CHAPTER 6

PSYCHOTHERAPEUTIC MODELS FOR ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

This chapter will focus on contemporary psychotherapeutic models that have been developed for adult survivors of childhood incest and sexual abuse. These models will comprise the fifth component of the treatment intervention developed and implemented in this study. Three trauma-focused treatment models will be discussed in detail as aspects from each of these models will be included in the psychotherapeutic process of the clients in this study. The shortcoming and strengths of each model is discussed.

The incest survivor may present a serious dilemma to therapists who have received training only in traditional models of psychotherapy (Meiselman, 1990). Some therapists even prefer not to counsel clients with abuse histories and refer them elsewhere. However, the focus of psychological research is on the client in therapy, not on the psychologists and their preferences in working with certain populations. Very few research studies include therapists' attitudes toward molested clients, while the scarcity of treatment models for adult survivors is as a result of a failure by practitioners to investigate existing abuse-focused interventions and developing new models.

The researcher suspects that psychologists may prefer not to counsel adult survivors of childhood sexual abuse, for reasons that may include:

a) the extent to which symptoms manifest differently intra-individually, which complicates treatment with this population (Chapter 2 to 4);
b) the co-occurrence of presenting symptoms that may require treatment, for instance a client may present a sexual dysfunction, depression, interpersonal conflict, and PTSD symptomatology (Chapters 3);
c) the controversy surrounding the validity of childhood sexual abuse memories (Chapter 5);
d) therapists may not feel competent to address such complex cases, or may simply have a preference for marriage therapy, sport or neuropsychology.

Descriptions of treatment interventions for adult survivors of sexual abuse date back to the mid-1970's although the focus of the treatment was primarily based on treating abused **children** and

families who were directly or indirectly involved in child abuse (Courtois, 1996). The treatment of **adult** survivors of incest and molestation was insignificant until the last few years (Courtois, 1996; Dale, 1999).

Many psychologists and counsellors specialising in treating survivors prefer to employ eclectic treatment approaches. Those interventions that document eclectic treatment modalities such as Courtois (1996), Draucker (1990), McCann and Pearlman (1990), and Meiselman (1990), generally employ principles of incest therapy and childhood sexual abuse that are based on the multitude of long-term consequences reported in clinical studies and those reported by clinicians with extensive experience in the field. These eclectic approaches import treatment strategies and procedures from cognitive-behavioural therapy, psychodynamic therapy, feminism, trauma models of therapy, object-relations theory, and self-development theory. Many of these models offer eclectic based *treatment guidelines* and *counselling procedures* and are not new treatment models, including the work of Hall and Lloyd (1989) and Salter (1995).

The majority of research studies did not investigate treatment interventions but the *consequences* of childhood abuse that persist into adulthood. More recently the need for specialised treatment interventions with this population has been recognised and received attention. These interventions suggest that sexually abused clients move through various stages in therapy as they deal with the abuse. The phase-oriented modalities divide the therapeutic process into discrete phases or stages. Each treatment model and the phases therein have particular treatment objectives or goals. Three of these stage-oriented models are discussed in this study, namely:

1) Kritsberg's (2000) three stage therapy,
2) Courtois' (1996) three-phased treatment plan, and
3) the cognitive-behavioural treatment intervention of Smucker and Dancu (1999), labelled 'Imagery Rescripting and Reprocessing Therapy' (IRRT).

Numerous abuse-focussed treatment models exist but only three will be discussed in detail for the purposes of this study. The treatment models of Kritsberg, Courtois and Smucker and Dancu are very comprehensive and address a) the therapeutic process, b) restructuring of faulty abuse related thoughts, and c) the management of negative affect. The additional five models do not introduce new data that has not already been described in the comprehensive discussion in these three models. The therapeutic strategies described in these models can be employed in the

hypnotic trance. Furthermore, the treatment strategies and guidelines depicted in these models can easily be integrated with the other four components of the treatment intervention designed for this study.

6.1 WAYNE KRITSBERG'S THREE STAGE MODEL

Kritsberg (2000) developed a three-stage model in which three stages of therapy overlap as the client progresses from one therapeutic stage into the next. Recovery from the abuse is non-linear and it is impossible to predict the length of time each person requires to make progress in any given stage. The time schedule is suited to each individual's healing needs and the stages of recovery therefore flow into one another. The three stages are illustrated in Figure 6.1.

Figure 6.1 Stages of Recovery (Kritsberg, 2000; p. 77)

Information concerning the abuse is gathered during the first stage of treatment by means of flashbacks, dreams, and clients' childhood memories. The appearance of these memories may result in feelings of fear, rage, grief, shame, hurt and disbelief. During this **first stage (Discovery)** the clients reflect on the manner in which the abuse affected their lives, including the difficulties they experienced regarding their emotional responses, relationships, personal goals and physical health. At this point the client may either resume or terminate the therapy, display resistance to the treatment or gradually come to accept the abuse.

During the **second stage**, the **Active Healing Stage**, healing and recovering from the abuse become the primary focus in the clients' life. The client may experiment with different methods of healing. The healing involves releasing built-up emotions, establishing personal boundaries, and learning self-nurturance. Kritsberg (2000) reports that one of the most important goals of the active healing stage is to establish ongoing support to the client. The client will begin to recognise specific clusters of symptoms and will continue healing them. This stage is a process that occurs over time and in cycles. Each healing cycle consists of four phases, namely, a) exposing the wound, b) re-experiencing the trauma, c) externalising the pain, and d) healing the wound.

Kritsberg (2000) uses imagery of an inner child to facilitate healing in these cycles. The client is requested to imagine two inner children as part of the past, the **wounded inner child** and the **magical inner child**. The wounded inner child represents the essence of who the client was at the time of the abuse. This wounded inner child carries the psychological defence mechanisms that prevent the client from healing and developing naturally. It is this child that re-experiences the trauma of the original pain and who is taught to externalise the pain. In contrast to the wounded inner child, the magical child is that part of the self that remains untouched by the sexual abuse. Kritsberg (2000) explains that it is the unwounded 'spirit' that is the essence of the magical child and has, as a birthright, the ability to experience happiness, joy, love, creativity and bliss. Clients are encouraged to *parent* their inner child and to externalise emotional pain through shouting, screaming, hitting pillows, crying and shaking. These techniques for externalising emotional pain are suggested as Kritsberg's treatment strategies are developed for professionals and for survivors of childhood sexual abuse. Other healing techniques and strategies include guided healing meditations for the hurt inner child, writing journals about the healing process, and creative colouring and artwork, letter writing and affirmations.

Integration (stage three) of the abuse experience is achieved and is the most gratifying stage of recovery. The client achieves a state in which the client is free from past abuse in the sense that it ceases to control the client's feelings and actions. Kritsberg (2000) explains to clients that they may then establish quality relationships with the kinds of people they enjoy having in their lives. During this stage clients reclaim their feelings, their history as well as the personal power that comes with confronting the past. Apparently it is not uncommon for clients to direct their energies toward spiritual activities during this time. This stage of integration can last for the rest of the client's life.

6.1.1 Critical review of Kritsberg's model

The treatment process follows logical steps and phases. Kritsberg's model is based on clinical experience and not research. The model can be put into practice by professionals, lay counsellors and by survivors of abuse who choose to embark on a healing journey alone. Although it does not emphasise the identification and reframing of specific cognitive errors generally made by abuse survivors, it offers numerous creative means in which survivors can express themselves emotionally. Kritsberg offers a variety of techniques ranging from creative

visualisations, dialoguing with the body, written expressions of emotions, inner child imagery, guided mediations, dream interpretations, use of affirmations, drawings and self-portraits. These forms of self-expression are practical as clients can select the activities that best suit their personalities.

The concept of tapping into the magical inner child may offer them hope for healing and remind them of their inner strength. However, Kritsberg does not explain alternate strategies if clients are unable to access the magical inner child. It is possible that clients abused at a very young age, by a few perpetrators over a period of many years, are able to find only their wounded inner child and not their magical inner child. Finally, clients who may consciously or unconsciously resist visualising would not be able to benefit from the wounded or magical inner child imagery.

6.2 TREATMENT APPROACH OF CHRISTINE COURTOIS

The eclectic treatment intervention implemented by Courtois (1996) integrated four distinct theoretical models, namely the feminist approach, the traumatic stress or victimisation model, a self-developmental paradigm, and loss theory. One of the most valuable contributions of Courtois's therapeutic approach is the emphasis placed on the manner in which clients in therapy may present abuse histories that primarily manifest themselves through disguised symptoms. Courtois (1996) provides a database of various behavioural, cognitive and emotional symptoms that clients may exhibit while failing to report their past abuse histories in therapy. Courtois asserts that, despite recent publicity, most survivors **do not** divulge their incest experience during the intake interview or early in treatment. The client may mention or display indirect behaviours that signal a history of incest to which the therapist must be sensitive and willing to consider and explore as a possibility of childhood incest. Courtois provides a comprehensive description of the dynamics of the pattern of silence these survivors display, symptoms of the disguised presentation and strategies followed in the treatment process. However, only clients who report abuse histories during the intake interview will be selected for this study.

As in Kritsberg's model, the therapy process consists of different stages, including: intake and diagnosis, building the adult relationship, working with the child within, integrating the helpless child with the nurturing child, disclosure to and confrontation of the family and others involved. Characteristics of each treatment stage are described below.

Stage 1: Intake and diagnosis

During the intake stage of therapy the therapist learns as much as possible about the client's presenting concerns or symptoms and their severity. Courtois (1996) explains that the therapist should assess the client's personality style and level of functioning. Information regarding the past abuse and its impact, as well as secondary elaborations and symptoms, should be gathered. During this stage Courtois's (1996) symptoms may become worse before they become better, and clients are instilled with hope as to their recovery.

Stage 2: Building the adult relationship

Courtois (1996) discusses two rules of thumb during this therapy phase, firstly, incest material should not be explored in any great detail if the client is experiencing a crisis, as this is likely to precipitate a new crisis, worsen the situation, or promote regression. Should this occur, crisis intervention strategies should be employed, aimed at stabilisation. This recommendation is similar to the treatment model described in the SARI model of hypnotherapy, which emphasises stabilisation during each phase of uncovering and addressing past traumatic traumas (Phillips and Frederick, 1995). Secondly, problems more severe or life-threatening than the incest take treatment precedence and should be managed before or simultaneously with any exploratory work. Establishing treatment priorities can be complicated as some conditions are not responsive to treatment until their functions and any secondary gains are uncovered. For example, anorexia or bulimia, self-destructive behaviours, addictions and compulsions may be resistant to treatment until the underlying dynamics, that may include self-hatred, the need for self-punishment, and identification with the aggressor, are uncovered and lessened. The client is provided with continued education about incest, its effects, and the recovery process in this treatment phase (Courtois, 1996).

Stage 3: Working with the child within

In stage 3, the therapist facilitates a process for the adult survivor to introduce the *child within* (inner child) into the treatment context. The supportive therapeutic relationship and environment allow for the adult survivor to reconnect with the abused child where the abuse is re-experienced, as well as feelings of guilt, confusion, ambivalence, shame, anger, sadness, and

loss. Regression and destabilisation may occur temporarily in this phase. Denial and intrusive symptoms should be managed and the client allowed to discover and validate the experience, thus allowing him/her to grieve what was lost (Courtois, 1996). These activities flow into the next treatment stage, where the child and adult are integrated.

Stage 4: Integrating the helpless child with the nurturing adult

During this fourth phase the various aspects of the trauma experience are integrated into the adult self. The client is encouraged to explore societal and familial patterns and dynamics that contributed to the abuse, and is then guided into formulating different perspectives from which to assess the client's past reactions. Grieving the past losses set the stage for personal development and empowerment. Old maladaptive mechanisms and patterns of interacting are analysed and replaced with healthier and more appropriate ones. Courtois (1996) observes that a radical redefinition of the self can result from this, one in which a sense of badness is lessened and from which self-forgiveness arises. This corresponds to Stage four of the SARI model, where a new identity is integrated during hypnotherapy and a new effective philosophy established, according to Ellis' RET.

Stage 5: Disclosure to and confrontation of the family and any involved others

Essentially, the purpose of confrontation is to allow further integration of the abuse experience. This is only achieved after much preparation and should be performed directly with family or others, or symbolically using imagery within the therapy context (Courtois, 1996).

The treatment goals to be achieved in the above five treatment phases include the following:

- The client needs to develop a commitment to treatment and establish a **therapeutic alliance**. The therapeutic alliance is an essential element in psychotherapy and allows for exploratory work to take place with the incest survivor. The support provided in therapy permits clients to face the repressed memories and emotions, while it counters feelings of loneliness and worthlessness, as well as beliefs of being undeserving of love.
- **Acknowledging and accepting** the occurrence of the incest is another treatment goal. Courtois (1996) observes that once the silence has been broken the survivor can directly acknowledge what happened and can then resolve the emotional repercussions.

- The incest experiences need to be **recounted** in therapy. It may be recounted in pieces and the therapist needs to be sure that the emotional impact is both tolerable and manageable for clients. Even though certain clients need to recite the details of the incest, others do not. The therapist should, however, learn about pertinent details of the abuse, such as its duration and frequency, age at onset and termination, the identity of the perpetrator, the use of force, prior attempts at disclosure, previous healing interventions and other incest reports and problems in the family (Courtois, 1996).
- Treatment should at some point focus on the breakdown of feelings of **isolation and stigma**. The therapeutic relationship may be the first step in breaking the pattern of isolation and persistent after-effects of incest, such as feeling different, lack of trust, and fear of intimacy (Courtois, 1996).
- The **recognition, labelling and expression of feelings** are crucial activities in therapy. Incest survivors commonly deny or suppress their emotions and operate on a rational basis, therefore the therapy should challenge this cognitive/emotional split. The therapist should consistently encourage and support the exploration of both conscious and unconscious material in order for the survivor to learn to recognise and label feelings. Through the hypnotic trance such unconscious material will be facilitated in this study.
- **Resolution of responsibility** and issues of survival need to be addressed. Courtois (1996) articulates the resolution of the issue of responsibility for the incest and the survivor's subsequent coping behaviours to be a major focus of therapy. The client needs to analyse the family dynamics in order to transfer responsibility from themselves to the perpetrator and other non-protective family members. This shift in accountability helps the client to understand powerlessness in a compromised situation and offers the potential for heightened self-empathy and self-esteem.
- **An opportunity to grieve** should be created for the client. The re-conceptualisation of the abuse results in grief and requires mourning. Feelings of sadness and loss are often preceded by anger and indignation. The survivor mourns the loss of the pre-incest identity, of self-development and family relationships. The losses may also include present concerns (Courtois, 1996).
- The aim of treatment is to **cognitively restructure** distorted beliefs and stress responses. Survivors often internalised negative and distorted beliefs about themselves during childhood. Through therapy clients must learn to separate beliefs from facts and critically examine incorrect beliefs that may result in increased self-esteem and self-confidence.

- **Self-determination and behavioural change** must occur in therapy. Survivors determine who they are apart from their incest experience and should shift away from former behavioural patterns conditioned by fear, anxiety, and guilt, to those behaviours determined by their desires and emotions. This process can be enhanced by referring to the Tibetan psychological concept of non-identification with mind and painful emotional experiences. Clients are encouraged to learn new roles and different ways of relating, and are encouraged to **accept both body and sexuality**.
- Finally, **education** and **skill-building** are further treatment objectives. Courtois (1996) explains that children from incestuous families grow up with misinformation or a lack of information regarding various life tasks and skills. Incest survivors have been deprived of the normal learning experiences stemming from a healthy family life. Basic life skills that can be taught include methods of communication, decision-making, conflict-resolution, friendships, intimacy, parenting, and boundary-setting.

The treatment offered by Courtois (1996) consists primarily of individual therapy treatment techniques and strategies. However, Courtois does recommend family and group therapy, as well as bibliotherapy wherever necessary. Family therapy is considered secondary to the individual therapy. Group therapy is often necessary to counter the effects of isolation, fear of intimacy and withdrawal.

6.2.1 Critical review of Courtois' treatment intervention

The therapy described by Courtois (1996) is comprehensive and practical in the treatment of adult survivors of incest. The symptoms as well as the short and long-term effects of incest are clearly documented. Existing psychological dynamics between different categories of perpetrators and victims, such as opposite-sex and same-sex incest, parent-child incest, sibling incest, extended family incest, are further described.

Furthermore, Courtois (1996) includes guidelines that can assist the therapist with almost every aspect or possible symptom that the incest survivor may present in therapy. Despite the valuable detail and comprehensive structure given in the treatment phases, Courtois emphasised that treatment should always be individualised for clients.

Courtois emphasises educating clients regarding their reactions to the abuse and therapy. This is valuable as it normalises symptoms for clients who already feel different from others. Courtois is one of the few specialist practitioners who explain the dynamics of the various reactions psychologists may experience while working with survivors. Reference to counter-transference issues is included in her therapy model.

A minor shortcoming of this treatment model is that it is limited to adult survivors of childhood *incest* abuse and not stranger and acquaintance abuse. However, most of the symptoms described and treatment procedures offered could probably be adapted for such clients. Courtois's model focuses primarily on female incest survivors. If certain modifications are made, the treatment approach can be implemented with males, although research is needed in this regard. One of the greatest strengths of Courtois's approach is that it is derived from many years of clinical experience with incest survivors, in both individual and group settings. The treatment guidelines offered have not been empirically tested nor their effectiveness for all survivors documented.

Courtois does not emphasise the importance of incorporating spiritual or religious aspects into the treatment intervention although she does explain that many of her clients dislike the idea of a God or a Higher Power, which is believed to result from feelings of abandonment following the abuse. Therapeutic aspects regarding the healing of spiritual problems caused by incest are not described.

6.3 IMAGERY RESCRIPTING AND REPROCESSING THERAPY (IRRT) BY SMUCKER AND DANCU

Imagery rescripting and reprocessing therapy (IRRT) was developed as an expanded **information-processing, schema-focused** model in which recurring traumatic childhood memories are conceptualised within a post-traumatic stress disorder framework, and as part of the individual's core schemata (Smucker & Dancu, 1999). This model is applicable to adult survivors of childhood sexual, physical and emotional abuse.

Imagery rescripting and reprocessing therapy (IRRT) is grounded on cognitive-behavioural therapy, which conceptualised affective distress cognitively. The cognitive therapy model suggests that emotional pain is directly linked to distressing cognitions and, by modifying the

distressing cognitions, affective distress is significantly alleviated (Smucker & Dancu, 1999). IRRT primarily uses **imagery and verbal interventions** to process the traumatic memories of childhood. Clients are systematically guided to modify traumatic imagery as a means of reframing the childhood trauma and transforming the meaning thereof. The use of imagery enables the traumagenic schema to be visually activated, as they were experienced during childhood. These traumagenic schema can, for instance, include feelings and beliefs of powerlessness, mistrust, unlovability, and abandonment, which are individually challenged, modified, and reprocessed by the empowered adult.

A therapeutic goal of IRRT is to assist the client in developing a **positive therapist-introject** that may compete with and even replace existing hostile introjects. It is hoped that the new therapist introject would form a foundation from which more adaptive schemata may develop. In addition, this new visual and auditory introject serves to have a calming effect on the client's mood during times of emotional distress.

Clients are requested to listen to audiotapes of the completed imagery sessions and to record their reactions in a journal on a daily basis. On completion of each imagery session, clients are provided with an opportunity to reflect with the therapist on their feelings and thoughts about the session with the therapist. Through the process of discussing the past and listening to the audiotapes, primary cognitive material becomes linguistically processed at a secondary level (Smucker & Dancu, 1999). Clients are requested to do homework assignments in which they are asked to do a number of activities including: writing down what is experienced during flashbacks; writing letters to the perpetrator or other individuals whom the survivor identifies as having been directly or indirectly involved in the abuse, and to note down the Subjective Units of Distress. During the course of therapy the client **confronts the perpetrator** and rescues the inner child through visual imagery.

IRRT is a comprehensive treatment intervention that addresses various aspects and dimensions of childhood abuse. A few key features of IRRT are listed below.

- As with the treatment intervention of Courtois, IRRT emphasizes the importance of educating clients regarding the nature of their symptoms and how PTSD symptoms result from the inadequate emotional processing of traumatic events.
- The purpose of treatment rational is handed to clients in written form.

- Clients are informed that they may in therapy experience emotional distress as a result of recalling the traumatic imagery.
- Smucker and Dancu (1999) suggest that a Socratic method of memory recall be applied as the imagery recalled by the client in this manner, is more empowering as it promotes mastery of the imagery.
- Although short-term therapy is uncommon when imagery rescripting and reprocessing therapy is employed, a certain degree of success can be achieved in one or a few sessions.
- IRRT can effectively be implemented when multiple traumas have been reported.

6.3.1 Critical Review of IRRT

One major shortcoming of IRRT is that it relies on the use of imagery and visualisations to resolve the abuse. This poses a problem for clients who are resistant to visualisations as they may believe that they are incapable of visualising, or simply perceive such therapeutic techniques to be impractical or of little value. However, the use of imagery in recovering abuse memories is beneficial as tacit knowledge, implicit memory of the abuse, may be gained, which is not gained in verbal expressions or psychotherapy (Dowd, 2001).

Smucker and Dancu (1999) stress that the goals of IRRT are not to alter memories, plant memories, retrieve memory fragments, or reconstruct vague memories for conjectured abuse experiences. They do however offer therapeutic suggestions for dealing with fragmented memories, but do not recommend the use of IRRT treatment procedures with such splintered memories. This is a limiting factor in IRRT. Research revealed that children have fewer mental capacities to construct a coherent narrative from traumatic events, and in combination with dissociation makes it very difficult for adult survivors to reconstruct a precise account of their past reality (van der Kolk & Fisler, 1995). Therefore, since traumatic memories from childhood are often fragmented, they remain unprocessed and unresolved when a treatment approach excludes them.

IRRT further advocates the use of listening to audiotapes of the therapy sessions, although this may not always be possible for those who live with others and who prefer to keep their treatment private. A further concern is that listening to the recorded session may re-traumatise a client while at home, as recollections of trauma may result in physiological arousal and subjective distress.

A thorough pre-treatment evaluation is conducted before the imagery re-processing commences. As part of the evaluation Smucker and Dancu (1999) ask specific questions about the presence, frequency, and intensity of intrusive traumatic recollections, dissociate flashbacks, and repetitive nightmares. These symptoms are recorded on the Traumatic Flashback Incident Record and consist mostly of the *re-experiencing* symptoms of PTSD. However, the researcher cautions against measuring the effectiveness of the treatment, based on the decrease in intensity and frequency of the re-experiencing symptoms, as many clients with PTSD display symptoms in the *avoidance* cluster, including psychogenic amnesia. Research has proven that "*the younger the age at the time of the trauma, and the more prolonged the traumatic event, the greater the likelihood of significant amnesia"* (van der Kolk & Fisler, 1995, p. 5). Furthermore, not all clients who have been abused in childhood ever meet the criteria of PTSD. Their progress could therefore not be recorded or monitored using the Traumatic Flashback Incident Record, as such attempts may be misleading.

In IRRT the client is guided to report the traumatic experience in the first person and in the present tense. Individuals are told to 'stay with it' when they feel uncomfortable and want to exit the trauma-based image (Smucker & Dancu, 1999). The researcher feels this is unnecessary and insensitive as this may re-traumatise clients. This re-experiencing is in opposition to contemporary hypnotherapeutic treatment modalities that advocate the use of fractionated abreactions for resolving painful memories. When the images and emotions are managed in a fractionated manner, the intensity of the emotions is reduced, resulting in the memories and affect being less overwhelming. Furthermore, hypnotherapeutic treatment approaches prefer to encourage clients to review the trauma from a dissociated perspective and not in the first person or present tense, thus avoiding further re-traumatisation (Frederick & McNeal, 1999; Philips & Frederick, 1995).

In IRRT, all adult-child images are monitored qualitatively on a session-by-session basis. The IRRT therapist administers a Post-Imagery Questionnaire (PIQ-A) aloud to the patient and records the client's numerical rating on each item. The author believes that this type of assessment is not recommended as it might create the impression that the client's progress in therapy is important to the therapist. In this regard, the client may report a higher rating on the PIQ-A than what was experienced, to avoid disappointing the therapist. Furthermore, this limits the extent to which clients may perceive and measure therapeutic success. The Post-Imagery

Questionnaire includes factors such as vividness of traumatic imagery, dissociation experienced during the session, and expression of such emotions as fear or anger. By focussing on these factors, therapists and clients may fail to notice progress in other areas of functioning, such as improved social and interpersonal functioning.

IRRT addresses numerous psychological issues relating to the childhood abuse. Information about the client's core schema are collected, focusing on trauma-related beliefs, while beliefs about body-image as well as spiritual and religious functioning are neglected in IRRT. A major point of criticism is that IRRT makes use of imagery and relaxation procedures that are no different from those employed in hypnotherapy, while Smucker and Dancu (1999) do not refer to these procedures and the trance state that clients experience as hypnosis. In this regard, Frederick and McNeal (1999, p. xvii) observe that "*... simply calling a procedure guided imagery or relaxation does not cause it to be anything other than hypnosis in the eyes of the law.*" From an ethical perspective this is considered to be misleading clients, which may explain why IRRT fails to incorporate valuable treatment strategies offered in hypnotherapeutic modalities, such as fractionated abreactions, and partial and dissociated age regressions.

Finally, the treatment offered by Smucker and Dancu (1999), as described in *Cognitive-Behavioral Treatment for Adult Survivors of Childhood Trauma,* provides excellent examples of managing specific aspects of trauma abuse, such as emotional and cognitive responses. Strategies for modifying negative cognitive schema are described in detail and are both practical and useful. The therapeutic procedures described in IRRT may be used as guidelines in hypnotherapy when working with adult survivors of childhood sexual abuse.

The three models described above share similar treatment objectives. There is also overlap in techniques and strategies employed by each. Their shortcomings relevant to this study include the lack of attention to spiritual and religious consequences of childhood sexual abuse. They further neglect spiritual techniques in treating adult survivors.

The treatment intervention designed as part of this study will import aspects of each of these three models. Treatment guidelines and techniques from these approaches will be incorporated into the treatment process discussed in Chapter 10, will integrate the clients' spiritual beliefs, concepts from Tibetan psychology, cognitive therapeutic strategies and hypnotherapeutic strategies, into a comprehensive treatment approach.

The following section summaries the additional five treatment models developed for survivors of childhood sexual abuse.

6.4 ADDITIONAL THERAPEUTIC MODELS

It is beyond the scope of this study to review all the documented treatment models employed with adult survivors of childhood sexual abuse. Reference will therefore only be made to five models, presented in Table 6.1. These five models below share similar treatment objectives to those in the abovementioned models. The former models are comprehensive and the next five do not offer treatment goals, strategies, or information not already contained in the models of Courtois, Kritsberg, and Smucker and Dancu, and the hypnotherapeutic models discussed in Chapter 5.

These five models overlap with regard to the treatment procedures and techniques described therein. The similarities include:

- Most treatment models divide treatment into three or more stages or phases. Phase-oriented treatments divide the therapy into discrete phases or stages, each containing unique treatment goals that overlap into the next stage.
- All models are eclectic, generally incorporating cognitive therapy, behavioural therapeutic procedures, visualisations and relaxation training. Techniques are recommended by all models to manage the emotional responses resulting from abuse, especially anger, fear and guilt. Without exception, all treatment modalities advocate the use of cognitive restructuring procedures to identify and rectify faulty beliefs regarding the abuse and the self.
- Creative and expressive therapeutic strategies aimed at confronting the perpetrator or parental figures are included in a number of treatment models and may include psychodrama, letter writing, the empty-chair technique, and visualisations.
- More contemporary models include an educative component in which clients are provided with information regarding the long-term consequences of childhood sexual abuse. This helps clients to normalise the symptoms they are presented with at the onset of treatment.
- Abuse-focused therapies recommend that individual therapy be complimented with bibliotherapy, family and group therapy.

- A number of interventions use psychological procedures and instruments to monitor the client's progress during the course of therapy and, further, on completion of treatment.
- All interventions regard the therapeutic relationship in highest regard and explain that it favourably contributes to treatment outcome.
- All the models emphasise the importance of conducting a comprehensive clinical interview as a prerequisite to the uncovering work. All practitioners recommend ensuring that the client is emotionally stable before regressing to the childhood abuse.

A number of limitations of these five contemporary models have been identified.

6.5 LIMITATIONS OF EXISTING MODELS

The following limitations were identified in the above models:

- The majority of models focus on **incest abuse**, not sexual abuse committed by friends, acquaintances and/or strangers.
- Treatment strategies are aimed at helping clients who have been incestuously **abused by adults**, not older children. In South Africa, *Childline* has reported a decrease in the average age of sexual perpetrators (Parliamentary Task Force on Sexual Abuse of Children, 2002).
- Incest and childhood sexual abuse studies are generally conducted on **female samples**, despite prevalence rates stating that many males have been abused as children.
- The **effectiveness** of most treatments has not been determined in clinical studies.
- Although numerous treatment models employ visualisations and imagery techniques, they are not referred to as hypnotherapeutic techniques. However, research has indicated that PTSD and trauma reactions are successfully treated in hypnosis (Janet, 1925; Phillips & Frederick, 1995; Frederick & McNeal, 1999).

Table 6.1 Psychotherapeutic models

Authors	Treatment Intervention	Description of Treatment
Derek Jehu (1988)	Individual therapy as well as family and sex therapy (systematic study of outcome of therapy, N=51)	General conditions and specific treatment procedures are discussed General conditions include conditions of a therapeutic nature such as client-therapist relationship. Specific treatment procedures are outlined for particular types of problems and include cognitive restructuring, assertiveness training, and sexual assignments.
McCann & Pearlman (1990)	Individual therapy (Grounded in constructivist self-development theory)	Therapeutic stages Assessment of life experiences Treatment planning Stabilisation Strengthening of self capacities and mobilization of ego resources Creation of a balanced need structure Restoration of positive schemas Integration of traumatic memories Ideal therapy outcome Ego strengthening Specific focus on transference reactions and resistance
Elmone & Lingg (1996)	Trauma-based models (PTSD symptomatology)	Three stages of treatment: 1. Personal safety and stabilization, crisis management, coping skills, improvement of interpersonal functioning 2. Addressing of traumatic content and emotions 3. Resolution of remaining issues Specific procedures included: Substituting healthier coping behaviours and beliefs with the old ones Addressing repetitive intrusive signals
Draucker (2000)	Counselling for survivors of childhood sexual abuse	Phase-oriented approach Assessing and disclosing the experience of child sexual abuse Exploring the abuse experience/s for purposes of integration and integration Reinterpreting the sexual abuse experience from an adult perspective Restructuring and making desired life changes Termination of counselling Treatment may include bibliotherapy and group therapy
Hall & Lloyd (1986)	Stage-oriented therapy	Six stages of recovery Acknowledging that help is needed Initial disclosure of child sexual abuse Finding appropriate help Beginning of the therapeutic contact Middle phase of therapeutic work Ending of therapeutic contact

- Hypnosis can assist in the recapturing of repressed memories, provide expressive techniques of releasing emotions, while providing creative techniques for managing faulty cognitions and unbidden images. **Self-hypnosis** techniques should be taught to facilitate relaxation training.
- Mention is made by a limited number of models regarding the **complications that exist on a spiritual level due to the abuse, while religious** and spiritual aspects are largely ignored in the existing treatment models. One of the goals of this study is to integrate hypnotherapy into the treatment protocol and to address and resolve spiritual problems that may have arisen.
- Most studies or models include only **heterosexua**l clients.

The following section briefly outlines the manner in which principles from the above contemporary models will be integrated into the psychotherapeutic intervention employed in this study.

6.6 CONTEMPORARY MODELS IN THIS RESEARCH STUDY

The researcher will import treatment principles or guidelines from Kritsberg, Courtois and Sumcker and Dancu's treatment models into the new treatment model employed in this study. These guidelines comprise the fifth component of the treatment intervention. In this study the therapeutic outline of this intervention will follow the same treatment stages described in Courtois's model.

Stage 1 will consist of a detailed clinical interview.

During Stage 2 the researcher/therapist will validate client's feelings, educate them with regard to the reactions they may experience in response to the therapeutic process (Smucker & Dancu), and will work on the therapeutic relationship (Courtois).

Stages 3 and 4 will consist of inner child work, with the researcher also referring to Kritsberg's (2000) wounded inner child, and clients will be encouraged to parent the inner child. Clients will be allowed to recognise, label and express their feelings (Courtois). Expression of emotional pain will be externalised (Kritsberg) by means of physical activities (Kritsberg), and talking (Courtois), as well as visualisations (Smucker & Dancu). Clients may give the inner

child an opportunity to grieve (Courtois) and to enjoy spiritual meditations (Kritsberg). Clients will further be encouraged to cognitively restructure their distorted beliefs (Courtois) and trauma-focused schemas (Smucker & Dancu) by means of affirmations (Kritsberg) provided by the therapist and the client, until a new positive therapist introject is created (Smucker & Dancu).

During Stage 5, the final stages of therapy, those clients who express such a need, may confront the perpetrators in visualisations (Smucker & Dancu) or face-to-face (Courtois).

6.7 SUMMARY

This chapter reviewed a number of treatment interventions that are currently used with adult survivors of childhood sexual abuse. Various therapeutic strategies comprise each model, although they aim to achieve similar therapeutic goals. Generally, all models follow a process in which the client is clinically assessed during an interview and in certain instances by psychological instruments. All models emphasise the importance of the therapeutic relationship. Clients are guided to recall their childhood sexual abuse experiences and to re-experience it to various degrees. They are also encouraged to express themselves emotionally, and to change former beliefs in an attempt to integrate the trauma. This is done using techniques such as inner child visualisations; cognitive reframing of faulty cognitions about the self, abuse and perpetrator; expression of affect through letter writing or imagery; and educating clients regarding the after-effects of abuse. Essentially, all therapeutic techniques are selected according to therapist's skills, preferences and training and, of course, the client's specific needs.

The following chapter, Chapter 7, will illustrate how the five components that comprise the treatment intervention will be integrated and applied to adult survivors of childhood sexual abuse.