowering to women as it qualifies them as victims, a term possibly indicative of a lack of control or ability to change the pattern of abuse in one's life.

(1999:335) defined repetition as “[recurrence] of sexual abuse later in life or the participation in a relationship that re-enacts the physical, sexual or emotional abuse that was suffered in childhood.” And, in the section of her book which deals with first stage trauma treatment, Haskell (2003:190) defines repetition as “multiple experiences of sexual violence, as well as the increased vulnerability to further sexual violence, most often resulting from an early experience of child sexual abuse.”

This analysis focuses specifically on repetition of sexual abuse; however, it is important to remember that studies conclude that women who were subjected to childhood sexual abuse have often experienced other forms of abuse such as neglect, as well as physical and emotional abuse throughout their lives. Doll, Koenig, and Purcell (2004) report the increased rates of repetition (e.g. sexual assault), sexual risk (e.g., multiple partners, commercial sex work), and other forms of maltreatment (e.g., physical assault, crime victimization) which are prevalent in the lives of women who experienced childhood sexual abuse, as compared to individuals who had not been subjected to such experiences in childhood. Similarly, women who have experienced abuse during childhood seem to be at higher risk of encountering other types of abuse while in an intimate relationship. These women are often abused physically and emotionally, and may experience difficulties in their interpersonal relationships (Van der Kolt, 1989; Briere, 2002).

Most studies addressing repetition seem to focus solely on understanding the woman’s role in this phenomenon. Similarly, it seems that many prevention programs focus uniquely on assisting women in changing aspects of themselves in order to prevent repetition from continuing. For example, the woman must examine her actions, those

which could be deemed to put her at higher risk of repetition. Similarly, it would be suggested that she receive professional counsel to help her recognize how to initiate change in her own life. Ideally, this would lead to a clearer understanding of the required decisions that will end the cycle of these repetitious patterns. Although this focus is an integral part of breaking these patterns, and can actually serve to empower women seeking change, it is also important to add a social constructionist perspective in the examination of repetition to this subjective approach. The social constructionist perspective becomes essential when dealing with cultural realities. Indeed, the dominant discourse in our society focuses mainly on the individual, thereby contributing to the pathology of women. In the article that highlights their work in a group setting with women who have experienced sexual abuse, Wood and Roche (2001: 6) explain that:

...violence against women takes place in a cultural context rife with oppressive discourses, master narratives that devalue, subjugate, and blame women, reinforced by institutionalized asymmetries in social power encoded in laws and official practices.

By focusing on the individual society does not have to address the more compelled context in which violence against women, and specifically repetition, is perpetuated.

Another author, Henriques (1984: 60) states the following:

...this dualism and the concomitant individualism which is central to it allows even radical analysis to be pressed into the service of existing social relations, thereby reinforcing and perpetuating them.

The focus to initiate the change required for preventing repetition should not be placed solely on the woman. In order to find a solution that will allow a retreat from the cycle of abuse, one must also consider how the following four components are affected by the

dominant discourse and how they perpetuate repetition: individual behaviours, her unconscious fears and motivations, the primary relationships in her life and societal values and beliefs about childhood sexual abuse and repetition (Henriques, 1984; Wood and Roche, 2001; Grauerholz, 2000). A thorough analysis of repetition therefore must also focus on the presence of these three components.

ii. Mediating Factors

A variety of factors have been predicted to mediate childhood sexual abuse with repetition of sexual abuse. Mediating factors can be both psychological – in that they may lead to repetition because of the individual’s psychological framework– and social – as the ways in which factors within society contribute to a woman’s experience(s) of repetition (Banyard et al., 1996; Sandberg et al., 1999; Kessler et al., 1999; Merrill et al., 1999; Arata, 2000; Noll et al., 2000; Messman-Moore et al., 2002; Noll et al., 2003; Rich et al., 2004; Casey et al., 2005). In addition, mediating factors can provoke (Mayal et al., 1995; Sandberg et al., 1999; Kessler et al., 1999; Merrill et al., 1999; Arata, 2000; Messman-Moore et al., 2000; Grauerholz, 2000; Noll et al., 2000; Messman-Moore et al., 2002; Noll et al., 2003; Rich et al., 2004; Casey et al., 2005; Randolph and Mosack, 2006) or impede repetition (Liem et al., 1997; Bogar et al., 2006). In this section, resiliency, post-traumatic stress symptoms, dissociation, alcohol and substance abuse, shame, and the severity of the original abuse are mediating factors identified by the cited authors.

Resiliency

For the most part, this review will address the mediating factors that negatively affect women to the point of causing repetition in their lives. However, it is important to identify resiliency also as a positive mediating factor. Some women who have experienced childhood sexual abuse do not re-experience the abuse throughout their life. In addition, some women who have experienced repetition are able to move away from this pattern of violence. Bogar et al. (2006:319) define resiliency as:

...a combination of innate personality traits and environmental influences that serves to protect individuals from the harmful psychological effects of trauma or severe stress, enabling them to lead satisfying and productive lives.

In addition, Liem et al. (1997:595) state that resiliency is the capacity to “prevail, grow, be strong and even thrive despite hardship.” The authors elaborate by explaining that resiliency comprises a fairly stable set of characteristics that are associated with managing well when potential risk factors for developmental impairment are present.

Studies have now identified the existence of individual and social factors that contribute to the way in which a woman, with a history of childhood sexual abuse, can prove to be resilient to repetition and other negative results of trauma in adulthood (Liem, James, O’Toole and Boudewyn; Tarakeshwar, Hansen, Kochman, Fox, and Sikkema; Bogar and Hulse-Killacky). Liem et al. (1997) identified that the differences between resilient and non-resilient women, who have experienced sexual abuse during childhood, are best described in *Garmezy’s Model of Resilience*. This model targets the differences among these women as:

- the personality factors;
- the nature of the early caregiving environment (attachment patterns);

- the support system; and
- the nature of the individual's current caregiving environment (attachment patterns).

Women who experienced a larger number of the more positive aspects within the scope of these individual and social factors were less likely to experience repetition. Bogar et al. (2006) conducted a qualitative research study which examined resiliency determinants and resiliency formation. Ten women, among the interviewees chosen, had the following qualifiers:

- been sexually abused during their childhood;
- were 30 years or older;
- endorsed a satisfactory current life situation;
- had positive self esteem; and
- believed that their lives had meaning.

The researchers found a strong relationship between the specific determinants and processes that emerged throughout the participants' lives. They identified that the processes of resiliency are both cognitive and behavioural. Some of the specific behavioural strategies mentioned are "depersonalizing, setting limits, keeping busy, writing, praying, and palliatives helped participants survive and cope during childhood, when the abuse was occurring and in adulthood, when other victimizations or tragedies occurred" (p. 84). Other activities such as "educational pursuits, family involvement, sports and religion or spirituality" (p. 84) were useful to the participants because it allowed them to focus their energies away from the abuse, it contributed to helping them move on with their lives, and also allowed them to become less controlled by their

abusive experiences. In addition, the participants in this study felt strongly that it was essential to focus on the more productive and rewarding aspects of their lives; this helped them to process their recovery and become more resilient as adults. Furthermore, the researchers found that in the case of a participant who experienced other serious problems during childhood, the aforementioned activities actually helped the woman to cope with the abuse; these activities helped to strengthen their inner resistance to severe stress, such as sexual abuse. Also, it was found that maintaining a healthy social network is an important factor involved in one's resiliency to experiences of repetition.

Post Traumatic Stress Disorder⁴

Post Traumatic Stress Disorder (PTSD) is common among people who have experienced trauma such as childhood sexual abuse. Haskell (2003) states that trauma changes a child's development in a way that disrupts "attachments, emotions, consciousness, memory, sense of self and relationships with others (p. 33)." This author suggests that PTSD can best be explained in a "bio-psycho-social framework;" in one respect, all responses to trauma are ways of coping and, similarly, people do adapt to traumatic experiences physiologically, behaviourally, and socially. Briere identifies three major symptoms associated with abuse-related PTSD; intrusive reliving, avoidance, and numbing and autonomic hyperarousal. The author stresses that social circumstances also define the ways in which women adapt to, and cope with, sexual abuse. Similarly, Briere (2002) emphasizes the fact that not all abuse victims will develop PTSD; he states that

⁴ Although I am aware of the literature that critiques and deconstructs PTSD, I have decided that this thesis is not the place to undertake such a task. However, I will include in the Prevention program a session where counsellors will be presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

the development of this disorder is dependent on pre-trauma variables. The author identifies three pre-trauma variables in his article (p. 6):

- temperament and biologically-based vulnerability to stress;
- the presence of pre-existing psychological difficulties that reduce stress tolerance; and
- the individual's ability to regulate negative affect.

PTSD has been identified by several authors as a factor that mediates between childhood sexual abuse and repetition of sexual abuse in adolescence and/or adulthood (Sandberg, Matorin and Lynn, 1999; Arata, 2000; Casey and Nurius, 2005). Sandberg et al. (1999) explained that women who are vulnerable to risk of repetition might experience several aspects of the PTSD symptomatology such as, triggered memories and avoidance of traumatic related emotions. In addition, the authors state that a woman who denies, minimizes, or fails to integrate her experiences of childhood sexual abuse into her narrative memory might not make up to date decisions due to partial or imprecise information, therefore, persistent avoidance becomes problematic and increases vulnerability.

In their study which examines the role of PTSD in mediating repetition, Sandberg et al. (1999) reviewed information from data relating to 323 college students⁵ which was gathered over a ten-week period. The researchers found that PTSD was not an underlying condition mediating repetition; however, their data did underline the importance of taking PTSD symptoms into consideration when examining the possibility of a link existing between childhood sexual abuse and repetition. Another study was

⁵ Many studies on repetition of sexual abuse were conducted with college students which is a limitation in the literature because it is only reaching a small percentage of women.

conducted by Casey et al (2005) which examined differences in outcome among the following three categories:

- women who have experienced a single sexual assault;
- women who have suffered ongoing abuse by a single perpetrator; and
- women who have experienced multiple sexual assaults by different offenders.

In this study, the researchers conducted 1,325 phone interviews with a diverse group of Washingtonian women. They found that, women who experienced repetition had significantly more lifetime and current symptoms related to PTSD. Arata's (2000) study, which consisted of testing a model that predicted repetition, was conducted using a population of 221 college women, all of whom were victims of childhood sexual abuse. Using the "Impact of Event Scale" to measure the PTSD symptoms, this research found that women who experienced repetition also displayed more PTSD symptoms; however, it was not determined whether PTSD symptoms preceded repetition or whether these symptoms had been triggered by the repetition. According to these studies, the findings appear to be relevant in the prediction of a still-existing uncertainty as to whether PTSD, of its own, mediates between childhood sexual abuse and repetition. The literature does indicate, however, that PTSD should be considered a possible factor that contributes to repetition.

Dissociation⁶

⁶ Although I am aware of the literature that critiques and deconstructs dissociation, I have decided that this thesis is not the place to undertake such a task. However, I will include in the Prevention program a session where counsellors will be presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

Dissociation is a common experience among women who have experienced childhood sexual abuse; this represents a protective mechanism that often gets carried into adulthood. Kessler and Bieschke (1999: 335) define dissociation as “a defence mechanism that is unconsciously used by persons to protect them from the psychological sequelae resulting trauma.” Sandberg et al. (1999: 129) quote the American Psychiatric Association’s definition of dissociation as “a disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment.” It seems that while dissociation may have protected and helped women to cope with abuse during their childhood, it can become problematic when carried into adolescence and/or adulthood.

Researchers have hypothesized that dissociation is a mediating factor which puts women at risk of repetition (Kessler et al., 1999; Sandberg et al., 1999; Noll, Horowitz, Bonanno, Trickett and Putnam, 2003). Noll et al. (2003) explain that dissociation may prevent persons from using protective measures which can put them at risk of repetition. The authors emphasize that people may be less able to process signs of danger, and may not experience the anticipatory anxiety that indicates a dangerous situation.

In 1987, Noll et al. (2003) conducted a longitudinal study of seven years that sought to examine the psychobiological impact of childhood sexual abuse on female development. The participants in this investigation were connected with this study after being referred to protective service agencies in Washington D.C., USA. The researchers found that dissociation was positively correlated with repetition; nevertheless, it is still unclear whether or not dissociation was found to be a mediating factor.

As part of the study conducted by Sandberg et al. (1999), which examined the possibility of PTSD mediating repetition of sexual abuse, the role of dissociation in mediated repetition was also explored. These researchers did not find that dissociation was a mediating factor between childhood sexual abuse and repetition. Kessler et al. (1999) conducted a study with a sample of 548 college students⁷. In this investigation, the researchers sought to establish whether dissociation mediated childhood sexual abuse and repetition; however, they were not able to find a statistically based significance to qualify dissociation as a mediating factor. After reviewing these studies it seems that while dissociation may be correlated with repetition, more research is needed to establish dissociation as a mediating factor.

Alcohol and Substance Abuse

Alcohol and substance abuse have been proven common among women who have experienced sexual abuse during childhood. Throughout the literature, it is suggested that alcohol and substance abuse are associated with women who have experienced sexual abuse and repetition of sexual abuse (Merrill, Newell, Thomsen, Gold, Milner, Koss, and Rosswork, 1999; Messman-Moore and Long, 2000; Messman-Moore and Long, 2002; Noll, Horowitz, Bonanno, Trickett, and Putnam, 2003; Rich, Combs-Lane, Resnick, and Kilpatrick, 2004; Casey and Nurius, 2005). However, few empirical studies have been conducted to assess whether alcohol and substance abuse were mediating factors between childhood sexual abuse and repetition. For women who have experienced childhood sexual abuse, alcohol and substance abuse serves as a way to chemically

⁷ A samples size of college students presents a limitation to this study because it is only reaching a small percentage of women.

induced dissociation; this allows them to disconnect from their environment, their painful internal states, and their distressing memories (Briere and Runtz, 1993). Many women who have experienced childhood sexual abuse use alcohol and drugs as a way to cope with their trauma. Messman-Moore and Long (2002) conclude that drug and alcohol use can lead women into high-risk situations, those which have the potential to escalate into to sexual abuse.

Using a sample population of 300 community women, Messman-Moore and Long (2002) conducted a study to examine whether women who have experienced childhood sexual abuse were more likely to end up with an alcohol and substance abuse diagnosis. They also studied whether alcohol and substance abuse were related to repetition. Research found that among the women who had experienced childhood sexual abuse there existed a higher rate of sexual abuse during adulthood, as well as a greater instance of both alcohol and substance abuse. Messman-Moore and Long also found that alcohol and substance can be used to predict repetition to some extent.

Shame

Women who have experienced sexual abuse in their childhood are susceptible to experiencing feelings of shame (Bradshaw, 1988; Bass and Davis, 1994; Kessler and Bieschke, 1999). Shame has been defined as “an emotion of self-contempt that leaves one feeling exposed and revealed to be vulnerable” (Kessler et. al., 1999) and develops during childhood, usually through the family, and is often triggered in a social context (Bradshaw, 1988; Kessler et al., 1999). Kessler et al. (1999) suggest that feeling shame can put women at risk of repetition. The authors explain that shame causes a deep sense

of stigmatization that may lead women who have experienced childhood sexual abuse to participate in activities that reinforce their feeling of low self-worth. These activities, which can include risky sexual behaviour, can put women at risk of repetition. In their study, which is comprised of a retrospective analysis of shame, dissociation, and repetition, these authors worked with a sample of 548 college students;⁸ the researchers looked at whether shame was a mediating factor between childhood sexual abuse and repetition. The study concluded that shame is a strong mediating factor. Kessler et al. explain that they found that women who experienced childhood sexual abuse exhibited higher levels of shame and were more likely to experience repetition.

Severity of Abuse

Severity of abuse incorporates an array of variables such as the presence of greater degrees of threat, force, and invasiveness; the duration of the abuse, and the relationship the victim has with the perpetrator (Arata, 2000; Casey et al., 2005). It has been suggested that the severity of sexual abuse is a mediating factor between childhood sexual abuse and repetition of sexual abuse in adulthood (Mayal and Gold, 1995; Arata, 2000; Grauerholz, 2000; Casey and Nurius, 2005; Randolph and Mosack, 2006). It has also been proposed that the severity of sexual abuse in childhood may predict the severity of the repetition (Casey et al., 2005). Only one empirical study was found in which this hypothesis was tested. A model for predicting repetition was tested by Arata (2000); it was based on a population sample of 221 college women who had been victims of childhood sexual abuse. The researcher found that the severity of abuse was the best

⁸ A samples size of college students presents a limitation to this study because it is only reaching a small percentage of women.

predictor of mediating factors. In order to draw stronger conclusions, more studies of this nature are recommended.

Banyard and Williams (1996) conducted a longitudinal study that sought to examine the relationship between the characteristics of childhood sexual abuse and mental health symptoms. The researchers hypothesised that participants who reported experiencing physical force (such as being beaten or threatened with a weapon) during childhood sexual abuse would report higher levels of symptoms, such as “anxiety, depression, dissociation and/or sleep problems” (p. 854). In addition, the authors examined the role of the relationship between the perpetrator and child.

Banyard et al. drew their hypothesis from both PTSD and traumagenic dynamics frameworks. The authors explain that symptoms observed among women who have been sexually abused in their childhood are the equivalent to the diagnostic PTSD. Banyard et al. exert that “hyperarousal, intrusion of memories of the event through flashbacks and constriction, as well as disconnection from human relationships” are symptoms that follow the overwhelming and threatening nature of trauma (p. 854). In the same line, Banyard et al. incorporate Finkelhor and Browne’s (1985) framework of four traumagenic dynamics (p. 854):

- betrayal and trust;
- stigmatization;
- traumatic sexualisation; and
- powerlessness.

The authors explain that the presence and severity of these dynamics affects the individual’s functioning both immediately after the abuse and later in life. Banyard et al.

assert that it is important to understand the ways in which the ensuing mental health symptomology mediate repetition of abuse, as well as assess the differences among women who were sexually abused in their childhood's life adaptation.

The first phase of this study was conducted between 1973 and 1975. At this time, 206 victims of childhood sexual abuse, aged 10 months to 12 years old (or their parents or guardians), were interviewed in a large city hospital regarding the effects of the sexual abuse they experienced. During the second part of the study, in 1990 and 1991, 136 of the original participants were re-interviewed. Using the prospective data collected in the 1970s, the researchers found an association between experiencing force as part of the sexual abuse and higher emotional distress in adulthood.

Banyard et al. found that a different pattern emerged in the 1990s when the participants were classified as having experienced different types of childhood sexual abuse based on the retrospective reports of their entire abuse history. The researchers reported that the relationship of the perpetrator to the child was the only significant abuse characteristic related to the level of emotional distress in adulthood. Banyard et al. express that the specific impact of age differences on the long-term impact of sexual abuse remain unclear and recommend that more complex understanding needs to be developed of how women who were sexually abuse in their childhood differ from each other.

iii. Prevention and Treatment Implications

Many empirical studies dealing with the topic of repetition of sexual abuse have highlighted the need for prevention and treatment programs targeting women who are at risk of experiencing repetition (West, Williams, and Siegel, 2000; Grauerholz, 2000; Gold, Sinclair, and Balge, 1999). Considering the prevalence of repetition among women who have experienced childhood sexual abuse, there are very few examples of articles that deal with the prevention and treatment implications specifically targeting this phenomenon.

Hanson and Gidycz (1993) examined the effectiveness of an existing college sexual abuse prevention program entitled *Acquaintance Rape Prevention Program* on 346 college students. The main objectives of this program were as follows:

- to increase awareness of the pervasiveness of sexual assault;
- to dispel common myths about sexual assault;
- to educate participants about social forces that foster a sexual assault-supportive environment;
- to educate participants about practical strategies for preventing sexual assault;
- to alter dating behaviours associated with acquaintance sexual assault;
- to foster effective sexual communication for participants; and
- to reduce the incidence of sexual assault in a 9-week period

In order to meet these objectives, the program developers included the following components: statistics, myth and fact worksheets, two videos depicting sexual assault scenarios, and a question and discussion section which deals with ways that the participants could safely avoid or retreat from a situation similar to that which was depicted in the video. While this study proved that the prevention program was

successful in reducing the incidence of sexual assault among women with no prior history of sexual abuse, it was not effective in reducing risk among women who had previously experienced sexual abuse (Hanson et al. 1993). Hanson and Gidycz (1993) hypothesized that elements addressing repetition needed to be added to the treatment program in order for it to be effective in serving women who had a prior history of sexual abuse.

In what seemed to be an attempt to test this hypothesis, Marx, Calhoun, Wilson and Meyerson (2001) developed a similar program to that of Hanson's and Gidycz' (1993). In fact, they chose to divide the program into two sessions, adding a "modified relapse-prevention approach" which targeted addressed repetition in a specific manner. This approach included "identification of high-risk situations, problem solving, coping-skills training, assertiveness training and the development of communication skills" (Marx et al, 2001). The results associated with this study indicated that the program appeared to be effective in reducing repetition (Marx et al. 2001).

For many women who are at risk of, or have had an experience of repetition, brief prevention programs, such as the two which were previously described, might not consist of an intervention which would allow them to gradually discard the patterns of repeated abuse. Alternatively, a prevention focused treatment, such as one that is implemented directly in individual counselling and is grounded by a specific theory; this could be a more beneficial means of helping women with patterns that repeat.

Cloitre and Rosenberg (2006) both recommend components for treatment that are grounded in the *Cognitive-Behavioural Therapy* for trauma. According to the authors, a woman who has experienced childhood sexual abuse, will be subject to an extremely hindered development, which is characterized by 'affect regulation' and 'interpersonal

relatedness'. The authors comment that the negative impact associated with childhood sexual abuse represents a developmental prerequisite to effective functioning later in life.

Through the application of this theory in counselling, Cloitre and Rosenberg (2006) argue that psychological risk factors are encompassed in three categories; problems in affect regulation, problems in interpersonal relatedness, and self-appraisal and symptoms related to Post Traumatic Stress Disorder (PTSD). The authors describe the two roots of this issue explicitly: the abuse itself, and its direct psychological effects as well as the child's family or caretaking situation. The authors' list two components of treatment: first, the skills training related to the development of affect regulation and adaptive interpersonal beliefs, and second, they continue to include the need to make better direct psychological sequelae of trauma. The above-mentioned researchers highlight the importance of taking the time to build a secure attachment within the counselling relationship.

To compliment various programs, Macy (2007) proposes the incorporation of a '*coping theory*' – more specifically, an adaptive, proactive and resistance-defence type of coping – into an overarching theoretical framework in order to prevent repetition. In addition, the author states that four out of the five core coping categories – problem solving, support seeking, distraction, and positive cognitive restructuring - if encouraged in women's lives, can contribute to the eventuality of a positive outcome. The writer elaborates on the topic of adaptive coping as a strategy, which offers possibilities in helping women to "marshal the strengths and resources to serve as a foundation on which to build proactive and resistance-defence coping" (p.187). Macy goes on to describe proactive coping as a means by which women can "develop knowledge and skills to help

them avoid future assaults” (p.187). The author states that resistance-defence coping will be helpful to women who are intent on developing the “capacity to use self-reflection skills” when in potentially dangerous situations (p.187). Macy (2007) cautions, however, that a woman may need to “alternate cognitive restructuring efforts with engagement in distracting activities” so that she does not get overwhelmed with recovery work. Furthermore, the author explains that counsellors should consider a woman’s individual circumstances, needs, and problems. The treatment program should be individualized for every woman, taking into consideration each person’s socioeconomic resources when understanding coping (Macy, 2007).

iv. Strengths and Weaknesses of the Literature

There is much literature dealing with the effects and outcomes of childhood sexual abuse in the lives of women; however, given the shortage of written material that specifically addresses repetition of sexual abuse, there is a need for additional research on this topic in order to make significant progress in this subject area. Within the literature that addresses repetition, a large number of the studies have been conducted by researcher in the United States and there seems to be a gap in Canadian research on this topic. Repetition of sexual abuse has proven to be a predominant risk factor and problem among women who have histories of sexual childhood abuse. Therefore, there is a need for more literature to address repetition. Most of the empirical studies reviewed here set out to prove whether or not repetition correlates with childhood sexual abuse. Furthermore, a large component of the reviewed literature focused on various factors and outcomes linked with this phenomenon.

Upon completing this review, which is based on finding information that discusses theories about repetition, mediating factors, and prevention programs, it became apparent that there is gap in all of these three areas. It seems evident that prevention programs are needed; however, before such intervention methods can be developed, professionals need to concentrate their efforts in the following areas:

- expand on the understanding of the repetition phenomenon itself;
- elaborate on the reasons for its occurrence; and
- identify and comprehend those factors which mediate experiences of sexual abuse.

The literature falls short in that it does not focus on the manner in which the unconscious mind can affect fears and motivations and promote the enactment of patterns that repeat. Rather, the sole focus is placed upon the conscious aspect of the mind. Contemporary neuropsychanalytic research demonstrates how emotions shape thoughts, contradicting the more prevalent paradigm of cognitive theory in counselling that operate under the assumption that thought generates emotions. Pally (2000: 73) explains that “emotion organises perception, thought memory, physiology, behaviour and social interaction so as to provide an optimal means for coping with the particular situation that is generating the emotion.” Without this pertinent knowledge, it seems impossible for prevention programs to successfully assist women in changing patterns of abuse. Moreover, it is recommended that more studies be conducted which addresses this topic while incorporating theoretical frameworks about repetition and prevention programs.

Most importantly, special attention needs to be placed on the subject of mediating factors, because this type of information will provide professionals with greater

knowledge of the links between childhood sexual abuse and repetition. From this vantage point, professionals can then develop prevention programs that address the link between emotions and thought as proposed by neuroscience findings (Solms, 2002) and begin to guide women into initiating change in their lives.

Another observation regarding current literature on repetition highlights the fact that most studies are conducted on female college students. Within the realm of empirical studies seeking to examine repetition, there remains the presence of a gap between community women and clinical sample populations (Messman-Moore and Long, 2002; Rich, Combs-Lane, Resnick, and Kilpatrick, 2004). By narrowing the empirical focus to mainly college students, a large number of the population is being missed. Since young Caucasian women from middle to upper class backgrounds were largely represented in this sample population, one might argue that this sample cannot be representative of the entire population.

In addition, new empirical studies need to be initiated whereby different cultures are part of the sample population. Only one study was conducted by West, William and Siegel (2000), which focused specifically on repetition among black women who have experienced childhood sexual abuse. Another study, conducted by Banyard and Williams (1996), examined the relationship of abuse characteristics to long-term mental health functioning among a population that was largely black women who were sexually abused in their childhood. Furthermore, studies need to be undertaken in which the focus is put on the other diversities among women: for example, studies highlighting class, sexual orientation, cultural, disability, racial differences and poverty.

Finally, it is recommended that more longitudinal studies focused on observing repetition be conducted. In this review only two longitudinal studies were found. Banyard and William's (1996) study that sought to examine the relation between the characteristics of childhood sexual abuse and mental health symptoms. Noll, Horowitz, Bonanno, Trickett and Putnam's (2003), study was based upon following seven years of the lives of children who had been referred to child protective services. More specifically, it is recommended that longitudinal studies be initiated in which researchers address mediating factors: the findings from such investigative studies would provide professionals with more accurate knowledge of the different dynamics of repetition so that adequate prevention programs can be developed with a goal of reducing the risk of repetition.

Chapter 4: Research Methodology

i. Introduction

In this exploratory study, I sought to identify the factors that mediate the initial incidence of childhood sexual abuse and the occurrence of repeated experiences of sexual abuse in adolescence and/or adulthood. The secondary aim of this study was to develop an outline of a psycho-social prevention program that takes into account these mediating factors. These objectives were achieved by the identification of the mediating factors in the research literature and by conducting semi-structured interviews. These interviews were conducted with experienced counsellors in Ottawa and their purpose was to discuss the prevention strategies that they use.

I applied grounded theory as a qualitative method in my work to analyze the data I compiled through my research and the interviews that I conducted. Grounded theory consists of a methodological process that supports the generation of hypotheses; these hypotheses are based on data which was systematically gathered and analyzed (Glaser & Stauss, 1967). Therefore, it holds a high practical application when used in qualitative studies. In this study, I followed four methodological steps. The first step was the systematic analysis of scholarly literature on mediating factors; its purpose was to extract, from these texts, all preventative strategies that take mediating factors into account. The second step involved locating and contacting counsellors in Ottawa who have four years of experience or more working with women who have been sexually abused. Interviews with this sample of counsellorss were conducted as the third step, and the application of the concepts of grounded theory to the text of these interviews in order to generate categories of analysis formed the fourth and final step.

ii. Data Collection Procedures

Recruitment of Participants

The professionals in this study were recruited from various social service agencies and private counselling practices throughout Ottawa. I contacted potential study participants, and provided them with oral and written information about the research. In addition, I presented the letter of information⁷ to counsellors who attend the Sexual Assault Network Committee meetings. These counsellors were given two options: to participate in this study, or to present the letter of information to the agency/counselling practice with which they were employed.

Interviews

When conducting this study, I used a qualitative approach to collecting data. Through the use of an interview guide, which was derived from the findings in the literature review and discussion with my supervisor, I conducted semi-structured interviews with thirteen counsellors that have worked with women who were sexually abused during their childhood. The interviews lasted for an approximate period of 1 hour, and I used a 17-question interview guide. The first two questions sought to obtain demographic information about each participant. The subsequent 12 question combined both open-ended and close-ended questions which targeted the topics of childhood sexual abuse, repetition, and the prevention of repetition. The final question asked each participant's opinion on whether women who have experienced repetition of sexual abuse have fallen, or are falling, through the cracks in the system that is currently in place, and if so, why they see this as a common occurrence. This final question was added before

⁷ The Letter of Information is included in Appendix A: Ethics Proposal

the third interview because gaps and unmet needs were common themes that surfaced in the first two interviews. Since repetition is more widely identified as re-victimization, I included a rationale which speaks to why I have chosen to use the term ‘repetition’ of sexual abuse. This rationale was presented only immediately before the participants were asked questions about prevention strategies so that their answers to the previous questions were not influenced.

Each professional was assured of both their anonymity and the confidentiality of the content of their interview. Participants were asked to sign a consent form which is included in Appendix A: Ethics Proposal. As the interviewer, I asked for the interviewee’s consent before audio taping each interview. One participant did not agree to the recording of the interview so instead, I obtained her consent before taking detailed written notes. Furthermore, before each interview, I asked permission to take keyword notes to assist me during the data analysis component of my work.⁸ Each interviewee was specifically asked to avoid using names or any descriptive information which could possibly directly identify the client whose experience was being discussed. Data was kept in a locked safe, and was accessible to the researcher only. All electronic data was stored on a memory stick, which was available only to the researcher. Responses to the questions were identified as anonymous. Answers were attributed to them in the interview summary.

While discussing sexual abuse is distressing, it is a topic that these professionals, in the scope of their clientele, are faced with on a daily basis. Counsellors commonly seek support through their employer; this helps them to cope more effectively with the trauma to which they are vicariously exposed to in their daily work life. It must be noted

⁸ Key-word notes were used to assist with coding during the analysis of the data.

that my interview guide does not go beyond a discussion of the skills that these professionals use in their daily workload.

iii. Sample

The sample size was 13 counsellors, which represented approximately 10 social service agencies and/or private counselling practices in Ottawa. The sample population for this research study included counsellors and social workers in the Ottawa community aging between 26-65; each counsellor/social worker had a minimum of four years experience in counselling women who were sexually abused during childhood and who experienced more abuse throughout their adolescence and/or adulthood.

Graph 1:

iv. Method of Analysis

From the outset of my analysis, I have used grounded theory to interpret each interview. I first transcribed each interview verbatim and then by means of close reading of the text and underlining key words, I extracted everything that is relevant to the research question. This included the following topics: childhood sexual abuse, mediating factors, repetition, and the prevention of repetition. Both the transcription and key word notes that were drawn up during the interviews will allow me to establish a variety of categories and nodes⁹.

I coded and organized the data using a qualitative research analysis program called NVivo. The NVivo research software helps to access, manage, shape, and analyze detailed textual information; this software also offers tools for classifying, sorting, and arranging information. The interview data was entered separately into the program in an electronic format. The NVivo computer tool has many advantages, among which is the simplification of the coding process as well as the program's advanced organizational capacity for the information collected and stored. An additional benefit is that it combines well with a grounded theory approach, the program allowed me to cross-reference variables, categories, and nodes easily, thus providing a more in depth analysis. All of the data analysis was performed using this program.¹⁰ After the data analysis was complete, I used Excel to create charts and graphs in order to clearly present my findings.

⁹ Node is a term used by NVivo which describes variables or keywords that are coded to create categories.

¹⁰ Although the collection of textual data was not extensive in this project, I wanted to use this opportunity to familiarize myself with this program for future use.

Grounded Theory

Grounded theory is a qualitative method of deriving theory from data. Hallberg (2006:143) explains that “the systemic abstractions and the conceptualization of empirical data constitute the theory-generating process.” Data analysis using grounded theory begins with basic description, moves to conceptual ordering, and then to theorizing (Walker and Myrick, 2006). Every grounded theory should depart from a working hypothesis. The working hypothesis employed in this research study is founded on the presence of factors that mediate between childhood sexual abuse and sexual abuse experienced in later adolescence and/or adulthood. These mediating factors place women who have experienced childhood sexual abuse at a greater risk of repetition of sexual abuse. According to my working hypothesis, professionals who work with this population of women use various counselling strategies to reduce the risk of repetition; a compilation of these strategies would be useful in the development of a prevention program model which would be valuable in the treatment of women who seek to prevent repetition of sexual abuse.

Using the NVivo software, I conducted the process of open-coding in which I obtained codes from the text and continually compared them until categories were established. Hallberg (2006:143) states that the “identification and verification of the relations between emerging categories, between categories and their properties in the data ensure that these conceptual relationships are grounded in the data.” Once a core category was identified, I stopped the process of coding the text that did not relate to the core categories, and focused purely on coding texts which did relate to one another. This process was sustained until theoretical saturation occurred, which meant that no new

information was being derived from the data (Hallberg, 2006). In addition to analysing these findings and reporting the results in Chapter 5, a prevention program model was developed and is presented in Chapter 7.

v. Methodological Limitations

The methodological limitations lie mainly in the size of the sample population. Bearing in mind that I was the sole researcher conducting this study, and that both the interviews and the analysis of the data were time consuming, I was only able to interview 13 participants from 10 agencies in Ottawa. However, a larger sample population would provide a more diverse set of data. A small sample could potentially prevent variations among the participants such as difference in race, class, age, sexual orientation, and ability.

Another possible limitation that is derived from the sample population is as follows; the participants had different educational backgrounds, various number of years of training, and the very diverse experiences. For example, there is the possibility that a counsellor, who is experienced in working with women that have been sexually abused, may have more knowledge regarding repetition of sexual abuse. Moreover, a counsellor assigned to work in a small non-government organization might have a different outlook on a woman's experience(s) with sexual abuse and repetition. Although these are simply assumptions, they are nonetheless valid points that should be considered when addressing the topic of limitations in this study.

A third limitation is that the counsellors may have worked with women that experienced different degrees of trauma. This had the potential to affect their knowledge

of repetition and of possible prevention strategies. In addition, each participant was self-reporting; therefore, their answers to the research questions were derived from their own experiences, introducing biases into the data.

The final constraint in this study is that I was the sole researcher gathering and analysing data. Although I had guidance from my thesis supervisor, there was still the potential for biases and/or misinterpretations of the data. Grounded theory is derived from the data and not from an already established hypothesis. It was imperative that I let myself be guided by the results of a rigorous coding of the data for this study.

Chapter 5: Results

i. Introduction

In this chapter, the categories and nodes¹¹ derived from the raw data through open-coding¹² using grounded theory¹³ and NVivo¹⁴ are presented. The raw data consists of the verbatim transcripts of the interviews conducted with thirteen (13) counsellors in the Ottawa area. These interviews were conducted for the purpose of identifying factors that mediate an initial experience of sexual abuse and the occurrence of repetition of sexual abuse in adolescence and/or adulthood. In addition, the aforementioned interviews included questions regarding preventative strategies that are currently being used by professionals with their clientele, as well as their vision for a prevention program which directly addresses repetition of sexual abuse.

The first section of this chapter includes a definition of each category and the number of times that a category, node and child node was sourced and referenced. Additionally, each category is followed by a graph which gives the reader a visual interpretation of their frequency. Each graph will consist of an abbreviated word describing the node or child node and a box below with direction to a more descriptive definition of the term.

¹¹ Node: the term used in NVivo for the key descriptors, which are words and phrases, which make up each category

¹² Open-coding: the identification of key descriptors, key words and phrases, for the purpose of generating Categories.

¹³ Grounded theory: a qualitative method of deriving theory from data.

¹⁴ NVivo: a research software that helps to access, manage, shape, and analyze detailed textual information.

NVivo Terminology

Throughout this chapter I will use NVivo terminology. The definitions of these terms are as follows:

Sources: This refers to each participant's transcribed interview and formulates the raw data.

References: This term refers to the rate of recurrence of a category, a node, and a child node, i.e. Frequency of appearance

Categories: This term refers to a core theme or variable which was extracted from the raw data – a set of key descriptors, words and phrases.

Nodes: The term used in NVivo for the sub-categories – key descriptors, words, and phrases – that compose each category.

Child Nodes: 'Child nodes' are sub-categories – key descriptors, words, and phrases – which make up a node. Only some nodes will have child nodes.

ii. Categories and Nodes

Thirteen (13) sources were analyzed by using the method of open-coding. Throughout this process, ten (10) categories were identified:

- I. Repetition
- II. Mediating Factors
- III. Presenting Issues
- IV. Therapeutic Approach:
 - a. Techniques
 - b. Theories

- c. Eclectic Approach

- V. Prevention:

- a. Content of Prevention Program
- b. Format of Delivery of Prevention Program
- c. Vision of Prevention Program

- VI. Gaps or unmet needs

These categories consisted of a variety of nodes and child nodes. Certain categories possessed a large number of nodes which made the data difficult to read, therefore general nodes were developed and the descriptive nodes became ‘child nodes’ – see ‘Example: 1’ below which presents a visual explanation of this process using the category ‘Mediating Factors’. This graphic presentation also demonstrates the different ‘weight’ of each node. In this example, the node ‘Mental Health’ contributes the greatest weight towards the construction of the category ‘Mediating Factor’ (illustrated in percentage (26%) in Graph 2)¹⁵.

¹⁵ The graphs for categories will be presented framed to distinguish them from the nodes graphs.

Example 1: Mediating Factors

Some nodes and child nodes will require a definition which will be provided in the footnotes. In addition, only the child nodes that were sourced three (3) times or more will be included in the description and summary of the categories; however, a list of the nodes not included in this analysis will be provided in the footnotes.

Categories and Nodes

I. Repetition¹⁶ – (13 sources, 23 references) subsequent to hearing two definitions of repetition, the researcher asked the counsellors if they were in agreement with the research that suggests that childhood sexual abuse is the strongest predictor of adult sexual abuse. Additionally, each participant was asked: “Do you recognize repetition of sexual abuse as a common occurrence in your clients who have experienced childhood sexual abuse?”

Nodes include: yes (13 sources, 23 references); and no (0 sources, 0 references).

II. Mediating Factors – (13 sources, 204 references), each participant was asked to identify the psychological and social factors that mediate childhood sexual abuse and the repeated abuse in one’s adolescence and/or adulthood.

Nodes include: alcohol and drugs (8 sources, 11 references); social network¹⁷ (8 sources, 14 references); poverty (8 sources, 14 references); learning disabilities (1 source, 1 reference); mental health effects of childhood sexual abuse (13 sources, 126 references); and cultural issues that mediate a woman’s experience of repetition (10 sources, 39 references).

¹⁶ A graph is not provided for this category because 100% of the participants stated they recognized repetition of sexual abuse to be a common occurrence among their clients who were sexually abused in their childhood.

¹⁷ Social network refers to the support women have had throughout their life and the term addresses the isolation and loneliness women who have experienced childhood sexual abuse and repetition may have experienced because of the lack of support. Support network could be friends, family and/or professionals.

Graph 2: Mediating Factors

Category: Mediating factors

Nodes: Alcohol and drugs; social network (see 'footnote 17' on page 56 for a definition of this node); poverty; learning disabilities; mental health effects of childhood sexual abuse; and cultural issues

Child nodes for mental health effects of childhood sexual abuse include:

Insecure attachments (7 sources, 12 references); boundary issues (5 sources, 8 references); dissociation (8 sources, 16 references); fight, flight, and freeze response¹⁸ (2 sources, 4 references); mental illness (6 sources,

¹⁸ This child node refers to the activation of the sympathetic nervous system by a stressful event. When in danger or threatened, people's bodies are programmed to have a fight or flight response. However, when they are unable to actually fight or take flight they are both emotionally and physically trapped so they freeze (Haskell, 2003).

12 references); perpetrators¹⁹ (12 sources, 29 references); Post Traumatic Stress Disorder (PTSD) (5 sources, 6 references); safety²⁰ (10 sources, 13 references); self-esteem and self-worth (9 sources, 17 references); sexuality issues (6 sources, 9 references); shame (6 sources, 11 references); and triggers²¹ (2 sources, 5 references).

¹⁹ This node refers to the perpetrators that seek out women who present themselves as vulnerable targets as a consequence of childhood sexual abuse.

²⁰ This node refers to the woman who cannot recognize and/or decipher between safe and unsafe situations and/or people and consequently exposes herself to unsafe environments.

²¹ “Triggers are any environmental or internal cue that serves as a reminder of a traumatic event – either directly or through a series of associations” (Haskell, 2003:190).

**Graph 3: Mediating Factors – Mental Health
Effects of Childhood Sexual Abuse**

Category: Mediating factors

Node: Mental health

Child nodes: Insecure attachments; boundary issues; dissociation; fight, flight, and freeze response (see 'footnote 18' on page 58 for a definition of this child node); mental illness; perpetrators (see 'footnote 19' on page 59 for a definition of this child node); PTSD; safety (see 'footnote 20' on page 59 for a definition of this child node); self-esteem and self-worth; sexuality issues; shame; and triggers (see 'footnote 21' on page 59 for a definition of this child node)

Child nodes for cultural issues that mediate a woman's experience of

repetition: colonization and residential schools²² (1 source, 6 references);

²² This node refers to the cultural issues that are a result of colonization and residential schools have placed Aboriginal people, who have childhood sexual abuse experiences, at a greater risk of experiencing repetition sexual abuse.

core beliefs/belief system²³ (8 sources, 16 references); gender inequalities (8 sources, 16 references); and taboo²⁴ (3 sources, 3 references).

Graph 4: Mediating Factors – Cultural Issues

Category: Mediating factors

Node: Cultural issues

Child nodes: colonization and residential schools (see 'footnote 22' on page 60 for a definition of this child node); core beliefs/belief system (see 'footnote 23' on page 61 for a definition of this child node); gender inequalities; and taboo (see 'footnote 24' on page 61 for a definition of this child node).

III. Presenting Issues – (13 sources, 74 references), each participant was asked to comment on the issues that their clients, who have experienced repetition of sexual abuse,

²³ This child node refers to the core beliefs a woman has internalized that comes from her culture to which she was raised in.

²⁴ This child node for cultural issues refers to the negation, denial, and disapproval of sexual abuse within families, communities, the media, and society as a whole.

have presented with during the initial access of services. These presenting issues surface during first or second counselling session and they are the reason the client entered into treatment.

Nodes include²⁵: Addiction (7 sources, 8 references); anxiety (3 sources, 8 references); depression (5 sources, 5 references); eating disorder (6 sources, 8 references); lack of support/isolation (3 sources, 3 references); mental illness (3 sources, 3 references); physical health problems (5 sources, 6 references); relationship problems (6 sources, 6 references); repetition of sexual abuse²⁶ (3 sources, 4 references); self-esteem issues (4 sources, 4 references); sexual abuse²⁷ (7 sources, 7 references); sexuality issues (5 sources, 8 references); triggers²⁸ (5 sources, 6 references); and violence (3 sources, 3 references).

²⁵ ***Nodes sourced two (2) and less that were not included*** - anger; basic needs; behaviour issues; bipolar disorder; boundary issues; court; cultural barriers; different type of support; dissociation; insomnia; loss and grief; obsessive compulsive disorder (OCD); perpetrator; power dynamics; post traumatic stress disorder (PTSD); self-harm; and shame.

²⁶ Repetition of sexual abuse takes place when someone who experienced childhood sexual abuse and one or more separated incidents of adolescent/adult victimization (Arata, 2000: 28).

²⁷ Sexual abuse is defined as any unwanted sexual acts.

²⁸ "Triggers are any environmental or internal cue that serves as a reminder of a traumatic event – either directly or through a series of associations" (Haskell, 2003:190). This node includes flashbacks, memories, and nightmares.

Graph 5: Presenting Issues **Category:** Presenting issues

Node: Addiction; anxiety; depression; eating disorder; lack of support/isolation; mental illness; physical health problems; relationship problems; repetition of sexual abuse (see 'footnote 26' on page 62 for a definition of this node); self-esteem issues; sexual abuse (see 'footnote 27' on page 62 for a definition of this node); sexuality issues; triggers (see 'footnote 28' on page 62 for a definition of this node); and violence

IV. a) Therapeutic Approach: Techniques – (13 sources, 58 references),

participants were asked what therapeutic techniques they are currently using with their clients.

Nodes include²⁹: Breathing/body work³⁰ (3 sources, 4 references); eye movement desensitization and reprocessing (EMDR) (5 sources, 6 references); experiential techniques³¹ (4 sources, 5 references); expressive therapy³² (8 sources, 10 references); gender psychoeducation³³ (6 sources, 10 references); grounding techniques³⁴ (4 sources, 6 references); instilling hope and recognizing strengths (7 sources, 10 references); and identifying patterns³⁵ (3 sources, 4 references).

²⁹ ***Nodes sourced two (2) and less that were not included*** - Eye movement integration; genograms; phase model approach; and psycho-education.

³⁰ This node refers to helping women learn how to regulate their breathing and be in-tuned with their body's reactions to triggers and other PTSD symptoms.

³¹ This includes journaling, non-dominant hand writing, visualization, writing letters, empty chair technique, and role playing.

³² This includes sandtray therapy, art therapy, creativity, dance, drama, and exercise.

³³ This refers to challenging myths and beliefs and addressing human rights and issues of power.

³⁴ This node refers to anything a woman can do before, during, or after a flashback or intense memory that helps to keep her in the present moment and increases her feelings of safety.

³⁵ This node refers to identifying patterns in a woman's life that might be placing her at risk of experiencing repetition of sexual abuse.

Graph 5: Therapeutic Approach – Techniques

Category: Therapeutic approach – Techniques

Nodes: Breathing/body work (see 'footnote 30' on page 64 for a definition of this node); EMDR; experiential techniques (see 'footnote 31' on page 64 for a definition of this node); expressive therapy (see 'footnote 32' on page 64 for a definition of this node); gender psychoeducation (see 'footnote 33' on page 64 for a definition of this node); grounding techniques (see 'footnote 34' on page 64 for a definition of this node); instilling hope and recognizing strengths; and identifying patterns (see 'footnote 35' on page 64 for a definition of this node).

IV. b) Therapeutic Approach: Theories – (13 sources, 62 references), participants were asked what therapeutic theories they are currently using with their clients.

Nodes include³⁶: Cognitive behavioural therapy (CBT) (7 sources, 10 references); client-centered therapy (3 sources, 5 references); feminist theory (4 sources, 7 references); inner-child work (3 sources, 5 references); mindfulness (3 sources; 5 references); narrative therapy (4 sources, 6 references); psychodynamic theory (4 sources; 7 references); solution focused therapy (3 sources, 4 references); and spiritual approaches (5 references, 13 resources).

³⁶ ***Nodes sourced two (2) and less that were not included*** - Aboriginal traditions; adaptive function; Anna Salter's research on perpetrators; attachment theory; dialectical behaviour therapy (DBT); ego stage theory; emotion-focused therapy; family systems theory; fight, flight, and freeze; gestalt theory; non-deliberate forms of therapy; rational emotive behaviour therapy; behavioural therapy; schema therapy; single-child learning theory; skills- based training; transactional analysis; trans-cultural psychotherapy; and trauma theory.

Graph 6: Therapeutic Approach – Theories

Category: Therapeutic approach – Theories

Nodes: CBT; client-centered therapy; feminist theory; inner-child work; mindfulness; narrative therapy; psychodynamic theory; solution focused therapy; and spiritual approaches

IV. c) Therapeutic Approach: Eclectic Approach³⁷ - (13 sources, 62

references), as discussed in the literature review, studies which incorporated various theoretical approaches into prevention programs were found. Participants were asked if they have a specific therapeutic approach that they would recommend for a prevention program, or if they would suggest using more than one therapeutic approach.

³⁷ A graph is not provided for this category because 100% of the participants said it is important to use an eclectic approach when working with women who are experience repition on sexual abuse.

Nodes include: One theoretical approach (0 sourced, 0 references); and more than one therapeutic approach (13 sources, 17 references).

V. a) Prevention: Content of Prevention Program – (13 sources, 93

references), participants were asked what topics they thought should be included in a prevention program for women who are experiencing, or are at risk of experiencing, repetition of sexual abuse.

Nodes include: Psychological counselling and program techniques³⁸ (13 sources, 72 references); health and nutrition³⁹ (2 sources, 5 references); and resiliency and recovery⁴⁰ (8 sources, 16 references).

³⁸ This node refers to the psychoeducation, counselling and techniques that should be used to directly address the mental health effects of childhood sexual abuse.

³⁹ This node refers to providing a client with information about her health and nutrition that will enhance her well-being so that she better participate in her recovery and live a more satisfying life. Also, this will help her understand how her childhood trauma impacted her ability to maintain a healthy lifestyle.

⁴⁰ This node refers to using resiliency theory and providing a woman with information about the recovery process so that they understand the various factors that can contribute to reducing the likelihood that they will experience repetition of sexual abuse.

Graph 8: Prevention – Content of Prevention Program

Category: Prevention – Content of Prevention Program

Nodes: Psychological counselling and program techniques (see 'footnote 38' on page 68 for a definition of this node); health and nutrition (see 'footnote 39' on page 68 for a definition of this node); and resiliency and recovery (see 'footnote 40' on page 68 for a definition of this node)

Child nodes for psychological counselling and program techniques⁴¹:

Addiction (3 sources, 5 references); assertiveness (5 sources; 5 references); boundaries (5 sources, 5 references); core beliefs⁴² (3 sources, 5 references); identifying patterns (5 sources, 8 references); flashbacks and

⁴¹ ***Child nodes for psychological counselling and program techniques sourced two (2) and less that were not included:*** emotions; experiential techniques⁴¹; forgiveness; grief; cultural history; identifying patterns; sexuality; trauma and PTSD; and visualization.

⁴² This node refers to unlearning messages/'myth busting'.

triggers⁴³ (4 sources, 4 references); importance of relational trust⁴⁴ (13 sources, 45 references); perpetrators⁴⁵ (3 sources, 4 references); healthy relationships (3 sources, 3 references); human rights⁴⁶ (3 sources, 3 references); importance of self-care (3 sources, 3 references); self-esteem (8 sources, 11 references); and the socialization of women (5 sources, 5 references).

⁴³ This node refers to providing psychoeducation about flashbacks and triggers, as well as, assisting a woman in identifying her triggers.

⁴⁴ This node refers to the importance of trust within the therapeutic relationship.

⁴⁵ Providing psychoeducational information about perpetrators.

⁴⁶ This node refers to informing a woman of her human rights.

Graph 9: Prevention – Content of Prevention Program – counselling and techniques

Category: Prevention – Content of Prevention Program

Node: Psychological counselling and program techniques

Child nodes: Addiction; assertiveness; boundaries; core beliefs (see 'footnote 42' on page 69 for a definition of this child node); identifying patterns; flashbacks and triggers (see 'footnote 43' on page 70 for a definition of this child node); importance of relational trust (see 'footnote 44' on page 70 for a definition of this child node); perpetrators (see 'footnote 45' on page 70 for a definition of this child node); healthy relationships; human rights (see 'footnote 46' on page 70 for a definition of this child node); importance of self-care; self-esteem; and socialization

Child nodes for health and nutrition: Biology (1 source, 2 references); health (1 source, 1 reference); nutrition (1 source, 1 reference); housing⁴⁷ (1 source, 1 reference).

Child nodes for resiliency and recovery: Safety⁴⁸ (7 sources, 8 references); decision making (2 sources, 3 references); recovery process (2 sources, 2 references); resiliency theory (1 source, 1 reference); and self-defence (1 source, 2 references).

⁴⁷ This node refers to the counsellor insuring that the client has adequate housing. It was suggested that without adequate housing, a woman would not be stable enough to complete any program relating to childhood sexual abuse and repetition.

⁴⁸ This node refers to safety in relationships and public domains.

Graph 10: Prevention program – Content of Prevention Program - resiliency and recovery

Category: Prevention – Content of Prevention Program

Node: Resiliency and recovery

Child nodes: Safety (see 'footnote 48' on page 72 for a definition of this child node); decision making; recovery process; resiliency theory; and self-defence

V. b) Prevention: Format of Delivery – (13 sources, 42 references), participants were asked if they thought that a prevention program for women who are experiencing, and/or are at risk of experiencing, repetition of sexual abuse would be more beneficial in an individual, group, or workshop setting, or using a combination of two or all three of these formats⁴⁹.

⁴⁹ Please note: each participant had the choice to choose one or more of the following nodes.

Nodes include: Individual therapy (11 sources, 16 references); group therapy (11 sources, 14 references); workshop (6 sources, 6 references); and the format of delivery is dependent on one's stage in recovery (6 sources, 6 references).

Graph 11: Prevention – Format of delivery

Category: Prevention – Format of delivery

Nodes: Individual therapy; group therapy; workshop; and the format of delivery is dependent on one's stage and progress in recovery

Graph 12: Prevention – Vision for Prevention Program **Category:** Prevention – Vision of Prevention Program

Nodes: Long-term treatment; public education; phase model; activism; mentoring program (see 'footnote 50' on page 75 for a definition of this child node); culturally sensitive; collaborative process (see 'footnote 51' on page 75 for a definition of this child node); constant support; traditional aboriginal ways of approaching treatment of childhood sexual abuse and repetition; and government-funded trauma centers

VI. Gaps or Unmet Needs – (13 sources, 42 references), participants were asked if they thought that women who were sexually abused during childhood were falling through the cracks in the system we currently have and why?

Nodes include: long-term therapy (5 sources, 7 references); funding for adequate services – training or professionals, programs for perpetrators, public education (8 sources, 24 references); and there is an increased vulnerability of marginalized groups because our current system is failing to provide programs for this population of women (7 sources, 11 references).

Graph 13: Gaps or Unmet Needs

Category: Gaps or unmet needs

Nodes: long-term therapy; funding for adequate services – training for professionals, programs for perpetrators, and public education; and increased vulnerability of marginalized groups

Child nodes for funding for adequate services – training or professionals, programs for perpetrators and public education:

Professional training (5 sources, 10 references); funding for programming (4 sources, 11 references); public education (3 sources, 3 references) and treatment for perpetrators (1 sources, 1 reference).

Graph 14: Adequate services – Training or Professionals, Programs for Perpetrators and Public Education

Category: Gaps or unmet needs

Node: Funding for adequate services – training or professionals, programs for perpetrators, and public education

Child nodes: Funding; perpetrators; professional training; and public education

Child nodes for increased vulnerability of marginalized groups:

Medicalization of women⁵² (3 sources, 3 references); and oppression⁵³ (6 sources, 8 references).

iii. Conclusion

This chapter outlined the results which included the categories and nodes taken from the raw data through open-coding using grounded theory and NVivo.⁵⁴ The raw data consisted of the verbatim transcripts from the interviews conducted with 13 counselling professionals in the Ottawa area. These interviews were conducted with the purpose of identifying mediating factors and included questions regarding preventative strategies which professionals are currently using with their clientele, as well as their vision of a prevention program that directly addresses repetition of sexual abuse. The open-coding involved reviewing each interview and identifying and extracting categories from the raw data. Altogether, ten (10) categories were identified: repetition; mediating factors; presenting issues; therapeutic approach: techniques; therapeutic approach: theories; therapeutic approach: eclectic; prevention: content of prevention program; prevention: format of delivery; prevention: vision for prevention program; and gaps or unmet needs. If the category possessed nodes and/or child nodes, they were identified in this chapter. Furthermore, the description of the categories was followed by a graph which provided the reader with a visual interpretation of their frequency. The chapter is concluded with a table which summarizes the results that were outlined in this chapter.

⁵² Many women are misdiagnosed with a mental illness when they are actually experiencing post trauma symptoms. This could prevent a woman from receiving adequate treatment for her traumatic experience.

⁵³ Participants identified both an anti-oppression framework and cultural sensitivity programs as a gap in our system.

⁵⁴ A table that summarizes the results can be found in Appendix C.

In Chapter 6, an in-depth analysis of the results that were presented in this chapter is provided.

Chapter 6: Analysis

i. Introduction

The purpose of this exploratory study was to contribute to the current literature on repetition of sexual abuse, mediating factors, and potential prevention strategies. Through a systematic analysis of scholarly literature and thirteen (13) interviews conducted with counsellors, the researcher sought to attain information on repetition of sexual abuse and identify factors that mediate between the original experience(s) of childhood sexual abuse and subsequent experiences sexual abuse in adolescents and/or adulthood. A secondary aim of this study was to extract information on prevention strategies from the collected data. In order to establish a prevention program model that can be used in practice with women who are experiencing, or are at risk of experiencing, repetition of sexual abuse.

In this chapter, the results are analysed and discussed. This includes the examination of the ten (10) categories identified in Chapter 5⁵⁴ and information collected from the systematic analysis of scholarly literature and other related themes which were taken from the thirteen (13) interviews. This chapter is divided into four sections: the first section, *Prevalence of Repetition and Social Incoherence*, speaks generally to repetition of sexual abuse and the prevalence of this phenomenon among woman who were sexually abused in their childhood; the next section, *Psycho-social Mediating Factors*, addresses mediating factors and issues that women initially present within

⁵⁴ The categories presented in Chapter 5: Results are: Repetition; Mediating Factors; Presenting Issues; Therapeutic Techniques; Therapeutic Theories; Theories; Prevention: Content of Prevention Program; Prevention Program: Format of Delivery; Prevention Program: Vision of Prevention Program; and Gaps or Unmet Needs.

treatment. The third section, *Prevention and Treatment of Repetition*, discusses prevention implications identified in the current study and the literature. The final section, *Gaps and Unmet Needs in our Current System*, discusses the gaps and unmet needs identified in the thirteen (13) interviews and those extracted from the literature.

ii. Prevalence of Repetition and Social Incoherence

In this study, one hundred percent of the counsellors interviewed identified repetition of sexual abuse as a common occurrence among their clients who had experienced childhood sexual abuse. Also, each counsellor identified childhood sexual abuse to be the strongest predictor or strongly correlated⁵⁵ with repetition of sexual abuse. Several counsellors recognized that often women who experience a single incident of sexual assault in their adulthood seem more resilient to repetition of sexual abuse, whereas, women who were sexually abused in their childhood seem less. Another counsellor explained that ninety-eight or ninety-nine percent of the women that access services for their experiences of adult sexual abuse were first victims of childhood sexual abuse and that it is rare for a woman to access services for a single incident of adult sexual abuse.

The present study's findings support widespread literature that repetition of sexual abuse occurs at a high rate among women who experience childhood sexual abuse. Current literature on repetition of sexual abuse reports that women who are sexually abused in their childhood more likely to experience adult sexual abuse than women who

⁵⁵ Two counsellors had difficulties with using the word 'predictor' and felt that 'correlate' was more appropriate when speaking of childhood sexual abuse and the connection with repetition of sexual abuse.

did not experience this in their childhoods (Messman-Moore & Long, 2003). Also, Doll et al. (2004) recognize that research consistently shows that childhood sexual abuse is one the strongest predictor of adult sexual assault.

Many counsellors emphasized that frequently women who were sexually abused in their childhood also encountered other forms of abuse in intimate relationships and often report being bullied at work or school. These findings are also consistent with the literature (Van der Kolt, 1989; Briere, 2002) and demonstrate that repetition of sexual abuse is not the only risk factor for women with a history of childhood sexual abuse. It seems evident that the lasting effects of childhood sexual abuse can also have a negative impact on one's ability to establish and maintain healthy interpersonal relationships. The absence of healthy interpersonal relationships can also play a significant role in the continuation of a woman's social incoherence.⁵⁶ This could be because the woman's reality does not resemble what the dominant social narratives⁵⁷ have taught her about what an intimate relationships is supposed to be (Lynn et al., 2004) – namely that a partner, friends, and family are supposed to provide love and support, not abuse.

Social incoherence can play out in many ways. In this present study, a couple of the counsellors expressed concern that this researcher was conducting a study about repetition of sexual abuse. Despite the acknowledgement that repetition exists they do not address it with their clients. When given the definitions⁵⁸ of repetition of sexual

⁵⁶ Social incoherence is "the extreme discrepancy between personal narrative and shared social narratives" (Lynn et al., 2004: 172).

⁵⁷ For example, what she learned at school, on the television, in her neighbourhood, through the media, ect.

⁵⁸ Please refer to Appendix C: Interview Guide for the definitions given to the counsellors.

abuse, one counsellor misinterpreted the content as 'blaming the victim'. The counsellor stated her discomfort:

I think there's a HUGE danger with drawing [a link between childhood sexual abuse and a woman's experiences of sexual abuse in her adolescent and/or adulthood]. It's not to say that it's not necessarily valid but I also think it makes us completely ignore some things. Like with the first definition – the participation in a relationship that re-enacts the physical sexual emotional sexual abuse that was suffered in childhood. I could say this about thousands of adult women's relationships that I see that we participate in relationships that re-enact forms of abuse that we've experienced or prior patterns that we've engaged in or whatever it happens to be and my concern is that we sometimes draw that link with childhood sexual abuse without recognizing that that might be a much larger link that its not that our relationship behaviour might have patterns that go beyond the childhood sexual abuse survivor concept, but it seems to be focused at women quite often – 'oh well she's dating this violent man because she was abused as a child.' Very simplistic kind of things – which is not at all what I'm saying you're purposing here but it gets me nervous – the whole topic makes me nervous as a service provider because I see that happen a lot where we take the notion of abuse or the abusive experiences that women have generally globally and we treat them as explainable and understandable from the individualized women's perspective so because she was abused as a child so that's why she's experiencing it as an adult, not because globally women experience violence and sexual abuse as by power and control but a very specific direction.

Also, some counsellors felt uneasy answering certain questions because they were concerned their answers were placing the blame on the individual. As one counsellor was answering a question, she said that she hoped her dialogue was not coming across as 'blaming the victim'. This reaction is not invalid because the idea of 'blaming the victim' is a widespread cultural belief. As discussed in Chapter 2: Theoretical

Framework, the cultural disposition to blame the woman for her own abuse has profound implications for women's recovery, as well as the potential for the occurrence of repetition of sexual abuse. Herman (1997:112) points out that "for too long psychiatric opinion has simply reflected the crude social judgement that [women who have experienced childhood sexual abuse] 'ask for' abuse. However, in an attempt to avoid these common beliefs, it is possible for one to believe the idea that repetition is solely the result of societal forces and ignore a fundamental sequelae of traumatic experience.

These various fears, confusions, and discomforts regarding the concept of repetition could prevent counsellors from talking to their clients about how psycho-social effects of childhood sexual abuse can lead to repetition. There is a 'huge danger' in not drawing this link. Consequently, not initiating an open dialogue about repetition in therapy can be a continuation of the social incoherence these women have endured throughout their entire lives. Just as repetition is not a part of the dominant discourse, it is not a part of the therapeutic dialogue. The invisibility of repetition in the therapeutic relationship can be disempowering women. As discussed in Chapter 2: Theoretical Framework, in order to break the pattern of repetition in a woman's life, counsellors must consider how the following three components are affected by the dominant discourse and how they perpetuate repetition: the individual behaviours, her unconscious fears and motivations, and the primary relationships in her life and societal values and beliefs about childhood sexual abuse and repetition (Henriques, 1984; Wood and Roche, 2001; Grauerholz, 2000). By communicating these components with their clients, counsellors can begin to erode the social incoherence and validate their client's sexual abuse experiences.

iii. Psycho-social Mediating Factors

Counsellors were asked what factors provoke or impede repetition of sexual abuse. When asked this question, many counsellors were not familiar with the term. After the second interview, the researcher modified the question to include a more in-depth definition of mediating factors, as well as some examples found in the literature, however, it still proved to be a term that counsellors were not familiar with. This could be because the literature lacks theoretical frameworks and research about the integral role mediating factors play in womens' experiences of repetition of sexual abuse. Similarly, it is possible that counsellors lack the appropriate language to articulate their ideas when discussing repetition and mediating factors. This can also be due to the gap in the existing literature on repetition and mediating factors. However, a lack of advanced training on trauma and repetition of sexual abuse can also play an integral role⁵⁹. After further discussion about mediating factors, each participant understood the language and answered the question. As expected, the counsellors reported a wide variety of mediating factors, both psychological and social in nature. In this study, six (6) overarching nodes were identified: mental health, alcohol and drugs, social network, learning disabilities, poverty, and cultural issues.

Overall, mental health was the most heavily weighted mediating factor identified in this study. This finding is not surprising given that the majority of the mediating factors identified in the literature are the mental health effects of childhood sexual abuse. Each counsellor recognized that, as a result of childhood sexual abuse, women develop various factors that affect their mental health and put them at risk of repetition of sexual

⁵⁹ Lack of training on trauma and repetition will be discussed further, later in this chapter.

abuse. The factors identified in this study are insecure attachments, boundary issues, dissociation, fight, flight and freeze, mental illness, perpetrators, post-traumatic stress disorder (PTSD), safety, self-esteem and self-worth, sexuality issues, shame, and triggers.

Of these factors, five (5) counsellors identified PTSD⁶⁰ as a mental health mediating factor (6%). This is not the most heavily weighted mental health factor; however, in considering the others identified by the counsellors, many are symptoms of PTSD. For example, fight, flight and freeze⁶¹ (3%), triggers⁶² (3%), shame (8%), low self-esteem and self-worth (12%), and mental illnesses⁶³ (8%), such as depression, have all been identified as post-trauma symptoms of childhood sexual abuse (Matsakis, 1996). As discussed in Chapter 9: Literature Review, women who experienced repetition had significantly more lifetime and current symptoms related to PTSD (Arata, 2000; Casey et al., 2005). The literature indicates that PTSD should be considered a possible factor that contributes to repetition. Schore (2002:25) asserts that:

A central feature of PTSD is a loss of ability to physiologically modulate stress responses which leads to a reduced capacity to utilize bodily signals as guides to action, and this alteration of psychological defence mechanisms is associated with an impairment of personal identity.

⁶⁰ Although I am aware of the literature that critiques and deconstructs the theories described in this section, I have decided that this thesis is not the place to undertake such a task. However, I will include in the Prevention program a session where counsellors will be presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

⁶¹ This child node refers to the activation of the sympathetic nervous system by a stressful event. When in danger or threatened, people's bodies are programmed to have a fight or flight response. However, when they are unable to actually fight or take flight they are both emotionally and physically trapped so they freeze (Haskell, 2003).

⁶² "Triggers are any environmental or internal cue that serves as a reminder of a traumatic even – either directly or through a series of associations" (Haskell, 2003:190).

⁶³ Although I am aware of the literature that critiques and deconstructs the theories described in this section, I have decided that this thesis is not the place to undertake such a task. However, I will include in the Prevention program a session where counsellors will be presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

Dissociation⁶⁴ was identified by ten (10) counsellors, and was frequently recognized in the literature as a mediating factor. As discussed in Chapter 3: Literature Review, dissociation may have protected and helped women to cope with abuse during their childhood; however, it can become problematic when carried through adolescence and/or into adulthood. Dissociation has been identified as a common symptom of PTSD and its occurrence, at the time of trauma, is a strong predictor of this disorder (Schoore, 2002). Schoore (2003:131) declares:

The initially defensive disruption of the capacity to depict feelings and thoughts in themselves and other becomes a characteristic response to all subsequent intimate relationships. It also drastically limits their capacity to come to terms with these abusive experiences.

PTSD symptoms place women at risk of repetition because its symptoms inhibit their ability to respond to stress. This is a significant finding because PTSD has been established to be the most common diagnosis among women who have experienced childhood sexual abuse (Arata, 2000). Therefore, more research needs to be conducted on PTSD and, in relation to repetition of sexual abuse, counsellors need to focus on the role PTSD symptoms has in their clients' experiences of repetition. Additionally, in combining dissociation, PTSD and the other symptoms previously identified as PTSD symptoms, PTSD becomes fifty-three (53) percent of the mental health effects (See 'Graph 15' below).

⁶⁴ Although I am aware of the literature that critiques and deconstructs the theories described in this section, I have decided that this thesis is not the place to undertake such a task. However, I will include in the Prevention program a session where counsellors will be presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

**Graph 15: Mediating Factors:
Mental Health and PTSD**

This is proof there is a lack of understanding about trauma and PTSD. Therefore, counsellors need to obtain more advanced training on PTSD and the role these symptoms have in a woman's experiences of repetition because the counsellors did not recognize that these are all mental health effects resulting from trauma.

An insecure attachment style was identified as a mediating factor by seven (7) counsellors. Many authors discuss the negative impact that insecure attachments have on children, especially when their parent is the abuser. Often this attachment style will extend into adulthood and impact their intimate relationships (Holmes, 2001; Haskell 2003; Johnson 2003; Schore 2002, 2003). Arata (2000:37) suggested that other types of abuse such as neglect, physical, and emotional abuse should be considered as mediating factors. As discussed in Chapter 2: Theoretical Framework, when a caregiver abuses the

child, the fundamental biosocial contract is broken because the caregiver used his/her power for personal gain, rather than using their power to protect and nurture the child (Holmes, 2001:96). In order to maintain a sense of security, children often blame themselves for the abuse rather than risking their relationship with the primary caregiver. An adult woman will develop similar attachments in her intimate relationships, if, as a child, that is the type of attachment they had with their primary caregiver. One counsellor expressed that:

Attachment patterns are often relevant elements of repetitive trauma, particularly Preoccupied Attachment styles where people can be in a mode of 'If you are pushing me away or mistreating me then there must be something wrong with me and I need to hold on tighter in order to not get rejected or abandoned.' The attachment becomes more important than safety or personal needs or rights. Holding onto it can feel like a matter of life or death, in much the same way that a child may plead to not be separated from their abusive parent.

Indeed, as discussed in Chapter 2: Literature Review, the relationship of the perpetrator to the child was found as the only significant abuse characteristic related to the level of emotional distress in adulthood (Banyard et al., 1996). This suggests that when a parent is the abuser or the parent does not protect the child, the chances that the child will experience repetition of sexual abuse are increased in her adolescence and/or adulthood. Conversely, Liem et al., (1997) found that if sexual abuse was perpetrated against a child who has a secure attachment with her primary caregiver, they may, in adulthood, develop resiliency and cope with trauma in much healthier ways.

Similar to the way insecure attachments affect intimate relationships, this attachment style can also affect womens' ability to develop healthy social network. In

this study, eight (8) counsellors identified social network as a mediating factor. This finding suggests that women who were sexually abused in their childhood have a difficult time finding and maintaining healthy interpersonal relationships.⁶⁵ Many women who experienced childhood sexual abuse did not have a healthy support system in their childhood and did not have someone they could trust and confide in. Additionally, it is common for this population of women to have never been exposed to or taught healthy boundaries, which would have an effect on past and present relationships. Each of these factors causes social isolation in which women with childhood sexual abuse experiences remain in the repetitious patterns. One counsellor stated:

I think the other piece is isolation because people have great difficulty forming attachments to friends and social networks which is really crucial. I think people who have experienced trauma don't have a sense of what's normal and if they can't collaborate with other people, how do they check out what is normal? ...In some cases, the perpetrator is a family member, then safe access to the family unit is prevented.

Obtaining a healthy social network is an important part of recovery because it decreases the isolation often experienced by women with childhood sexual abuse histories, and allows them to begin developing secure attachments.

Eight (8) counsellors identified alcohol and drug abuse as a factor that mediates repetition of sexual abuse. Cohen (2000) affirms that approximately seventy percent (70%) of women who report substance abuse histories also report experiences of sexual abuse before the age of sixteen. As discussed in Chapter 3: Literature Review, throughout the literature, it is suggested that alcohol and drug abuse are associated with women who have experienced sexual abuse and repetition of sexual abuse. Alcohol and

⁶⁵ This point was also discussed in the previous section of this chapter.

drug abuse is often used as a coping mechanism to deal with trauma. This finding suggests the importance of looking at the combination of trauma and addiction. Mate (2008) asserts that addictions are emotional anaesthetics that always originate from pain, whether felt openly or hidden in the unconscious. One counsellor stated that:

Drugs and alcohol really suppress some of those feelings which also makes them vulnerable because it takes away some of their control. In a way, it makes it easier for them to loosen up on their inhibitions so they can be with other people...and it really affects their ability to set boundaries.

While alcohol and drugs might temporarily extinguish some of the emotional pain, substance abuse can lead to women ending up in high-risk situations, which can lead to sexual abuse. Another counsellor pointed out that abusers use drugs and alcohol as a tool to reduce the women's inhibitions in order to be sexually violent.

Perpetrators were identified as a mediating factor by twelve (12) counsellors, which was the most heavily weighted mental health effect (14%). This refers to perpetrators that seek out women with certain vulnerabilities, derived from childhood sexual abuse, which include issues of power and control. Also, ten (10) counsellors identified that safety is a mediating factor (14%); this is when a woman with childhood sexual abuse experiences cannot decipher between safe and unsafe situations and/or people. These two mediating factors are closely related as they both involve perpetrators benefiting from women's vulnerabilities. One counsellor suggested that perpetrators take advantage of the mediating factors. Salter (2003) asserts that perpetrators look for victims with vulnerabilities that they can control. Correspondingly, one (1) counsellor as a mediating factor identified having a learning disability. Studies show that children with

disabilities are more vulnerable to sexual abuse (Sinason, 2002) which could be a vulnerability that perpetrators look for in children.

In using a social constructionist perspective whilst looking at repetition, there are many ways to interpret the complex means in which perpetrators become a mediating factor. Studies show that as a result of childhood sexual abuse, women develop mental health issues that put them at risk of repetition. As discussed in Chapter 2: Theoretical framework, Grauerholz (2000) explains that mediating factors can lead to increased contact with potential perpetrators and/or can increase the likelihood that perpetrators will act aggressively. For example, increased sexual activity in adulthood, impaired ability to judge risky situations or people, dissociative disorder, stigmatization, and low self-esteem are all mediating factors that can trigger a woman's individual behaviours and her unconscious fears and motivations that would make this more plausible. At the same time, society plays a significant role in perpetrators offending. Haskell (2003:19) explains that:

...sexual behaviour is an adaptation to early childhood experiences of sexual violation and that this behaviour is then reinforced by our sexist society, in which far too many men have learned to be sexually coercive and/or violent.

While the mental health effects of childhood sexual abuse place women at greater risk of re-experiencing the abuse, our patriarchal society perpetuates violence against women.

Also to be considered are the cultural issues that impact the women who have experienced childhood sexual abuse. In this study, ten (10) counsellors identified cultural issues as mediating factors. The child nodes are: core beliefs/belief system⁶⁶ (42%);

⁶⁶This refers to the core beliefs a woman has internalized that comes from her culture to which she was raised in.

gender inequality (37%); taboo⁶⁷ (16%); colonization, and residential schools⁶⁸ (5%). As stated in Chapter 2: Theoretical framework, when examining mediating factors, it is important to be aware of both the social and subjective participation that recreates patterns of violence – in a sense, one can view society and the individual as co-authors. In this case, negative cultural beliefs about women's sexuality can have a direct impact on the individual, which can lead to development of mental health issues. As discussed in Chapter 3: Literature review:

...violence against women takes place in a cultural context rife with oppressive discourse...[and] beliefs embedded in these dominant texts and practices, internalized as "truth", impact profoundly on women's safety, their constitution of identity, and their interpretation of experience from a socially disempowered position (Wood and Roche, 2001:6).

For example, negative cultural beliefs concerning women cause gender inequalities, which affects communities, families, and the individual child that is experiencing the abuse. In turn, these cultural beliefs are internalized by the child, which extends into her adulthood. Grauerholz (2000:12) states, "one must pay attention to how social power is derived and how (lack of) social power contributes to vulnerability within [society]. This author explains that the goal is to develop a more integrated understanding of repetition of sexual abuse by delineating the structural relationship between the individual, families, communities, and cultural factors that have been implicated by others as causation.

⁶⁷ This refers to the negation, denial, and disapproval of sexual abuse within families, communities, the media, and society as a whole.

⁶⁸ This refers to the cultural issues that are a result of colonization and residential schools have placed Aboriginal people, who have childhood sexual abuse experiences, at a greater risk of experiencing repetition sexual abuse.

Additionally, sexual abuse remains taboo⁶⁹ within families, communities, the media, and society as a whole, which is a continuation of social incoherence.

In this study, eight (8) counsellors identified poverty as a mediating factor. This is a significant finding because it really demonstrates that repetition of sexual abuse does not only rest in the individual, but that it is a much larger cultural issue. One counsellor said that

...financial security becomes an issue. Often people with a lot of victimization, you're not going to find them in high paying jobs so poverty is an issue, and if there's been a lot of different factors that have interfered with their development, it will interfere with their school.

Another counsellor stated:

I work with almost entirely a highly marginalized and highly criminalized population. Most of the women I work with are street-involved, very few are housed, and really very marginalized population. And within that population absolutely there's a huge pattern of women who have multiple experience of violence over and over again throughout their lives and if you ask the vast majority of those women if they've experienced childhood sexual abuse, they did also on top of the violence they are currently experiencing.

Grauerholz (2000) asserts that it is more likely for women who were sexually abused in their childhood to be more socially disadvantaged. This author explains that this mediating factor reduces or limits women's social power and causes a withdrawal from others, a lack of social support, as well as disadvantaged circumstances. In many ways, poverty shapes women's interactions and can potentially put them at risk of repetition. For example, when women are living in poverty they often live in poorer neighbourhoods, are working at night, and/or they may feel forced to stay in abusive

⁶⁹ Taboo was identified as a mediating factor by 3 counsellors.

relationships due to financial reasons. Often, women living in poverty cannot afford the treatment they need to heal from their childhood sexual abuse and repetition, which can bring about social isolation and increase mental health effects. Grauerholz states that social isolation and poverty resulting from early abuse and family experiences may reduce the woman's social power by reducing her resources and social alternatives (p. 13). Poverty is an over-arching mediating factor that negatively affects all other mediating factors. Essentially, poverty could influence all the other mediating factors identified in this study, actually increasing the likelihood of repetition of sexual abuse.

In this study, a variety of issues that women present in therapy were identified. It seemed that when counsellors identified presenting issues, the issues depended on the organization where the client is accessing services - ex. more pronounced multi-purpose agencies versus specialized agencies. Also, there was not one presenting issue that significantly more weighted then another.⁷⁰ This could suggest that the presenting issues may or may not hold the answers to why someone is experiencing repetition. One counsellor explained that her clients will often present with an issue and then, at a later date, different issues will surface. It seems that in many cases the presenting issues are often different from the mediating factors; however, they can also be the same. The data presented thus far in this chapter and the information found in the literature suggests that there is an overdetermination of presenting issues and mediating factors which suggests that there is not one single cause and effect. The data in this study have revealed the complexity of repetition in relation to mediating factors. This complexity is also demonstrated in the literature on repetition of sexual abuse (Arata, 2000; Grauerholz, 2000; Messman-Moore et al., 2000). The complexity could show that there is not one

⁷⁰ See 'Graph 5: Presenting Issues' in Chapter 5: Results.

mediating factor that is the key in a woman's experiences of repetition, and that there are many factors involved in the continuation of repetition. Additionally, the mediating factor is not something that a woman with repetitious experiences of sexual abuse is likely to present with. Counselling can be used to move past the presenting issues and begin to gather more information about mediating factors so that treatment around childhood sexual abuse and repetition can be tailored to fit that woman's needs. More research needs to be conducted on the overdetermination of mediating factors and, in order to provide adequate services for women which childhood sexual abuse experiences and repetition, counsellors need advanced training that specifically focuses on trauma, sexual abuse, and repetition of sexual abuse.

iv. Prevention and Treatment of Repetition

Overall, counsellors are eclectically orientated when working with women who have experienced childhood sexual abuse and repetition. This means that counsellors use a variety of theories and techniques in their work with women who have experienced childhood sexual abuse. Because women are coming to therapy with varying issues and there are a wide variety of factors mediating childhood sexual abuse and repetition, an eclectic approach to working with this population appears to be imperative. In essence, embodying one theoretical approach and using a limited number of techniques would be insufficient in beginning to decrease one's experiences of repetition. Another consideration when working eclectically is the different populations that are accessing therapy. As the counsellors were discussing their vision for a prevention program, one

counsellor suggested a program using Aboriginal traditions and another suggested a culturally sensitive program.

This could indicate the need to tailor a prevention program to fit the needs of each individual. For example, if an Aboriginal woman with an addiction is coming for treatment, the counsellor might provide culturally sensitive treatment that includes Aboriginal traditions and addiction treatment, in combination with an eclectic approach to treating the repetition of sexual abuse. One counsellor who works specifically with Aboriginal women said that the program would have to be Aboriginal specific and include components about colonization, residential schools, and the culture's traditional healing so that these women can have an understanding of the impact these components have on their culture and the healing elements within their traditions. She suggested that these components can be delivered in individual and group counselling, as well as, through a workshop. Another counsellor who works with Immigrant women said that language would need to be a consideration and that the counsellors implementing the program must be careful not to blame the woman's religion or culture. In a sense, the counsellor would be treating the presenting issue, in a culturally sensitive way, while also working to identify mediating factors and address the repetition of sexual abuse.

In analyzing 'Graph 5: Therapeutic Approach: Technique' and 'Graph 6: Therapeutic Approach: Theories', there seems to be some discrepancy between the techniques and theories counsellors identified as part of their current practice.⁷¹ For example, counsellors emphasized the use of experiential techniques and expressive therapies; however, when they were asked about theories, counsellors most frequently

⁷¹ See 'Chapter 5: Results', page 62 and 63, for a visual representation.

identified cognitive behavioural therapy (CBT). CBT is a behaviourist modality that focuses extensively on changing thoughts and behaviours through talk therapy, while the experiential techniques and expressive therapies use a combination of talk therapy and non-talk therapy. Also, the former theory places very little focus on unconscious fears and motivations, while the latter forms of therapy place a significant focus on all these components. This could suggest that while talk therapies, such as CBT, are the most commonly used treatment modality, alone they might not completely address individual behaviours, unconscious fears and motivations, and the primary relationships in her life and societal values and beliefs, which have been identified as integral components when working toward reducing the likelihood of repetition.

When discussing the content of the prevention program, counsellors identified psychological counselling and program techniques more frequently than the resiliency, recovery, health, and nutrition. Within psychological counselling and program techniques, a variety of issues that need to be addressed were provided which were, for the most part, evenly distributed. The importance of relational trust in counselling was the only child node with significantly more weight. It seems that in order for the woman to make gains within any program relating to childhood sexual abuse and repetition, she must first feel safe and secure with her counsellor. Herman (1997) asserts that recovery can only take place in the context of the relationship not in isolation. These finding suggests that the presence of relational work within the counselling relationship is, above all, the most important part of therapy, and that the process of the counselling relationship is more significant than the content of the session. Herman explains that the core experience of childhood sexual abuse is disempowerment and disconnection from others;

therefore, recovery is based on the empowerment of the woman and the creation of new connections. Earlier in this chapter, insecure attachment was discussed in the context of a mediating factor in repetition of sexual abuse. Since insecure attachment is a mediating factor, beginning to develop secure attachments would be important in the prevention of repetition; however, in order to accomplish this, the counsellor must understand the complexity of the primary relationships in the woman's childhood and how it is affecting her relationships today. This alludes to the importance of continually working with the transference⁷² that occurs in the counselling relationship. Since such an emphasis was placed on the counselling relationship, it is surprising that not one counsellor talked about addressing transference in the relationship, because the transference might have answers to which relational issues are contributing to repetitious patterns. This could be due to a lack of training on working relationally with their clients.

As discussed in Chapter 2: Theoretical Framework, Carey (1997) incorporated *Object Relation Theory* into a prevention program for repetition of sexual abuse. These authors listed two components of treatment: first, the skills training related to the development of affect regulation and adaptive interpersonal beliefs, and second, they continue to include the need to better understand psychological sequelae of trauma. These authors highlight the importance of taking the time to build a secure attachment within the counselling relationship. Even though only one (1) counsellor suggested this theory be a part of the program, *Object Relation Theory*⁷³ would be ideal as a foundation

⁷² Herman (1997) defines transference as the client's emotional responses to any person in a position of authority have been deformed by the experience of terror; therefore, traumatic transference reactions have an intense, life-or-death quality unmatched in ordinary therapeutic experience.

⁷³ Self-Psychology was identified by another counsellor, which is similar to Object Relationship Theory, in that there is a focus on working relationally.

of this program because attachment and impact of one's primary relationship has been a constant theme throughout this study. The use of this theory in a prevention program of repetition could allow for the woman and her counsellor to continually work on the therapeutic relationship in and among workshops and groups, which will set the groundwork for the women to build healthy interpersonal relationship with others, which has been identified as a key component to recovery. In a sense, working relationally with women who have experienced childhood sexual abuse and repetition is what provides consistency in the eclectic approach. Programs need to be individualized to fit each woman's needs (Macy, 2007), for example, an Aboriginal woman might benefit more from traditional Aboriginal healing rather than traditional psychotherapy. This said, in recent years, traditional Aboriginal healing centers in Ottawa have made adaptations to include attachment theory. However, at the core of her recovery, working relationally with her counsellor is imperative.

In the literature, resiliency was identified as a mediating factor that impedes repetition and also places a focus on the impact of primary relationships throughout the lives of women who had prior sexual abuse experiences. As discussed in Chapter 3: Literature Review, the differences between resilient and non-resilient women who have been exposed to sexual abuse during childhood is best described in *Garmezy's Model of Resilience*. This model examines the differences among these women's the personality factors, the attachment patterns in their childhood, their current environment and support systems. Women who characterized a larger number of the more positive aspects within the scope of these individual and social factors were less likely to experience repetition. Bogar et al. (2006) suggested depersonalizing, setting limits, keeping busy, writing,

praying, and calming helped participants to survive and cope during childhood, when the abuse was occurring, as well as in adulthood, when other victimizations or tragedies occurred. Although the counsellors did not identify resiliency as a mediating factor, they did recommend using resiliency theory in a prevention program. Possibly, the aforementioned strategies could be used in prevention programs to increase the women's emotional regulation and help self-soothe their pain.

v. Gaps and Unmet Needs in our Current System

Funding for adequate services was identified as a gap in our current system as it pertains to childhood sexual abuse and repetition by eight (8) counsellors. In this study, counsellors possessed valuable information for treatment of childhood sexual abuse and repetition; however, they lacked an understanding of the complexity of this phenomenon. One counsellor stated that:

I think there's an education piece that's missing that when any woman presents with any form of an addiction or mental illness, it's treated as that without going further in to it and my guess is 9 times out of 10 there's a trauma background.

It seems clear that counsellors need more training on repetition and mediating factors, attachment theory, and how to use this information in their work with women who are experiencing or are at risk of experiencing repetition. Counsellors seemed to have an understanding of the importance of building trust in the therapeutic relationship; however, most participants in this study did not have an understanding of how to work relationally with their clients. As one counsellor pointed out, many educational

programs do not provide courses on trauma, or they do provide it as an elective but do not make it mandatory. Furthermore, the training available in the community is often not sufficient to educate counsellors on the complex roles that both transference and counter transference have in the counselling relationship, as well as the importance of continually addressing it. This type of education takes advanced training that cannot be provided in community workshops.

The lack of public education regarding childhood sexual abuse and repetition was identified as a gap. This type of public education in schools, for parents, and professionals, such as police officers, is an important part of prevention because it informs the public of the severity and repercussions that childhood sexual abuse can have. This way, sexual abuse can be more commonly recognized as a social problem and become less of a taboo, which will decrease the social incoherence children and adult women's experience. Furthermore, treatment for perpetrators was identified as a gap in our current system. This is significant because, up to this point, most of the focus has been placed on the victim, while the perpetrator either walks away and re-offends or spends time in prison with very little psychiatric treatment. However, more focus must be placed on various cultural issues involved in the perpetuation of violence against women. While treatment for victims and perpetrators is imperative, it does not get to the root of the social problems that exist.

Seven (7) counsellors identified that there is increased vulnerability of marginalized groups. The medicalization of women was identified by three (3) participants as making women more vulnerable to repetition of sexual abuse. It seems

that many people with childhood sexual abuse experiences are misdiagnosed with a mental illness when they are actually experiencing post trauma symptoms. One participant said that:

Many times people present with a mental illness like Bipolar Disorder, which is often a misdiagnosis and later it comes out that their trauma survivors and their symptoms were actually symptoms of PTSD.

Women who are in recovery due to experiences of sexual trauma are often given a variety of diagnostic labels – bipolar disorder, anxiety disorder, and borderline personality disorder to name a few. However, many of the symptoms they have are a result of childhood sexual abuse. Mental health practitioners do not take into account the context in which women have developed the symptoms they are displaying. Haskell (2003:20) explains that:

Many traditional psychiatric and psychological categories and approaches are not gender sensitive and do not account for or address the ways in which abuse and trauma factor into women's lives to shape women's mental health issues.

This modality reflects how society as a whole individualizes and, in a sense, blames women for their experiences of violence. Draucker (1998) explains that by focusing on the individual's symptoms, political implications of sexual violence are obscured; this drains energy and resources away from political action and prevention efforts. With a firm focus on the individual in treatment, the public does not have to look at the societal context in which the violence against women is perpetuated. Additionally, the focus in treatment is deflected from the experiences of sexual violence to the treatment of mental

illness. In essence, the focus is taken from the real issues of oppression, patriarchy, and violence against women, and it is placed on the individual woman.

The prevention program provided in this thesis is psycho-social in nature so it will address both the psychological and social effects of trauma. Therefore, it will not embody a 'blame the victim' mentality but it will take into account the mental health effects of trauma that the individual women possess. This will allow women to feel more empowered in their treatment because they will have an understanding that they can make changes within themselves that can reduce the occurrence of repetition.

Correspondingly, six (6) participants identified both an anti-oppression framework and cultural sensitivity programs as a gap in our system. The counsellors interviewed in this study work for a variety of agencies with differing mandates and they serve diverse populations of women.⁷⁴ This is noteworthy because it suggests that the prevalence of repetition of sexual abuse is widespread and affects a significant number of women of different races, classes, sexual orientations, religious and cultural backgrounds, ages and abilities. In this study, four specific groups of women were identified as

⁷⁴ Some counsellors fit into more than one of these of the categories. For example, someone might work in an agency and also have their own private practice or someone might work in a hospital, specifically with women who were sexual assaulted.

- eleven (11) counsellors work women of varying race, class, age, religious and cultural backgrounds, sexual orientation and ability.
- five (5) counsellors work with clients who are accessing therapy regarding their experience(s) of sexual abuse;
- two (2) counsellors work with clients who are seeking therapy due to mental health issues;
- two (2) counsellors work in their own private practice;
- one (1) counsellor works in a shelter for women who need protection from violence and abuse;
- one (1) counsellor works with Aboriginal women;
- one (1) counsellor works with immigrant women;
- one (1) counsellor works with young women at-risk
- one (1) counsellor works in a trauma centre;
- one (1) counsellor works in an addiction centre; and
- one (1) counsellor works in a hospital. Involved

vulnerable –Aboriginal women, marginalized women,⁷⁵ youth⁷⁶ and immigrant women. For each of these groups, cultural ideologies play a significant role in women's experiences of repetition and access to treatment. It seems that some women might have extra barriers that prevent them from accessing services. One participant who works with immigrant women pointed out that "intervention in many of my client's country is totally different then North America Psycho-therapy." It seems important that programs change depending on the recipient and incorporates cultural traditions. Also, Shulman (1999:67) stresses that it is "crucial to understand the elements of resilience that help individual, families, communities and entire populations groups to survive and thrive in the face of adversity."

Many counsellors put a large emphasis on cultural issues. Specifically issues concerning gender; however, there were some marginalized groups that were not mentioned in this study. It seemed difficult for some counsellors to see beyond the scope of their own lens or the lens that the agency at which they are employed. Also, there is a gap in the literature, in that there were no studies found that examine the relationship between childhood sexual abuse and repetition among marginalized groups. For example, throughout this study there was no mention of women with disability or GBLT⁷⁷ women. The Centre for Research of Women with Disabilities (Internet report: 2004) details:

⁷⁵ Women ages 19 and older. Often these women are street involved, homeless and/or living in a shelter. They often have substance abuse issues and work in the sex trade.

⁷⁶ Young, marginalized women, ages 14-18. Often these women have left home because of abuse, are living on the streets, homeless shelter and/or 'couch surfing'. Often have substance abuse issues and are involved or at risk of becoming involved in the sex trade.

⁷⁷ Gay, bisexual, lesbian and transgender (GBLT)

...women with disabilities reported a larger number of perpetrators, with the most common being intimate partners, followed by family members, and the duration of the abuse was longer. They were also more likely to experience abuse by attendants, strangers, and health care providers. Compared to women without disabilities, women with disabilities were more likely to report more intense experiences of abuse, including the combination of multiple incidents, multiple perpetrators, and longer duration.

It seems surprising that in a study where so much focus is placed on cultural issues, such as gender inequality, these groups were not mentioned. This could be identified as another gap in our system.

Affordable, long-term trauma treatment was identified as a gap by five (5) counsellors. In our current system, many programs run for eight to twelve weeks and it is difficult for women to find long-term individual treatment with an experienced counsellor. It has been established that, especially in the beginning, much of the therapy needs to happen within the counselling relationship. In this study, many counsellors emphasized the importance of establishing a secure individual relationship in order to build trust and safety before beginning group therapy. This type of relationship can only be developed in a long-term therapeutic relationship.

One counsellor explains,

Adequate services are not available for people who cannot afford them and there are only short-term services available and short-term services are not appropriate for a trauma survivor. I would love to see a trauma centre funded by the government that offers open-ended trauma therapy or three year trauma therapy.

This is another area that women living in poverty are affected by. Poverty has been discussed as a mediating factor between childhood sexual abuse and repetition and, in

this case, poverty infringes on a woman's ability to access adequate treatment in order to reduce the occurrence of this pattern and begin to heal from their childhood trauma.

vi. Conclusion

These findings are indicative of the lasting bio-psycho-social effects of childhood sexual abuse which can lead to repetition of sexual abuse in a woman's adolescence and/or adulthood. Additionally, these results reinforce the importance of understanding repetition of sexual abuse, mediating factors, and developing prevention strategies that specifically address repetition of sexual abuse. These findings suggest that childhood sexual abuse and repetition remain taboo among professionals and society as a whole, which can contribute to social incoherence.

Another significant finding was the complexity with which factors mediate between childhood sexual abuse and repetition. It was found that not one sole factor mediates repetition and that clients often present with issues differing from the mediating factor. Additionally, while perpetrators seek out women who have certain vulnerabilities, there are a variety of cultural issues that perpetuate violence against women. Furthermore, poverty seems to be an overarching social problem that mediates repetition; women have fewer options for employment, live in dangerous neighbourhoods, and may feel forced to stay in abusive relationships, which prevents women from accessing adequate treatment for their trauma experiences.

Another relevant finding was the importance of incorporating attachment theory into treatment and working relationally with women who have experienced childhood sexual abuse and repetition. Additionally, all thirteen (13) counsellors emphasized the importance of working eclectically, while placing a strong focus on the therapeutic relationship. From this standpoint, a significant finding was that women entering into treatment should begin with individual counselling and then, when the relationship is established, she can begin group sessions and can participate in workshops. However, it was emphasized that the individual relationship between the woman and her counsellor must remain intact for the duration of treatment.

Overall, these findings revealed that there is a need for more adequate training for professionals around childhood sexual abuse in relation to repetition and mediating factors. Additionally, there is a need for long-term treatment programs for trauma, sexual abuse, and repetition. It was emphasized that women who experienced childhood sexual abuse and repetition need three years or more in a program. Furthermore, there is a gap in the services that are currently provided; they are not all accessible to marginalized groups, which include people living in poverty. The next chapter will present an outline of a psycho-social prevention program that professionals can use in treatment with women who have experienced childhood sexual abuse and repetition.

Chapter 7: Outline of Prevention Program

i. Introduction

This chapter will outline a psycho-social prevention program that can be further developed by counsellors and used in practice. This study found that there is a need for professional training regarding repetition, mediating factors, and the prevention of the phenomenon, therefore, this model will be presented in the form of a workshop designed for counsellors working with women who were sexually abused in their childhood, and have experienced, or are at risk of experiencing, repetition of sexual abuse. In this chapter, for the most part, the reader will not find new material. Instead, an organization of texts in the previous chapters will be combined with some new material for the purpose of initiating more advanced training of counsellors about childhood sexual abuse, mediating factors, and prevention. The goal of this workshop is that professionals can begin to understand the complexity of childhood sexual abuse and repetition. A workshop such as the one presented in this chapter should be the starting point of more advanced training around repetition of sexual abuse and counselling.

In the first section of this workshop, the workshop leader will discuss the psycho-social nature of repetition of sexual abuse. In section two, childhood sexual abuse and the impact of resulting mental health effects; in doing so, the workshop leader will introduce four theories and concepts.

1. *Attachment Theory* – The workshop leader will explain the significant role the primary caregiver plays in a child's development and how the child's attachment style will impact her interpersonal relationships and experience(s) of repetition.

2. *Mediating factors* – The workshop leader will define mediating factors and discuss the importance of identifying them so the counsellor and client can have an understanding of the factors that provoke or impede repetition.
3. *Grauerholz's Ecological Approach to Repetition of Sexual Abuse* – The workshop leader will explain repetition as a psycho-social phenomenon that is a result of both individual and social problems.
4. *Social Narrative Model* – The workshop leader will explain that repetition is, in part, the product of dissociated or conflicting social relations that do not mirror their clients' personal experience. The leader will also present the concept of social incoherence and explain the importance of having an open dialogue about repetition with their clients.

Next, the workshop leader will establish the foundation of the prevention program by presenting Object Relations Therapy and Resiliency Theory.

1. *Objects Relations Therapy* – The workshop leader will introduce this therapy as a basis for counsellors to work relationally with their clients.
2. *Resiliency Theory* – The workshop leader will introduce factors that have contributed to some women's resiliency. These factors can be embodied by women experiencing repetition of sexual abuse to reduce the occurrence.

Finally, the workshop leader will provide counsellors with a variety of treatment implications that can be used in their counselling practice.

*ii. A Psycho-Social Prevention Program Model: A Workshop for Counsellors***Section I:**The Psycho-Social Nature of Repetition

When work with women who have experienced childhood sexual abuse, it is extremely important to have a clear understanding of the psycho-social nature of this phenomenon. Childhood sexual abuse has mental health effects that put women at risk of repetition; however, sexual abuse is a social problem that is a result of a patriarchal society that perpetuates violence against women and girls. Also, there are many social effects that create barriers and prevent women from accessing treatment and healing from the abuse. When implementing this program, you must encompass a culturally sensitive framework and have an understanding that women coming from differing cultural backgrounds will have varying barriers and needs. In some sense, all women possess issues related to their cultural identity; consequently, you must have cultural sensitivity towards all your clients. For especially marginalized women, this type of prevention program might not be the first course of action. For example, crisis situations such as finding housing or leaving an abusive relationship should take precedence over individual therapy, groups, and workshops. As previously stated, it is important to individualize your program to fit each woman's needs.

Poverty is a common factor for women who have childhood sexual abuse experiences, and it can be a factor that puts women at risk of repetition. Women who live in poverty often live in poorer neighbourhoods are working at night, and/or they may feel forced to stay in abusive relationships for financial reasons. As a counsellor working with this population of women, it is important to be aware that poverty is a fundamental

mediator. Therefore, it is recommended that you advocate for your client's needs, and be an active participant in the struggle to end poverty.

Section II:

Mental Health Effect of Childhood Sexual Abuse

Throughout the literature, it has been documented that childhood sexual abuse causes mental health effects that put women at risk of repetition of sexual abuse. Current studies in neuroscience demonstrate that “the overwhelming stress of maltreatment⁷⁵ in childhood is associated with adverse influences on brain development” (Schoore, 2002:11). Additionally, some mental health effects of childhood sexual abuse include cognitive delays and lowered IQ, dysfunctional behaviours such as behavioural problems, substance abuse and aggression, an increased risk of depression, suicide, anxiety disorder, and somatisation disorders (Collishaw et al., 2007). Fortunately, with appropriate treatment, women can begin to heal and reduce their experiences of repetition and live more satisfying lives. In order to begin to decrease the occurrence of repetition, the complexity of this phenomenon must be understood. This workshop will provide you with information about repetition of sexual abuse, mediating factors, and prevention; however, this is only the starting point. Much more advanced training is needed to embody the concepts presented in this workshop.

1. Attachment Theory

Attachment theory sheds light on the crucial role that the primary caregiver plays in a child's development. This includes providing a child with love, affection, safety, and

⁷⁵ This refers to emotional, physical, sexual abuse and neglect.

security, which permit the child to develop a secure attachment and explore the world safely. A complete session of the workshop will include worksheets outline this material and case examples illustrating the following ten tenants of attachment theory. Johnson (2003:4-9) had identified ten tenets of attachment and they are as follows:

1. Attachment is an Innate Motivating Force – Seeking and maintaining contact with significant others are innate in human beings. The primal nature of attachment as a motivational system is rooted in the child's need to maintain physical proximity to her primary caregiver to ensure survival, not just promote emotional security (Wallin, 2007).
2. Secure dependence compliments autonomy – There are only two kinds of dependency - effective or ineffective, and there is no such thing as over dependency or complete independence.
3. Attachment offers a safe haven for the child; this means that significant others (ex. the primary caregiver as a child and intimate partners as adults) provide comfort and security.
4. Attachment offers a secure base in which the child can safely and confidently explore her surroundings.
5. Both accessibility and responsiveness of emotions from others build bonds.
6. Fear and uncertainty activates attachment needs whether the child is threatened by a traumatic event or by negative aspects of everyday life.
7. The process of separation distress is predictable if attachment behaviours fail to bring about a comforting response from the child's primary caregiver.
8. There are a finite number of insecure forms of engagement that have been identified.

The most common classifications are (Wallin, 2007)

- a. *Secure attachment*: A child with a secure attachment has equal access to her impulses to explore when she feels safe and return to her primary caregiver for solace when she feels threatened.
 - b. *Avoidant Attachment*: An avoidant child appears to be 'peculiarly blasé' when her primary caregiver is absent in an alarming environment.
 - c. *Ambivalent Attachment*: The two kinds of ambivalent attachment are angry and passive. A child with ambivalent attachment will be too preoccupied with her mother's whereabouts to explore freely and will react with extreme distress to her departure.
9. Attachment involves working models for self and others. One's attachment style is an indication of how she is in interpersonal relationships.
 10. Isolation and loss are inherently traumatizing – attachment is a theory of trauma. Traumatic stressors such as loss, deprivation, loss, rejection, and abandonment, experienced in isolation, can have a major impact on the development of one's personality and her ability to deal with stressors later in life.

Attachment theory provides some insight into the reasons why a woman who has experienced sexual abuse during her childhood might encounter the repetition of this experience in her adolescence and/or adulthood. Also, this theory offers insight into patterns that could potentially develop later in life. Here are some examples:

- In the case of a child who has experienced sexual abuse, a secure attachment, or lack thereof, one can often predict how she might react to a similar trauma later in life.
- If a child has an insecure attachment to her primary caregiver, as an adult woman, this individual may be unable to establish healthy relationships.
- In contrast, if sexual abuse was perpetrated against a child who has a secure attachment with her primary caregiver, they may, develop resiliency in adulthood and cope with trauma in much healthier ways.

Recent developmental psychobiological models indicate that (Schore, 2002):

- Events experienced early in life may be particularly important in shaping peoples patterns of responsiveness later in life.
- Lack of care on the part of the primary caregiver represents a source of stressful environmental information for the developmental and maturational pattern of the neural circuitry of the child's stress system.
- Pre and post stressors can negatively or positively impact later mental health, especially when their primary caregiver's care is absent.

It is, however, important to remember that adult women who had insecure attachments with their primary caregiver may not trust their counsellor in the beginning, so it is important to take time to build trust during the initial stages of treatment. Essentially, attachment theory is an optimal theory since the internal working models can be changes and women can begin to develop healthier relationships and social networks.

2. *Mediating Factors*

In this next section, the workshop leader will define and discuss mediating factors. Mental health effects that can develop as a result of childhood sexual abuse can mediate childhood sexual abuse and repetition of sexual abuse.

Definition of Mediating Factors:

- This term refers to the psychological and social dynamics that intercede between childhood sexual abuse and the repeated abuse in one's adolescence and/or adulthood⁷⁶. Some examples are:
 - *Resiliency* – various factors have been identified that seem to protect women from experiencing repetition of sexual abuse (this will be discussed further in Section II of this workshop).
 - *Post-traumatic stress symptoms* – women who deny, minimize, or fail to integrate her experiences of childhood sexual abuse into her narrative memory might not make conversant decisions due to partial or imprecise information, therefore, persistence avoidance becomes problematic and increases vulnerability (Sandberg et al., 1999).
 - *Dissociation* – this may prevent a person from using protective measures which can put them at risk of repetition (Noll et al., 2003).
 - *Alcohol and substance abuse* – this may be used as a coping mechanism; however, alcohol and drug use can lead to women finding themselves in

⁷⁶ Although I am aware of the literature that critiques and deconstructs the various mental health issues described in this section, I have decided that this thesis is not the place to undertake such a task. However, a session is included in this prevention program where counsellors are presented with a critique of the DSM IV approach of describing and constructing 'disorders'.

high-risk situations that have the potential to escalate into an exposure to sexual abuse (Messman-Moore and Long, 2002).

- *Shame* – this causes a deep sense of stigmatization that may lead women who have experienced childhood sexual abuse to participate in activities, such as risky sexual behaviour, that reinforce their feeling of low self-worth and places them at risk of being sexually abused (Kessler et. al., 1999).
- *Severity of the original abuse* - it has been proposed that the severity of sexual abuse in childhood may predict the severity of the repetition (Casey et al., 2005)

It is important that these factors be addressed within the scope of the prevention program and counselling relationship. Also, when examining mediating factors, it is important to be aware of both the social and subjective participation that recreates patterns of violence.

The Many Levels of Repetition of Sexual Abuse

When working with women that have had repetitious experiences of sexual abuse, it is important to understand the various levels that contribute to the continuation of this phenomenon. In a sense, you can view the individual and society as co-authors. Our society plays a significant role in the continuation of violence against women and repetition of sexual abuse. When working with your clients, it is important to always take into account the societal factors that mediate repetition.

3. *Grauerholz's Ecological Approach to Repetition of Sexual Abuse*

Grauerholz (2000) uses an ecological approach to explain repetition of sexual abuse. This theory presupposes that a woman's experience with repetition can only be understood by considering factors at three levels. These three levels are the individual, interpersonal, and sociocultural levels. This theory is multifaceted in nature and avoids focusing solely on a primary issue: one which targets the ways in which the woman may have put or will put herself at risk of repetition. There are four levels of analysis in this framework (the presenter will show the visual diagram of this model that is presented in 'Appendix A'):

- the ontogenic development;
- the microsystem;
- the exosystem; and
- the macrosystem.

The *ontogenic development* is associated with the woman's personal history and her subjective participation in the current relationship; these two components will have an impact on her current behaviour or will serve to shape it. The most critical ontogenic factor is the initial victimization; it shapes the woman's personality and thus affects her interactions with others in a manner which makes repetition more likely. Another essential ontogenic factor is developed through the early family experiences. These have been established by the author to represent an important factor used to determine the level of a woman's psychological distress in adulthood.

The *microsystem* explains the immediate context of the abuse; this usually involves a family member or an intimate relationship. The author explains that prior sexual abuse can cause vulnerability to repetition of abuse in two ways:

- factors that may lead to increased contact with potential perpetrators such as increased sexual activity in adulthood, impaired ability to judge risky situations or people, dissociative disorder, stigmatization, and low self-esteem; and
- factors that increase the likelihood that perpetrators will choose to act aggressively. The author suggests that perpetrators are skilled at identifying indications of women's vulnerabilities; he also states that certain factors may contribute to the decrease of the woman's ability to respond assertively and effectively.

The *exosystem* is defined as the "formal and informal social structures such as work, neighbourhood and social networks" (p.6). In order to understand the exosystem, one must take into consideration the way that social power is developed, and how a woman's lack of power can contribute to her susceptibility to repetition. The exosystem focuses on the ways in which a woman's socioeconomic status, social isolation, and support system may contribute to her lack of power in society and, consequently, will put her at a higher risk of repetition.

The *macrosystem* is defined as representing "cultural values and beliefs that foster their influence on the other three systems" (p.6). The author identifies two main cultural beliefs that put women at a higher risk of repetition. They are:

- the blame placed on the victim; and
- the social construction of the good girl/bad girl.

These cultural tendencies have profound repercussions on a woman's life: whether it is concerning her recovery, or in the context of her liability that her exposure will lead to repetition of the abuse.

4. A Social Narrative Model

This theory sheds light on the intrinsic role that society plays in the perpetuation of sexual abuse. A social-narrative model is conducive to the comprehension of mediating factors in that they are not all results of individual pathologies, but are largely influenced by social factors. It is extremely important to incorporate this theory into your practice so that childhood sexual abuse stops being taboo and your clients start being validated for their experiences.

Lynn, Pintar, Fite, Ecklund, and Staffor (2004) developed a social-narrative model of dissociation which provides a further understanding of repetition. Dissociation has been labelled a functional defence mechanism: one which outlives its usefulness and becomes a persisting dysfunctional symptom of abuse and it "arises as a result of the social conditions in which victims live and are abused, and as a reflection of intolerably conflicted social relations" (p. 170). The conflicting or dissociative social relations are the central focus of this model. This model focuses on contradictory or dissociated social relations, rather than being centered on locating dysfunctional dissociation in the individual.

There are contradictions between the explanation as related to the personal experience of a sexually abused child, and the other meaning associated with the dominant social narrative: traumatic interpersonal violence is a contradiction of cultural

norms as expressed in shared social narratives (p. 170). For example, children experience childhood sexual abuse in isolation because they do not see their reality mirrored in their classroom, their neighbourhood, in cartoons, or in books. This extreme discrepancy between personal narratives and a shared social narrative is called “*social incoherence*”; this is not a situation in which the problem stems from a woman’s cognitive expectations. Essentially, society’s expectations do not match those attributable to women who have experienced sexual abuse. Therefore, the woman is limited in her ability to recover if the dissociated social conditions remain.

Conclusion of Section I

When explaining repetition of sexual abuse to your client, it is always imperative that you emphasize that the mental health effects are a result of her trauma, and that there are a variety of societal factors that contribute to the continuation of her abuse. This will ensure that your client does not internalize the ‘blame the victim’ mentality that is often present in our society. Also, she will feel more empowered by the understanding that she has some control over her recovery, as treatment can help to heal the effects of her abuse. Additionally, by having an open dialogue about childhood sexual abuse and repetition, your clients will no longer experience social incoherence.

Section III:

Theoretical foundations in an Eclectic Approach

While it is important to work eclectically in a prevention program for repetition of sexual abuse, it is imperative to always make working relationally with your client the

core of treatment. In order for your client to feel safe and secure, they will need to take the time to build a secure attachment with you, which in itself will be healing.

Object Relations Therapy

Object Relation Theory is an ideal premise for working with women with repetitious experiences (Carey, 1997). This relational model that establishes relational configurations as the foundation of existence in that all human behaviour and experiences are relationally derived (Cashdan, 1988). Counsellors who are grounded in this theory attest that people are “interpersonally motivated, using interpersonal defences to protect attachment with significant others” (Carey, 1997). Children develop their most significant attachment through “object relatedness”, which signifies self-other patterns. Additionally, children seek to protect this attachment: therefore, in a situation in which they are subject to sexual abuse, the child-victim internalizes the abuse and begins to blame herself. This situation causes an “object relation disturbance”, which in turn prompts maladaptive interpersonal behaviours and perceptions in the child’s life. Ultimately, this can be the root of the child’s behaviour; it can cause the child to carry similar distorted beliefs into adulthood which can lead to repetition and re-enactment.

When implementing this theoretical perspective in treatment, it is important to consider and facilitate three main propositions during counselling sessions. They are as follows (Carey, 1997):

1. Facilitate the development of a healthy therapeutic attachment in which empathy, respect, and collaboration should exist.
2. There should be an emphasis on the dynamics of re-enactment, and how you should consider this aspect both inside and outside of the counselling relationship.
3. In the process of such a re-enactment, you should set clear boundaries with the woman and be observant of signs indicative of a self-destructive relationship.

It is necessary that you facilitate interpersonal awareness through the preferred means of emphasizing attachments more than the confrontation of interpersonal awareness. Also, it is your responsibility to facilitate gradual recognition of interpersonal defences. In order to understand what motivates your client and how she views herself, you need to understand how relationships are internalized and how she became transformed into a sense of self (Cashdan, 1988).

Resiliency Theory

Studies show that some children that were sexually abused in their childhood seem more resilient and do not re-experience the abuse throughout their life. Also, not all children exposed to high degrees of trauma have negative developmental outcomes (Shulman, 1999). Children that are resilient to repetition seem to have characteristics in their environment that may reduce the risk of repetition (Liem et al., 1997). Resiliency seems to arise from the interaction between “heritable factors, individual characteristics and experiential factors over time (Collishaw et al., 2007). Some definitions of resiliency are as follows:

- A combination of innate personality traits and environmental influences that serves to protect individuals from the harmful psychological effects of trauma or severe stress, enabling them to lead satisfying and productive lives (Bogar et al., 2006:319)
- The capacities to prevail, grow, be strong, and thrive despite hardship (Liem et al., 1997:595).

Shulman (1999:68) outlines Rak and Patterson’s *Buffering Hypothesis* which are factors that might provide protection against life events. They are as follows:

- Personal characteristics of the child – the ability to gain others’ positive attention from childhood.

- Family conditions – focused nurturing during the first year of life, and little prolonged separation from the child's primary caregiver. In other words, the child had a secure attachment with their primary caregiver.
- Supports in the environment – for example, role models, such as teachers, school counsellors, mental health workers, neighbours, and/or clergy.
- Self-concept factor – having the capacity to understand self and self-boundaries in relation to long-term family stressors.

Resiliency theory provides insight into skills that your clients can develop which can help reduce the risk of repetition of sexual abuse. This can include developing a secure attachment with significant others, developing a healthy social network, maintaining health and spirituality, building self-esteem and self-worth, and having the ability to be assertive and set healthy boundaries to name a few.

Conclusion of Section III

Using Object Relations Therapy and Resiliency theory will provide you with a foundation for work with women who have experienced childhood sexual abuse and repetition. However, individual therapy will not be sufficient for your clients to fully heal from the abuse. The next section outlines a variety of treatment implications when implementing this program in your work with this population of women.

Section IV:

Treatment Implication

In this program, you should use an eclectic approach when working with women who have experienced childhood sexual abuse and repetition. While using an eclectic approach, the foundation of the program must include working relationally with your client in individual therapy. This focus should continue throughout groups and

workshops. Essentially, the practice of working relationally provides consistency throughout the eclectic approach. Here are some implications for treatment and prevention of repetition:

The Relationship

First and foremost, it is imperative to establish a secure counselling relationship with your client. In this relationship, always be aware of the transference that is occurring in the sessions and begin addressing these issues with your client.

Individual, Group, and Workshops

Individual counselling should be the first course of treatment. Once the client feels safe and secure within the individual relationship, they should start participating in support groups where they will obtain validation and support for their experiences and work towards dispelling the social incoherence. This will begin the process of building a healthy social network so that the women are no longer isolated in their experiences. Through this renewed connection with others, women rebuild their psychological senses that were damaged or deformed by the traumatic experience (Herman, 1997). It is also recommended that clients attend psycho educational workshops that will provide information about childhood sexual abuse and repetition; these will also address a variety of issues that affect women who have had these experiences. Some topics that should be covered in groups and workshops are:

- the recovery process;
- emotions – ex. Anger;
- Addiction;
- assertiveness;

- boundaries;
- self-esteem/self-worth;
- core beliefs;
- identifying patterns;
- flashbacks and triggers;
- safety;
- self-care;
- perpetrators;
- healthy relationships; human rights; importance of self-care; self-esteem;
- socialization.

It is important to tailor the direction of treatment to fit the needs of your individual client.

Long-Term Treatment

It takes time to build trust and safety within the counselling relationship. Once this relationship is established, your clients will be ready to branch out and participate in other aspects of the program, such as group therapy and workshops. This process needs time so it is recommended that this program be no less than two years.

Presenting Issues versus Mediating Factors

There is an overdetermination of presenting issues and mediating factors. Also, clients will often present with issues that differ from the factors that mediate repetition of sexual abuse. As the relationship with your client develops, mediating factors will begin to surface and they can potentially provide you with answers to what issues have been contributed to repetition of sexual abuse. This phenomenon is extremely complex and there is often an over determination of presenting issues and mediating factors. It is important to expect that there will be mediating factors that extend beyond the presenting issues.

Critique of the DSM IV and the Medicalization of Women

When implementing this program with women who have experienced childhood sexual abuse and repetition, it is important to encompass a critical analysis of the DSM IV. This includes an understanding of the literature that critiques and deconstructs the theories that explain mental health effects of childhood sexual abuse such as PTSD, depression and dissociation. Also, counsellors must be aware of the ways in which traditional psychiatric and psychological approaches label women with mental illnesses when they are really experiencing the effects of trauma. Counsellors need to have an understanding that with a firm focus on the individual in treatment, the public does not have to look at the societal context in which the violence against women is perpetuated. In essence, the focus is taken from the real issues of oppression, patriarchy, and violence against women, and it is placed on the individual woman.

iii. Conclusion

This chapter presented a workshop for professionals that outlined a psycho-social prevention program for repetition of sexual abuse. The program is divided into three sections. The first section explained repetition of sexual abuse and the factors involved in the continuation of this phenomenon. Specifically, *Section I* looked at the psycho-social nature of repetition. Next, *Section II* discussed attachment theory, mediating factors, Grauerholz's ecological approach to repetition of sexual abuse, and a social narrative model. While this prevention program model takes an eclectic approach to prevention of repetition, *Section III* outlines object relations therapy and narrative therapy as two theories to utilize as a foundation for this program. Finally, *Section IV* provides

treatment implications to be used in practice. Included in this section is an emphasis on the fact that counsellors must embody a culturally sensitive approach and must always understand that poverty is a fundamental mediator. This program continually emphasizes the importance of working relationally with this population of women.

This chapter summarizes a workshop for counsellors that outline a prevention program model that, when implemented, should be expanded to include handouts and a more in-depth analysis of the treatment implications. This workshop should be divided into a five days with three of the five days being dedicated to 'Section III: Theoretical Foundations' because this section, counsellors will learn about relational trust and resiliency theory which is the foundation of this eclectic program. See 'Chart 1: Program Schedule' below for details:

Chart 1: Program Schedule

Day 1:

- a) Introduction
- b) Section I – The Psycho-Social Nature of Repetition
- c) Section II – Mental Health Effects of Repetition and the Many Levels of Repetition of Sexual Abuse.

Day 2-4:

- a) Section III – Theoretical foundations in an Eclectic Approach: Object Relations Theory and Resiliency Theory.

Day 5:

- a) Section IV – Treatment Implications
- b) Advocacy Strategies
- c) Conclusion

Also, this program should not be the only training counsellors receive on working with women who have repetitious experiences. This workshop should be the beginning of

much more advanced and ongoing training that is needed when working with women who have experienced childhood sexual abuse and repetition.

Chapter 8: Conclusion

The purpose of this exploratory study was to examine the role of mediating factors in women's experiences of repetition of sexual abuse. Also, this study sought to compile information about repetition and mediating factors in order to develop an outline of a psycho-social prevention program that counsellors can use in their treatment of women who have experienced childhood sexual abuse and repetition. This information was compiled through thirteen (13) interviews which were conducted with counsellors in Ottawa as well as through the information collected from current literature on repetition of sexual abuse. Grounded theory was used to conduct this research and in analyzing the data.

The pervasiveness of sexual abuse among women and girls is high all around the world. It has been reported that 20 percent of adult women and a wide range of girls will experience some form of sexual abuse (Draucker, 1998; Doll et al., 2004). Additionally, the mental health effects of childhood sexual abuse have been well documented throughout the literature (Messman-Moore et al., 2002). Miller et al. (2006) report mental health effects occurring around safety, trust, power, and self-esteem. For many women, the abuse does not stop after childhood. Studies show that women who are sexually abused during childhood are two to three times more likely to re-experience sexual abuse in their adolescence and/or adulthood. Furthermore, these women are more likely to experience other forms of abuse in their relationships.

Repetition of sexual abuse is a complex phenomenon with many contributing factors, both social and psychological in nature. The literature revealed some mediating factors that either provoked or impeded repetition of sexual abuse (Banyard et al., 1996;

Sandberg et al., 1999; Kessler et al., 1999; Merrill et al., 1999; Arata, 2000; Noll et al., 2000; Messman-Moore et al., 2002; Noll et al., 2003; Rich et al., 2004; Casey et al., 2005). These factors included: resiliency, post-traumatic stress symptoms, dissociation, alcohol and substance abuse, shame, and the severity of the original abuse. However, there is a gap in the literature that defines and explains mediating factors and their roles in repetition of sexual abuse. This gap extends more practically in that counsellors seem to lack a clear understanding of mediating factors and their role in repetition of sexual abuse.

Due to the vast amount of literature confirming the prevalence of repetition, many studies recommend developing a prevention program for women with these experiences (West et al., 2000; Grauerholz, 2000; Gold et al., 1999); however, very few studies were found that did so. Some programs that were found provided short-term workshop type programs (Hanson et al., 1993; Marx et al., 2003); though this study found that short-term treatment would not be sufficient in reducing repetition among women with childhood sexual abuse experiences. Instead it was found that long-term individual counselling is needed. Once the relational trust is established, these women should then participate in groups and workshops to compliment their individual counselling. In accomplishing this goal, counsellors need to obtain more advanced training and embody more congruent lines of thought about trauma so that women accessing services receive clear information about repetition of sexual abuse. As it stands now, many women who are experiencing repetition feel as though there is something inherently wrong with them and often lose hope that change can occur.

In this study, a social constructionist framework combined with attachment theory, object relations theory, a social narrative model, and an ecological approach to repetition has allowed for an in-depth analysis into the complexity of repetition. Attachment theory provided insight into the integral role that a child's primary caregiver has in her early development. For example, a child who has a secure attachment with her primary caregiver will often show more resiliency to the repercussions of childhood sexual abuse (Liem et al., 1997; Bogar et al., 2006). Also, object relations therapy emphasized the importance of understanding a woman's relationship with their primary caregiver and the ways in which these dynamics will play out in the therapeutic relationship. A social-narrative model provided insight into the ways in which repetition is the result of dissociated or conflicting social relations that were not represented in one's personal experience. Finally, an ecological approach took into account power relationships and views repetition as the result of bio-psycho-social factors. Throughout this study it became clear that using a variety of theories to understand repetition is imperative. Due to the complexity of this phenomenon, there is no one theory would provide a complete analysis of this problem. In a sense, the theory can become a psycho-social eclectic approach to understanding and analyzing repetition of sexual abuse.

The findings in this study supported the working hypothesis outlined in Chapter 4: Research Methodology, which is as follows:

This research study is founded on the presence of factors that mediate between childhood sexual abuse and sexual abuse experienced in later adolescence and/or adulthood. These mediating factors place women who have experienced childhood sexual abuse at a greater

risk of repetition of sexual abuse. According to [this] working hypothesis, professionals who work with this population of women use various counselling strategies to reduce the risk of repetition; a compilation of these strategies would be useful in the development of a prevention program model which would be valuable in the treatment of women who seek to prevent repetition of sexual abuse.

Every counsellor interviewed in this study reported that repetition of sexual abuse is a common occurrence among their clients who have experienced sexual abuse in their childhood. However, even though the counsellors confirmed the prevalence of repetition, some had difficulty discussing this phenomenon out of concern that they might be expressing the 'blame the victim' mentality that is often portrayed in society. This fear has actually prevented counsellors from including an open dialogue about repetition with their clients which becomes problematic because it re-establishes the social incoherence often experienced throughout the clients life.

Numerous psychological and social mediating factors were identified. This revealed the complexity of repetition of sexual abuse and the importance of identifying factors that mediate a woman's experiences of repetition. Also, a variety of presenting issues were discussed and it became clear that counsellors need to look beyond the presenting issues and identify the mediating factors to truly understand repetition. Moreover, it was found that there is no one specific factor that mediates repetition. This indicates that each woman's experience is individual and should be treated as such.

In this study emphasis was placed on the importance of counsellors working relationally with clients who are coming to treatment for experiences of childhood sexual abuse and repetition. Therefore, counsellors should ensure that at the core of the

prevention program is the establishment of trust and security. Once this relationship has been established, it was identified that women should begin to attend support groups and workshops on topics related to childhood sexual abuse and repetition.

In this study, it was found that it is imperative to continually work with a cultural awareness and to have an understanding of the integral role that poverty plays in mediating repetition sexual abuse. Additional efforts must be made in this respect, in particular because the implications of these unmet challenges ensue on women living in poverty who are not able to access long term counselling professionals in private practice. Frequently, counsellors with advanced training who can provide long-term, weekly therapy work in a private practice and charge a high fee which is not accessible for many marginalized women living in poverty. For women who are living in poverty and have to endure sub-standard living conditions in unsafe neighbourhoods and low paying jobs, counselling services are short term provided by frontline workers who have limited training.

In concluding this thesis, I have developed a much more sophisticated understanding of trauma and sexual abuse. When I began this study, my hope was to develop an outline for a psycho-social prevention program that could be delivered to clients in a short period of time. I recognized that many of my clients with childhood sexual abuse experiences were reexperiencing the abuse throughout their lives but programs addressing repetition remained a gap in our system. My hope was to bring this taboo topic to the surface and begin an open dialogue so that the confusion about this phenomenon would dissipate. The process of writing this thesis has provided me with insight into the complexity of this phenomenon which cannot be resolved in a simplistic way. This study, along with the

vast amount of literature on trauma and sexual abuse, has revealed my own need for advanced training which has since improved my work as a counsellor. I have also revised my programming to include modules on repetition and the psycho-social mediating factors. Furthermore, I am now doing more relation work with my clients and insuring that trust within the counselling relationship remains the foundation of our work. My hope is that the outline for the psycho-social prevention program can be further developed and delivered to professionals so that they can understand the importance obtaining more advanced training on trauma. However, the process of planning for and developing inclusive services that meet the needs of all women in this group is a difficult task and will require the efforts of a variety of counsellors, agencies and funders.

Recommendations for Further Research and Practice

While research reveals the prevalence of repetition among women who have experienced childhood sexual abuse, very little literature exists that provides theories about the cause of this phenomenon, and no research was found that tests these theories. Literature needs to be expanded to include theories relating to the occurrence of repetition, and further studies must be conducted to test these theories. Although some prevention program models were found that address repetition of sexual abuse, this topic remains a gap in the literature. Further research needs to be conducted that looks at repetition of sexual abuse and prevention so that models can be developed and used in practice.

While there were mediating factors identified in the literature, no research has been conducted that examines the role that mediating factors can have in the prevention

of this phenomenon, therefore, research needs to be conducted in order to fill this gap. Also, all thirteen (13) counsellors in this study identified the importance of relational trust in therapy. Therefore, further research needs to be conducted that studies the role of attachment in the prevention of repetition and how the understanding of this aspect of their clients' childhood can be used in the counselling relationship in order to reduce the occurrence of repetition.

A prominent finding from the research indicates that counsellors working with this population of women need to acquire more advanced training. In Ottawa there are substantial challenges confronting women with childhood sexual abuse experiences in accessing advanced trained counsellors. This type of training is rarely available to front line workers and few of the counsellors are able to competently give their time and expertise to assist women who present the puzzling complexities of traumatic repetition. Expanding their understanding to the unique needs and challenges will assist counsellors in gaining a more in-depth understanding of repetition of sexual abuse and the bio-psycho-social factors that mediate their experiences which will help to reduce social incoherence. It is recommended that counsellors access training on object relations therapy and resiliency theory, which have both been identified as theories that can be the foundation of an eclectic approach to the prevention of repetition. However, funds must be provided to establish such training and counsellors must be allotted more time to work individually with their clients on a long-term basis.

Finally, it was found that poverty is an overarching mediating factor that can negatively impact all other mediating factors increasing the likelihood that women who were sexually abuse in their childhood will experience repetition. Therefore, more

research needs to be conducted that examines the role poverty plays in women's experiences of repetition of sexual abuse. Also, counsellors need to develop culturally sensitive programs for marginalized women, taking into account issues perpetuated by poverty.

Role of this Study in the Literature

This study contributed to the growing body of literature on repetition of sexual abuse, mediating factors, and the prevention of this phenomenon. By conducting such research, women who are experiencing, or at risk of experiencing, repetition of sexual abuse will have a better chance of understanding and reducing the occurrence. Also, counsellors working with this population will have further direction in their counselling practice.

9. Departmental thesis review: *Indicate if your thesis proposal has been reviewed by the appropriate departmental committee.*

☐ Not applicable for this project

☒ No, expected date of review (dd/mm/yyyy): 01/16/2008

☐ Yes, documentation attached

My thesis second reader, Prof. Therese Jennissen, is on sabbatical until January 2008, an advance draft of my proposal has been reviewed and approved by my supervisor Prof. Cecilia Taiana.

DECLARATION and SIGNATURES:

I declare that the project information provided in this application is accurate. I agree to conduct the research in accordance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, the *Carleton University Policies and Procedures for the Ethical Conduct of Research* and the conditions of approval established by the Carleton University Research Ethics Committee.

Signature of Researcher Date

Signature of Researcher Date

Signature of Researcher Date

Signature of Researcher Date

Signature of Supervisor (if applicable) Date

10. SUMMARY OF RESEARCH PROJECT: *Use plain language to briefly describe the research (approx. 100 words.) Avoid jargon and language exclusive to your field of research.*

Research studies have indicated that women who have been sexually abused during their childhood are 2-3 times more likely to be sexually abused in their adolescence and/or adulthood. This phenomenon is called re-victimization (Rich, Cindy L. et al., 2004; Casey, Erin A. et al., 2005).

As a counsellor who works with women who were sexually abused during their childhood, I have observed that traumatized clients expose themselves to situations reminiscent of the original trauma. Other forms of non-sexual abuse and abusive relationships are also overrepresented in these women's lives. Furthermore, women who have been sexually abused in their childhood are at a higher risk of developing Post Traumatic Stress Disorder (PTSD), depression, addiction(s) and/or develop inappropriate sexual behaviours (Follette, Victoria M. et al., 1996; Arata, Catalina M., 2000; Sandberg, David A. et al., 1999).

This study has two objectives:

- *To review current literature on re-victimization, re-enactment and repetition for the purpose of identifying mediating factors that might lead to repetition of abuse.*
- *To identify common therapeutic strategies used by counselling and/or social work professionals with their clients who have experienced repetition of abuse in their adolescence and/or adulthood.*

Using the findings of this research, I will develop a prevention program model that will provide women with the knowledge and skills that they may use in preventing repetition of abuse before it occurs. It is my hope that this program will empower women.

11. AGENCY PARTICIPATION:

Will the agency play an active role in the project? ☐ Yes ☒ No

If you answered **yes**, please explain that role in detail (50 words)

12. PARTICIPANTS:

Participants are: (mark all that apply)

- ☐ Aboriginal peoples
- ☐ Immigrant groups
- ☐ Marginalized group
- ☐ Children (underage of 18)
- ☐ Senior citizens
- ☐ Incarcerated persons
- ☒ Professionals
- ☐ Patients or residents of a long-term care facility
- ☐ Other, specify: _____

Participants Gender: (mark all that apply).

- ☐ Male × Female ☐ Transgendered
☐ Not applicable (ex. random sampling where gender is not an issue)

How many participants in the project?

There will be 10-12 counselling and/or social work professionals participating in this research.

Participants will be contacted by: (mark all that apply)

- × Researchers ☐ Agency ☐ Other, specify:

13. RECRUITMENT: Explain how participants will be located and approached. *Example: by phone, advertising, mailing list, snowballing, etc. (25-50 words).*

The professionals in this study will be recruited from various social services agencies and private counselling practices throughout Ottawa. I will phone potential research participants and provide oral and written information about the research.

Please see the Letter of Information in Appendix A.

SPECIAL CONCERNS: Some participants may face circumstances that require special attention and handling, please detail these

NOTE on ADVERTISING: If advertising your project, please submit a copy of the advertisement with your application.

NOTE on CHILDREN: If you are working with children, under the age of 18 (Ontario law) parental or legal guardian consent will be required. Therefore submit a letter of information and consent form for the parent or legal guardian. In some cases parental or legal guardian consent is not possible. (See Guidelines for more information).

14. REQUIREMENTS OF PARTICIPANTS: (mark all that apply).

- ☐ Brief survey/questionnaire (mail out or hand out)
- ☐ Brief survey/questionnaire conducted in person
- ☐ Brief interview (10-30 minutes)
- × Long interview (over 30 minutes)
- ☐ More than one interview (several small or longer interviews)
- ☐ One interview with a follow-up to verify information
- ☐ Observation in workplace, home, etc.
- ☐ Participatory Action Project
- ☐ Other:

15. RISK LEVEL TO PARTICIPANT:

- × The risk level is minimal
- ☐ The risk level is mid-range

- ☐ The risk level is high
- ☐ The risk level is unknown

Please use this section to explain the risk level and why it is being assessed at a certain level (50-100 words).

Minimal risk level:

I will interview 10-12 counselling and social work professionals who work with women who experienced repeated abuse throughout their adolescence and/or adulthood. While the discussion on sexual abuse is distressing, this is nevertheless a topic these professionals deal with on a daily basis when working with their clientele. As a common rule, counsellors and social workers regularly seek support through their place of employment in order to better cope with the vicarious trauma to which they are exposed through their work. My interview guide will not go beyond a discussion of the skills they use to do their work every day.

16. MITIGATING RISK: For projects that have an element of risk, provide a brief description of the risk and what steps you will take to mitigate it. If you indicate "unknown" explain why an assessment cannot be made at this time. (50-100 words)

To further minimize risk, I will offer each professional anonymity and confidentiality. I will ask them to avoid using names or any descriptive information that might directly identify the client whose experience is being discussed. Responses will remain anonymous and their answer will not be attributed to them in the interview summary final thesis.

COUNSELING: If you are offsetting risks by providing independent counseling to participants please note it is the practice of the School of Social Work to provide participants with a letter from an agency or councilor indicating that they will provide free counselling services. **Attach a copy of this letter with your application.**

17. DANGEROUS OR ILLEGAL ACTIVITY:

- × This study will not reveal dangerous or illegal activity.
- ☐ This study may reveal dangerous or illegal activity.

NOTE: If participants reveal dangerous or illegal activity to you during the course of the research you are obligated to report such matters to the appropriate officials. *Example: child abuse, suicidal thoughts or behaviour, etc.*

18. ANONYMITY AND CONFIDENTIALITY:

- ☐ Participants will not be offered anonymity and confidentiality.
- × Participants will be offered anonymity and confidentiality.
- ☐ Participants will not be offered anonymity but will be offered confidentiality in that no responses will be directly associated with them.

19. BENEFITS:

- ☐ Participants will not directly benefit from the research project.
 × Participants will directly benefit from the research project
 (Explain the benefits).

Summary of benefits (25 words) NOTE: Do not promise what you cannot deliver.

Repetition of sexual abuse is a common experience for many women. Through this project, professionals will be able to identify various therapeutic strategies that social workers and counsellors are currently using in preventing further re-victimization. Furthermore, a prevention program model will be developed combining a variety of therapeutic strategies which address the unique needs of women who have experienced or are at risk of experiencing repetition of sexual abuse. Copies of the program model will be offered to all participants.

20. AUDIO OR VIDEO TAPING:

- ☐ Participants will not be audio or video-taped
 × Participants will be recorded: × Audio taped ☐ Video
 taped

I will ask consent to audio tape the interview. If the participant does not consent to audio taping the interview, I will ask for their consent so that I can take written notes.

21. INFORMED CONSENT:

- ☐ Consent is implied (applies to surveys and questionnaires)
 × Written consent is being sought
☐ Oral consent is being sought
☐ Third party consent

Please see Letter of Informed Consent in Appendix B.

ORAL & THIRD PARTY CONSENT: Describe the steps you propose for obtaining consent.

22. REMUNERATION:

- × Participants are not being remunerated
☐ Participants are being remunerated

The remuneration involves:

- ☐ Payment of money, the value of which is:
☐ Presentation of a gift, the value of which is:
☐ Free service, which is:
☐ Other, specify:

23. SAFEGUARDING DATA: Explain what steps you will take to protect the data you are collecting. For example; consent forms, interview materials (tapes, notes & transcripts) and survey sheets must be stored in a locked filing cabinet that only you or the research team has access to. In the case of electronic data the computer system should be and access limited to you or the research team members.

Data will be kept in a locked safe accessible by the researcher only. All electronic data will be stored on a memory stick that will only be accessible to the researcher.

24. DISSEMINATION: (mark all that apply).

- ☐ Participants will receive a copy of the project results or conclusions.
- ☐ The agency will receive a copy of the project results or conclusions.
- ☒ The university and/or course professors will receive a copy of the project results or conclusions.

25. OWNERSHIP OF RAW DATA:

- ☐ Participants will receive the raw data for their own use (applies to PAR projects).
- ☐ The agency will receive the raw data for their own use.
- ☐ The course professor(s) will receive the raw data for their own use.
- ☒ The researcher or research team will receive the raw data for their own use.
- ☐ The raw data will be destroyed.
- ☐ Proposed date of destruction of raw data:

I will inform the participants and request permission to re-use the data.

NOTE: Should an agency change how it intends to use the raw data during a research project, the participants must be informed of this and consent to the changes. Researchers cannot control what happens to raw data held by an agency after the conclusion of a project.

26. RESEARCH INSTRUMENT: Attach a copy of the questions, survey, themes, etc.

Please see a copy of the questions in Appendix C.

SPECIAL CONSIDERATIONS:

27. FOR DATABASE WORK/ACCESS TO PRIVATE INFORMATION:

Will you have access to private personal information contained in files or databases?

☐ Yes ☒ No

If you answered **yes**, please indicate what assurances of confidentiality the host agency requires of you. (Example: A letter from the agency indicating that you will have access to the private data).

NOTE: DO NOT sign a letter of confidentiality without first consulting with your supervisor. A Letter of Confidentiality is sometimes required by an agency or business when private information is being shared with an outsider. Generally such letters of agreement will bind the researcher to certain regulations regarding what information can be used and what cannot be used.

IMPORTANT: Some letters may include a statement about the ownership of any raw data collected by a researcher. Be careful about who owns the raw data and results.

Letter of Information

Dear Madam;

I am conducting a study for my MSW thesis that seeks to know more about the subject of repeated experiences of sexual abuse and how to best respond to these clients in treatment. As a part of this study, I would like to collect valuable contributions of counsellors and/or social workers who have experienced working with this group of clients. I am writing this letter to recruit counselling and/or social work professionals who have worked with this clientele for a minimal period of three years.

This study has two objectives:

- To review current literature on repeated experiences, re-enactment and repetition or sexual abuse, for the purpose of identifying mediating factors that might lead to repetition of abuse.
- To identify common therapeutic strategies used by counselling and/or social work professionals with their clients who have experienced repetition of abuse in their adolescence and/or adulthood.

Using the findings of this research, I will develop a prevention program model that will provide women with the knowledge and skills that they may use in preventing repetition of abuse before it occurs.

Using the findings of this research, I will develop a prevention program model that will provide women with the knowledge and skills that they may use in preventing repetition of abuse before it occurs.

Procedures

The data for this study will be collected through one interview that will last approximately one hour. Interviews will take place at your place of employment. If this is not convenient, we will establish another location prior to the interview date. During the interview, I will ask you questions relating to your work with clients who, as children, experienced sexual abuse. My particular interest is to understand the reasons for re-victimization in adolescence and/or adulthood for the purpose of developing a preventive program that would empower women in this situation.

The interview will be audio taped with your consent. Audio taping the interview will then permit me to transcribe your answers to the questions for data comparison. If you do not consent to audio taping the interview, I will ask for your consent so that I can take written notes.

Benefits

Repetition of sexual abuse is a common experience for many women. Through this project, professionals will be able to identify various therapeutic strategies that social

workers and counsellors are currently using in preventing further re-victimization. Through this project, a prevention program model will be developed combining a variety of therapeutic strategies which address the unique needs of women that have been sexually abused in their childhood and then experienced or are at risk of experiencing repetition of sexual abuse. If you would like to receive a copy of the prevention program model, I will send you one upon the completion of my thesis.

Risks, Stress or Discomfort

I will be asking you questions about your work with a clientele who were sexually abused in their childhood and experienced repeated abuse throughout their adolescence and/or adulthood. While the discussion on sexual abuse is distressing, this is nevertheless a topic with which you, as a professional, deal with daily when working with this clientele, therefore, I anticipate a minimal risk level for this project. If you feel otherwise, please express your concern to me.

At any time during the interview, you have the right to refuse to answer a question. Also, you may withdraw your agreement to participate at any time during the study and have data withdrawn without reprisal.

Your participation is on a voluntary basis and will not involve any financial compensation.

Confidentiality

All data and information collected will be kept anonymous and you will not be identified by name. In addition, all quotes from your interview will not be attributed to you. Raw data and information will only be available to myself and Prof. Cecilia Taiana, my thesis supervisor. All data and information will be stored in a locked safe to which I alone have access. Any electronic data and information will be kept on a memory stick that will only be available to the researcher. All identifiers in my notes and on the audio tape will be removed. You will only be identified by your profession and years of experiences.

The data collected in this research study may be used for future projects. You would be contacted and asked for your consent beforehand if the data were to be used again.

Security of Data

All data will be kept in a locked safe that is stored at my home and accessible only by me. All electronic data will be stored on a memory stick that only I will have access too.

Dissemination

The findings from this research may be used in one or two scholarly articles and for presentation at social work conferences.

Consent Form

Emily Bain is conducting a study for her MSW thesis that examines counselling skills used by counsellors who work with women who were sexually abused during their childhood and who have re-experienced sexual abuse in their adolescence and/or adulthood.

This study has two objectives:

- To review current literature on re-victimization, re-enactment and repetition, for the purpose of identifying mediating factors that might lead to repetition of abuse.
- To identify common therapeutic strategies used by counselling and/or social work professionals with their clients who have experienced repetition of abuse in their adolescence and/or adulthood.

Using the findings of this research, Emily Bain will develop a prevention program model that will provide women with the knowledge and skills that they may use in preventing repetition of abuse before it occurs.

Procedures

The data for this study will be collected through one interview that will last approximately one hour. Interviews will take place at my place of employment. If this is not convenient, Emily Bain and I will establish another location prior to the interview date. During the interview, Emily Bain will ask me questions relating to my work with clients who, as children, experienced sexual abuse. Emily Bain's particular interest is to understand the reasons for re-victimization in adolescence and/or adulthood for the purpose of developing a preventive program that would empower women in this situation.

The interview will be audio taped with my consent. Audio taping the interview will then permit Emily Bain to transcribe my answers to the questions for data comparison. If I do not consent to audio taping the interview, Emily Bain will ask for my consent so that Emily Bain can take written notes.

Benefits

Repetition of sexual abuse is a common experience for many women. Through this project, I will be able to identify various therapeutic strategies that social workers and counsellors are currently using in preventing further re-victimization. Through this project, a prevention program model will be developed combining a variety of therapeutic strategies which address the unique needs of women that have been sexually abused in their childhood and then experienced or are at risk of experiencing repetition of sexual abuse.

☐ I would like to receive a copy of the prevention program model.

☐ I would not like to receive a copy of the prevention program model.

Risks, Stress or Discomfort

Emily Bain will be asking me questions about my work with a clientele who were sexually abused in their childhood and experienced repeated abuse throughout their adolescence and/or adulthood. While the discussion on sexual abuse is distressing, this is nevertheless a topic with which I, as a professional, deal with daily when working with this clientele, therefore, risk level is anticipated to be minimal for this project. If I feel otherwise, I will express my concern to Emily Bain.

At any time during the interview, I have the right to refuse to answer a question. Also, I may withdraw my agreement to participate at any time during the study and have data withdrawn without reprisal.

My participation is on a voluntary basis and will not involve any financial compensation.

Confidentiality

All data and information collected will be kept anonymous and I will not be identified by name. In addition, all quotes from my interview will not be attributed to me. Raw data and information will only be available to Emily Bain and Prof. Cecilia Taiana, Emily Bain's thesis supervisor. All data and information will be stored in a locked safe to which Emily Bain alone has access. Any electronic data and information will be kept on a memory stick that will only be available to the Emily Bain. All identifiers in Emily Bain's notes and on the audio tape will be removed. I will only be identified by my profession and years of experiences.

The data collected in this research study may be used for future projects. I would be contacted and asked for my consent beforehand if the data were to be used again.

Security of Data

All data will be kept in a locked safe that is stored at Emily Bain's home and accessible only by her. All electronic data will be stored on a memory stick that only Emily Bain will have access too.

Dissemination

The findings from this research may be used in one or two scholarly articles and for presentation at social work conferences.

Contact Information

This research project has been reviewed and has received ethics clearance by the Carleton University Research Ethics Committee.

Appendix B**Interview Guide**

1. Age: 18-35 26-35 36-45 46-55 56-65 66-75 76-85 86-95
2. Number of years working with women who have experienced childhood sexual abuse:
3. Just so were on the same page, I'm going to read out some definitions of Repetition of sexual abuse. Definition of Re-victimization or Repeated victimization:

Repetition is...

"[Repeated experiences of sexual abuse] later in life OR the participation in a relationship that re-enacts the physical, sexual or emotional abuse that was suffered in childhood." (Kessler, Bonnie L. et al., 1999: 335)

"[Repetition of sexual abuse] was defined as having experienced childhood sexual abuse and a separated incident of sexual abuse in adolescent/adult victimization." (Arata, Catalina M. 2000: 28)

4. *Some research suggests that childhood sexual abuse is the strongest predictor of adult sexual abuse.*
(Doll, Linda S. et al., 2004: 5).

Based on your experience, do you consider this to be true in your work with women who have experienced sexual abuse?

5. **Do you recognize repeated experiences of abuse as a common occurrence in your clients who have experienced childhood sexual abuse?**
If yes, what does this look like and can you give examples:
6. **Do you address these experiences of repetition in your work?**
If yes, Please elaborate on how you address repeated experiences of sexual abuse:
7. **What do you think are the presenting issues these clients have?**
8. **What are some of the pre-existing/mediating factors you believe are linked with these experiences of sexual abuse?**
What was the state of affairs for that woman prior to coming to see you?
NOTE: This alludes to vulnerability – Ex. She was assaulted three times, but each time she was drunk

9. Do you use specific therapy models/techniques with these clients?

10. *You perhaps have noticed that I have used the language of repetition of sexual abuse during this interview. I have chosen this language throughout my thesis for the following reasons – Repetition vs. Re-victimization:*

- a. It more correctly describes the woman's experience – repeated experiences of sexual abuse.*
- b. The term re-victimization can be disempowering to women as it qualifies them as victims.*
- c. A term possibly indicative of a lack of control or lack of ability to change the pattern of abuse in one's life.*

11. If I were to develop a prevention program for women who have experienced repetition of sexual abuse, do you think it would be more beneficial in an individual, group or workshop setting? Or a combination of two of these?

12. In the literature some prevention programs were found that incorporated a theoretical perspective into the treatment – Ex. Cognitive Behavioural Therapy, Psychodynamic theory, Spiritual Approaches. Is there a theoretical lens you would recommend in a prevention program?

13. Or, would you recommend using more than one theoretical perspective. If so, what would they be?

14. What topics do you think should be covered in a prevention program?

15. If you could envision a prevention program, what would it look like?

16. Do you think many of the women are falling through the cracks in the system we currently have? Why?

Appendix C**Summary of
Categories and
Nodes**

Category	Sources	References
Repetition	13	23
Nodes	Sources	References
Yes	13	23
No	0	0
Category	Sources	References
Mediating Factors	13	204
Nodes	Sources	References
Alcohol and Drugs	8	11
Social Network	8	14
Poverty	8	14
Learning disabilities	1	1
Mental Health	13	126
Child Nodes		
Insecure attachment	7	12
Boundary issues	5	8
Dissociation	8	16
Fight, flight, freeze	2	4
Mental Illness	6	12
Perpetrator	12	29
PTSD	5	6
Safety	10	13
Self-esteem & Self-worth	9	17
Sexuality issues	6	9
Shame	6	11
Triggers	2	5
Nodes	Sources	References
Cultural Issues	10	39
Child Nodes		
Colonization & Residential Schools	1	6
Core beliefs/Belief System	8	16

		Gender inequalities	7	18
		Taboo	3	3
Category		Sources	References	
Presenting Issues		13	74	
	Nodes		Sources	References
	Addiction		7	8
	Anxiety		3	3
	Depression		5	5
	Eating Disorder		6	8
	Lack of support/Isolation		3	3
	Mental Illness		3	3
	Physical health problems		5	6
	Relationship problems		6	6
	Repetition of sexual abuse		3	4
	Self-esteem issues		4	4
	Sexual abuse		7	7
	Sexuality issues		5	8
	Triggers		5	6
	Violence		3	3
Category		Sources	References	
Therapeutic Approach: Techniques		13	58	
	Nodes		Sources	References
	Breathing/body work		3	4
	EMDR		5	6
	Experiential techniques		4	5
	Expressive therapy		11	13
	Gender psychotherapy		6	10
	Grounding techniques		4	6
	Instilling hope and recognizing strengths		7	10
	Identifying patterns		3	4
Category		Sources	References	
Therapeutic Approach: Theories		13	62	

	Nodes	Sources	References
	Cognitive Behavioural Therapy	7	10
	Client-Centered Therapy	3	5
	Feminist approach	4	7
	Inner-child work	3	5
	Mindfulness	3	5
	Narrative therapy	4	6
	Psychodynamic theory	4	7
	Solution-focused therapy	3	4
	Spiritual approaches	5	1

Category	Sources	References
Therapeutic Approach: Eclectic	13	17

	Nodes	Source	References
	One theoretical approach	0	0
	More than one theoretical approach	13	17

Category	Sources	References
Prevention: Content of Prevention Program	13	93

	Nodes	Sources	References
	Psychological counselling and program techniques	13	72

Child Nodes	Sources	References
Addiction	3	5
Assertiveness	5	5
Boundaries	5	5
Core beliefs	3	5
Identifying patterns	5	8
Flashbacks and Triggers	4	4
Importance of relational trust	13	45
Perpetrators	3	4
Healthy relationships	3	3
Human rights	3	3

		Importance of self-care	3	3
		Self-esteem	8	11
		Socialization	5	5
	Nodes:		Source	References
	Health and Nutrition		2	5
		Child Nodes		
		Biology	1	2
		Health	1	1
		Housing	1	1
		Nutrition	1	1
	Nodes:		Sources	References
	Resiliency and Recovery		8	16
		Child Nodes		
		Decision making	2	3
		Recovery process	2	2
		Resiliency	1	1
		Safety	7	8
		Self-defence	1	2
Category		Sources	References	
Prevention: Format of Delivery		13	42	
	Nodes		Sources	References
	Individual		11	16
	Group		11	14
	Workshop		6	6
	Dependant on recovery process		6	6
Category		Sources	References	
Prevention: Vision for Prevention Program		13	30	
	Nodes		Sources	References
	Activism		3	3
	Collaborative process		2	3
	Constant support		1	1
	Culturally sensitive		2	6
	Long-term treatment		7	11
	Mentoring program		3	3
	Phase model		4	6
	Public education		6	10
	Traditional		1	1

	Aboriginal ways Government-funded trauma centre	1	1
Category	Nodes	Sources	References
Gaps or Unmet Needs	13	42	
	Nodes	Sources	References
	Long-term therapy	5	7
	Funding and Adequate Services – Training of professionals, Programs for perpetrators, and Public education	8	24
	Child Nodes		
	Funding	4	11
	Perpetrators	1	1
	Professional training	5	10
	Nodes	Sources	References
	Increased Vulnerability of Marginalized Groups	7	11
	Child Nodes		
	Medicalization of women	3	3
	Oppression	6	8

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