Sources of Difficulty in Counselling Sexual Abuse Victims and Survivors

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Abstract

During the last decade, societal awareness of the problem of sexual abuse of children has reached unprecedented heights, and one result has been an increase in the reporting of childhood sexual abuse. Since the psychological effects of childhood sexual abuse impacts the functioning of both children and adults, a practicing counsellor in any setting will probably encounter clients who have experienced childhood sexual abuse. This article will look at problems both counsellors and clients face when confronting dysfunctional behaviour and symptoms resulting from sexual abuse.

Résumé

Au cours de la dernière décennie, la prise de conscience de l'abus sexuel chez les enfants a rejoint un grand nombre de la population et l'une des implications fut l'augmentation des dénonciations de cas d'abus dans l'enfance. Les effets psychologiques de l'abus sexuel dans l'enfance affectent le fonctionnement des enfants et des adultes, ainsi quelque soit le contexte, le conseiller recontrera fort possiblement des clients ayant subi un abus sexuel dans leur enfance. Cet article se penchera sur les problèmes auxquels les conseillers et les clients ont à faire face lorsque les comportements dysfonctionnels et les symptômes résultant d'un abus sexuel sont confrontés.

During the last decade, public awareness of the problem of sexual abuse of children has reached new heights. Prior to 1962, child abuse, itself, was not of major concern to the general public, and child abuse reporting laws were not passed until 1963 and afterwards (Olafson, Corwin & Summit, 1993). The Women's Movement, which also gained strength during the 1960s and 1970s, encouraged women to speak out about many forms of victimization they suffer as a result of institutionalized patriarchy (Olafson et al., 1993), and one result has been an increase in the reporting of childhood sexual abuse. Because of the increase in public awareness of child abuse, many adult women and an increasing number of men have begun disclosing that they were fondled, molested or raped as children. Some of the increase in public awareness has occurred because adult survivors have remembered previously suppressed abuse, sometimes as a result of counselling. Changes in province or state laws have also mandated the reporting of child abuse, including suspected sexual abuse (Genius, Thomllison & Bagley, 1991). Since 1980, the National Center of Child Abuse and Neglect (1988) has reported an increase in recognized cases of child abuse by more than 300%. Research has shown that psychological effects of childhood sexual

abuse persist without treatment for about 50% of the population of those abused (Finkelhor, 1987), and impact adolescent and adult functioning (Browne & Finkelhor, 1986; Fromuth & Burkhart, 1989; Trickett & Putnum, 1993). Thus, a practicing counsellor in any setting will probably encounter clients who have experienced childhood sexual abuse (Courtois, 1988; Hibbard & Zollinger, 1990).

Throughout this article the definition of childhood sexual abuse will include any sexual behaviours with minor children, whether wanted or unwanted, which occurred either by surprise or where there was a power deferential or significant age difference between the persons involved (Sgroi, 1988). The term victim will be used to apply to children who may still be in an abusive situation. Even children not currently in an abusive situation are still potential victims due to age and prior abusive experience. The term survivor will apply to adults who were abused as children (Rencken, 1989). This distinction is important because adults who were molested as children are, in most cases, no longer victims, but they are survivors of childhood trauma, and, as such, have developed strengths which can aid them in recovery. This article will address problems both counsellors and clients encounter as a result of childhood sexual abuse along with suggestions for diagnosis and treatment.

DIFFICULTIES RELATED TO THE IDENTIFICATION OF ABUSE

1. *Difficulty with presenting problems*

In early sessions with clients, many presenting problems may not appear to be related to sexual abuse (Hopping, Frady & Plaut, 1988). In our experience clients who have been or who are being sexually abused rarely present current or past sexual abuse as their presenting problem. For example, one of the authors worked with a client whose presenting problem was obesity. None of the structured behavioural plans she followed for losing weight seemed to be working. When examining the feelings the client had when she craved certain foods or had a desire to binge, the client became increasingly uncomfortable. Finally, one day the client disclosed having strange feelings while watching a television program on sexual abuse. As those feelings were explored, the client became aware that she might have been sexually abused by her father. Her presenting problem, by itself, would not have led to that diagnosis.

Adult or adolescent substance abuse may also be related to sexual abuse (Browne & Finkelhor, 1986; Hanson, 1990; Singer & Petchers, 1989). There appear to be at least two reasons for the high percentage of addictions among sexual abuse survivors. First, chemical use or misuse serves as a survival strategy by numbing pain and helping to reduce isolation and loneliness (Singer & Petchers, 1989). Second, alcoholism may also be a factor in incestuous families, and adult children of alcoholics are more likely to become addicted or become involved with

someone addicted (Blume, 1990). Recovery is possible if individuals face the truth about their sexual trauma and the feelings associated with it. It is not uncommon for women to bounce from one addiction to another until the underlying problem is identified (Ryan, 1989). For many people, addictions may actually be the secondary problem and may provide a sense of protection for the survivor (Blume, 1990).

In addition to addictions, adults who were molested as children may present a variety of other problems when seeking counselling. Some of these are: marital difficulties (Finkelhor & Browne, 1986; Caffaro-Rouget, Lang & Van Santen, 1989), suicidal ideation (Finkelhor & Browne, 1986; Hoier, 1987; Hopping et al., 1988; Lanktree, Briere & Zaidi, 1991; Ryan, 1989), eating disorders (Finkelhor, 1987; Hoier, 1987; Ryan, 1989), and depression (Finkelhor & Browne, 1986; Feinauer, 1988; Hanson, 1990; Hoier, 1987; Lanktree et al., 1991). To illustrate, while working for a nationally recognized weight loss program, one of the authors surveyed patients in the program and found that over 70% of the women had been sexually abused as children (Markos, 1989). Most of these women were also assessed as moderately to severely depressed. All the problems mentioned above could have many sources, but when two or more appear together, the possibility of a history of past sexual abuse should be examined.

2. *Problems in diagnosing children*

Another problem in diagnosis is that a history of abuse may be masked by another behaviour, especially in children. For example, doing poorly in school, for children, may be related to current or past sexual abuse (Hoier, 1987); it may also be related to current factors in the child's life, such as divorce, or an absent parent (Caffaro-Rouget et al., 1989; Massie & Johnson, 1989). Children who are experiencing depression, withdrawal, anxiety or nightmares may be experiencing sexual victimization (Sgroi, 1988). Children who run away from home may also be fleeing from sexual abuse (Blume, 1990).

Although problems in diagnosis may initially confuse the inexperienced counsellor, one characteristic of sexually abused children which has been consistently documented is age-inappropriate sexual behaviour (Goldston, Turnquist & Knutson, 1989; Hanson, 1990). Sgroi (1988) contends there are three behavioural indicators of current or past sexual abuse in children. They are excessive masturbation, promiscuity, and sexual abuse of another person. Preadolescent or adolescent children who have multiple sexual partners frequently have a history of past or present sexual abuse (Sgroi, 1988). Children who abuse others sexually, especially those who are younger or weaker, have most likely been victims of sexual abuse themselves. Therefore, when counsellors encounter

children who are acting out sexually, they should be alert to the possibility that those children may have been sexually abused.

3. *Post-traumatic stress disorder*

Several authors have reported that both abused children and adult survivors meet the criteria for diagnosis of post-traumatic stress disorder (PTSD) (Edwards & Donaldson, 1989; Famularo, Kinscherff & Fenton, 1990). The DSM III-R (The American Psychiatric Association, 1987) requires that a number of symptoms be present for PTSD to be diagnosed. Those that occur in adult survivors include re-experiencing the event, feelings of detachment and the general numbing of responsiveness, avoidance of activities that lead to recollecting the traumatic event, and intensification of symptoms by exposure to events that resemble the original trauma (American Psychiatric Association, 1987). In a study on the occurrence of post-traumatic phenomena in children, symptoms listed in the DSM III-R were found in acute (i.e., sleep disturbances, exaggerated startle response, generalized anxiety) and chronic (i.e., feeling of detachment and the general numbing of responsiveness) PTSD subjects (Famularo et al., 1990). These symptoms may also be present in children who are suffering from either current or past abuse although, as Armsworth and Holaday (1993) have pointed out, PTSD criteria may not sufficiently describe all the symptoms occurring in abused children and adolescents. Awareness of PTSD criteria is important both in the area of diagnosis and in treatment of sexual abuse victims and survivors but it may not be sufficient. In diagnosis, the counsellor needs to continue to be alert to the prospect that the presenting problem or problems may mask underlying abuse. In the area of treatment, information about other PTSD situations (i.e., Vietnam veterans; survivors of natural disasters) can comfort clients with the knowledge that what they are experiencing is not unique but shared by many others.

DIFFICULTIES ARISING FROM THE CLIENT'S EXPERIENCE

Counselling clients who have experienced sexual abuse in childhood may be difficult for several reasons. Since their abuse was interpersonal in nature, during counselling they may experience difficulty relating to the counsellor. Additionally, these clients can be difficult for the counsellor to understand because they may not remember their abuse and do not know why they are feeling and behaving the way they do. So much of what is triggering painful emotions in the client or motivating dysfunctional behaviour often seems shrouded in the mist of the far off, distant past.

1. *Denial*

Clients who have experienced sexual abuse may not be aware that the abuse is a problem for them (Forward & Buck, 1978; Mannarino, Cohen

& Gregor, 1989; Sgroi & Bunk, 1988). Children may think such behaviour is normal if it is occurring in their family, or they may have been terrified into silence by threats of punishment from the perpetrator (Finkelhor & Browne, 1986; Ryan, 1989). Adolescents and adults may have dissociated or repressed the actual abuse so they have no memory of it (Emerson, 1988; Mannarino et al., 1989). The authors have worked with clients who, during counselling, began to experience flashbacks, fragments of memories of being sexually abused. The typical response is, "I'm just imagining this," or "I must be crazy—it never happened." Even after beginning to retrieve memories of past sexual abuse, clients still may deny that they were sexually abused.

Children may deny that they were abused out of loyalty to the family or fear that the perpetrator will go to jail (Gelinas, 1988). One of the authors supervised a student counsellor who was working with a ten-year-old girl whose presenting problems included a variety of unusual behaviour, some of which involved self-mutilation. Suspecting that sexual abuse might be a factor, the counsellor read, with the child, a book on good touching and bad touching. At the point in the story where a male adult was inappropriately fondling a female child, the young client turned pale and asked to be excused to go to the bathroom where she vomited. However, she never admitted that the sexual abuse described in the book was happening to her.

Clients who are mentally handicapped present special concerns in that their expressive and receptive language skills are often lacking. Such clients may have difficulty remembering past events. When asked general questions, they may answer, "Yes," because they think this is the answer the counsellor wants to hear. One of the authors worked with a woman who was physically aggressive, sexually inappropriate with men, severely obese, as well as being moderately mentally retarded. The client was unable to give accurate information about possible abuse, and her parents vehemently denied that sexual abuse had ever occurred. There is a possibility that this person was sexually abused, but it was impossible to determine an accurate assessment of what took place.

Many sexual abuse survivors do not want to work on remembering, reliving, or changing their perception of the abuse (Drews & Bradley, 1989; Forward & Buck, 1978). Even if clients do remember abusive incidents, they may discount the effect on their present functioning (Hopping et al., 1989). Also, clients may feel shame about what happened in childhood and choose not to talk about it (Porter, Blick & Sgroi, 1984). In either case, defenses were created that, although functional at the time of the abuse, interfered with treatment or adjustment (Sgroi, 1988). The authors have experienced clients saying, "I don't want to know what happened," or "That's in the past; I want to forget about it and get on with my life," or "I don't want to remember what happened to me

when I was a child; it has nothing to do with me now." Counsellors need to walk a fine line between being sensitive to their clients' wishes not to discuss the more painful details, and continuing to help their clients connect the impact of their past abuse to present functioning. Coping mechanisms, such as denial, may have served to eliminate the pain (Drews & Bradley, 1989); yet, one of the goals of treatment for sexual abuse survivors is to develop more successful coping mechanisms for everyday living (Sgroi, 1988).

Eliminating denial may require remembering and reliving the actual sexual abuse, and thus, experiencing emotional, and sometimes physical pain. However, for clients to hold on to the belief that they are making up the memories of sexual abuse can be just as painful. One of the authors worked with an adult client who experienced severe pain as a result of uncovering memories of her grandfather raping her as a child. While discussing what happened to her emotionally after leaving the session, the counsellor asked her, "Are you in more pain when you believe that your grandfather did all of those things to you, or when you think you are making all of that up?" The client responded that she was in more pain when she believed that she was just imagining the abusive events. She was feeling tremendous pain because she thought she was a despicable and disgusting person for making up memories of being raped.

2. *Resistance and reluctance to work on sexual abuse issues*

Although working with the family has been recommended for children and adolescents (Gelinas, 1988), doing family counselling with incest families is extremely difficult due to the closed nature of the abusive family system (Rencken, 1989). Families tend to resist disclosing during counselling sessions due to the potentially embarrassing and traumatic nature of sexual abuse issues and because of the subsequent impact on the family system (Lanktree et al., 1991); they also may have poor attendance, and discontinue counselling as soon as there is no longer legal pressure to do so (DeLuca, Boyes, Fuer, Grayston & Hiebert-Murphy, 1992). The counsellor, instead of finding a willing client family, may find both children and parents colluding to hide the family secret because of family loyalty (Drews & Bradley, 1989; Kitchur & Bell, 1989; Porter et al., 1984). Also, the relationships in the family may be imbalanced with a pattern of persistent unfairness towards the victim (Gelinas, 1988). Parents may bring the child to counselling to fix him or her without delving into the dynamics or problems in the family (Sgroi, 1984). For counsellors, this is particularly frustrating because, in cases of incest, the parents are obviously part of the problem. Because of the relationship imbalances in incestuous families, the authors believe that working with a minor child without working with other family members may be merely putting a bandaid on the problem. Although the offender

in sexual abuse situations must accept responsibility for what occurred, the family, as a unit, bears the responsibility for changing those patterns which led to the abuse.

DIFFICULTIES ARISING FROM THE COUNSELLOR'S EXPERIENCE

While we have described the contributions of client issues and dynamics to the difficulty in working with this population, one confounding variable is the issue of the counsellor as the source of difficulty. Counsellors may bring emotional baggage, knowledge and skill deficits into counselling which contribute to their difficulty in hearing, acknowledging, and being with a client who is dealing with sexual abuse or its aftermath.

1. *Lack of Information*

Counsellors who are uninformed of the manifestations of sexual abuse may not recognize the signs and symptoms and may wonder why their clients are not improving (Eisenberg, Owens & Dewey, 1987; Hibbard & Zollinger, 1990; Kaplan, 1992). The authors see this frequently when supervising beginning counselling students in their clinical practice. Students often miss some of the most obvious signs and symptoms of sexual abuse (Briere & Zaidi, 1989; Hibbard & Zollinger, 1990). The authors frequently supervise students who seem oblivious to symptoms in children which suggest the possibility of sexual abuse, such as self-mutilation, age-inappropriate sexual acting out, suicide ideation, among others. Research in this area indicates that some helping professionals are unaware that many runaway children and adolescents have been sexually abused (Hibbard & Zollinger, 1990).

This lack of knowledge may translate into an incorrect diagnosis and treatment. If helping professionals do not routinely ask about a possible history of abuse, the possibility of sexual abuse may go undetected. Lanktree et al., (1991) found that disclosure of sexual abuse increased four-fold when clients were directly asked whether they had been molested. Recently, critics, in both the public and academic press (Gardner, 1991), have suggested that many claims of sexual abuse, especially in custody cases, may be fabricated (Corliss, 1993); in other words, some children may lie (Eberle & Eberle, 1986). Investigators and helping professionals have been criticized for the way questions about sexual abuse have been asked, suggesting that sometimes to ask directly is to implant ideas in the heads of impressionable children (Lanktree et al., 1991). However, it is now generally accepted that, in most cases, children do not misrepresent sexual abuse (Goodman & Clarke-Stewart, 1991).

2. *Counsellor denial*

Counsellor denial of abuse in his or her own life may allow the counsellor to deny the possibility of abuse when dealing with client prob-

lems (Duncan, 1987). Counsellor denial may take many different forms. Counsellors who have repressed the memory of their own abuse or who have minimized it, may be unwilling to help clients prepare to disclose the abuse, they may be unwilling or unable to confront perpetrators or they may be unable to deal with reporting the abuse (Pollack & Levy, 1989). For example, one of the authors supervised a beginning counsellor who had been sexually abused as a child. The counsellor was working with a family where sexual abuse had been suspected. As the case progressed, the counsellor was extremely reluctant to explore possible abuse with the child nor was she willing to pursue the possibility of sexual abuse with the parents or report that sexual abuse was suspected to the proper authorities. The counsellor did report that sexual abuse was suspected, but only because her supervisors required her to do it. Her own unresolved issues with her past abuse prevented her from seeing the possibility of sexual abuse in this case. It is a strong belief held by the authors that counsellors who have not been clients, who have not examined their own unfinished business in a therapeutic setting, will have blind spots when working with most clients. As with other populations involved in recovery from addiction or trauma, it is essential for the counsellor to have explored his or her attitudes, feelings, opinions, and personal issues about sexuality, abuse, and, more specifically, sexual abuse (Johnson, Glen-Owens, Dewey & Eisenberg, 1990).

3. *Personal boundaries*

Counsellors who have problems with personal boundaries may have difficulty maintaining limits in the counsellor-client relationship (DeLuca et al., 1992). They may want to rescue their clients, rather than counsel them. Some of the more graphic details that clients share about their sexual abuse may awaken such strong feelings in counsellors that they may wind up feeling so sorry for their clients that they lose all objectivity (Frenken & Van Stolk, 1990). One of the authors supervised a counsellor who had extreme difficulty with the degree of compassion she felt for her clients. The counsellor was afraid to probe more deeply for fear of upsetting her clients; therefore, her clients would talk endlessly about their problems while the counsellor sat mesmerized, almost inconsolable at the pain and loss they had suffered. Many counsellors who work extensively with abuse victims may also find themselves absorbing the pain their clients experience, becoming haunted and drained emotionally by the stories of abuse they have heard (Daniluk & Haverkamp, 1993). Another boundary issue involves taking too much responsibility for the success or failure of counselling. The counsellor may identify with the client when his or her self-esteem becomes tied up with the client's progress or lack of it. Personal boundary issues in the counsellor are problematic because many abuse victims come from families whose

members have either distorted boundaries or lack them altogether (Gelinas, 1988). Not only may this recreate the experience in the client's family of origin, but these clients may not have the defenses to withstand a personally invasive counsellor.

4. *Counsellor disbelief*

Naïve counsellors may not be willing to believe that childhood sexual abuse is a major societal problem in our culture. Such a counsellor might defend the perpetrator or deny, discount, or dismiss the survivor's account of events (Pollack & Levy, 1989). In cases of suspected abuse, many helping professionals will choose to believe that abuse involving children did not happen or that it was not that serious (Daro, 1988; Zellman, 1988). When adult clients deny that they were abused or say that it was all a fantasy or a dream, the counsellor will be tempted to agree.

Dealing with sexual abuse can be problematic for many reasons. Sexual abuse is not always a physically painful experience; sometimes, it may have been enjoyable. Therefore, some clients may feel responsible for their abuse. For example, clients may say things like, "But part of the time, I liked it; so, I must have wanted him to do those things to me." Counsellors can guard against supporting client denial and blame-taking by accepting fully that incest occurs and that children have been and can be exploited (Courtois, 1988).

An opposite problem is that of the counsellor who sees sexual abuse in every client. Every client who is depressed or even suicidal has not been sexually abused. Helping professionals are currently being criticized in the media for encouraging clients to believe that they were sexually abused whether or not this actually occurred (Shapiro, Roseberg, Lauerman & Sparkman, 1993). Diagnosis should be a careful and thoughtful procedure; care should be taken not to see abuse in every presenting problem.

Adults in western society have difficulty discussing sex in general (Rencken, 1989). Thus, many counsellors may be too embarrassed to discuss sexual issues and, because of those feelings, may be unable to help clients deal with issues related to sexuality (Duncan, 1987). Children who have been sexually abused often display age-inappropriate sexual activity and adolescents may act out sexually as well (Hanson, 1990). Adults may report a variety of sexual problems and dysfunction stemming from childhood abuse (Massie & Johnson, 1989). Counsellors need to feel comfortable with their own sexuality if they are to help clients discuss, experience, and come to terms with the sexual abuse in their past. To do that may require counsellors to examine their own issues about sexuality (Duncan, 1987).

5. *Counsellor inexperience*

Counsellors who have never worked with a client who was sexually abused or who have not had training dealing with this area may be more willing to believe that the victim is making up the details of their abuse (Hibbard & Zollinger, 1990). An opposite problem may be overreacting to client disclosures of abuse; this can be as damaging as not believing a client (Feinauer, 1989). The counsellor may react in a number of ways that can reinforce the client's negative feelings. Some of these are expressing horror, denial, avoidance, shame, pity, disgust, guilt, rage, or grief at what the client shares. Other reactions include minimizing of the client's experience, using indirect language, voyeuristic behaviour, sexualizing the relationship, as well as problems related to the counsellor's gender (Courtois, 1988). Working with young children may especially trigger the counsellor's emotions. The counsellor may want to make the child better, quickly, but will need to recognize that a child most likely will not work on the counsellor's timetable (Rencken, 1989).

WORKING WITH VICTIMS AND SURVIVORS OF SEXUAL ABUSE

Working with survivors of sexual abuse is different, in many ways, from working with clients from the general population. There are problems in diagnosis and in the intrapersonal reactions of these clients that differ from clients who were not sexually abused as children. In terms of treatment, one major difference is the amount of emotional and physical pain they may be experiencing in their current lives and the ways in which they have learned to cope with such severe pain. Counsellors need to be sensitive to the pain of sexually abused clients while continuing to work on issues surrounding their sexual abuse. Because of the extreme pain felt by these clients, counsellors also need to be aware that initial recollections of abuse may lead to an increased risk of suicide. Clients who are for the first time beginning to recall what happened during their abuse may be subject to extreme stress involving decompensation or psychological disorganization. Naïve use of the methods and techniques described below may harm clients rather than help them. The counsellor may also need to wait until the client is strong enough to deal directly with the possibility of being abused or with the memory of the actual abuse.

Another difference in working with this population is that the counselling process may take longer than with other presenting problems. Due to the sexual nature of the abuse, including the difficulty clients may have remembering what happened to them and the painful memories involved, the counselling process will move slowly; progress will be measured in tiny steps. The counsellor will need to keep in mind that the wounds of their clients are deep, in some cases hidden, and were often acquired over time. Thus, it will take time for their wounds to heal. It is

critical that the counsellor respect the client's defenses and move slowly to dismantle them (Courtois, 1988).

The following are some suggestions for working with victims, survivors, and families who have experienced sexual abuse.

1. *Working with children*

The counselling process is different with children than with adolescents and adults. Sexual abuse, for children, is usually of more recent origin, and most children will still remember what happened to them. Often, children are seen in counselling because they are still being abused. Based upon recommendations by Blick and Berg (1988), Gazda (1989), and Marvasti (1988), the authors recommend using play therapy with children under ten years of age (depending on the developmental level of the child). Playing with dolls, dollhouses, puppets, or clay helps children express their feelings about what has happened to them sexually. Art therapy can be a powerful tool in aiding the child to express through drawing and painting what he or she is unable to say in words. Over time, play can also help children to understand that they are not to blame for what happened, to feel less victimized, and to be able to cope with the consequences of being abused. Psychodrama is also useful to help children act out the roles of different family members or to play act stories about children who are victimized by more powerful adult figures. Despite the power of the methods described above, counsellors have an ethical obligation to seek specialized training in play therapy, art therapy, or psychodrama before attempting these methods with clients.

2. *Working with families*

Both younger children and adolescents may need to be involved in family counselling. For incestuous families, a family systems approach may be considered if it focuses on prevention and breaking the intergenerational cycle of abuse by changing the dynamics in the family (Rencken, 1989). Because children learn about relationships from their families, as adults they may repeat the patterns they learned in childhood unless there is therapeutic intervention (Gelinas, 1988). If children can be assured of protection from further abuse, then family therapy may help all the family members understand and accept how their particular family system contributed to the maintenance of the abuse (Atwood, 1992). On the other hand, Courtois (1988), and others, have warned that traditional family therapy may only serve to perpetuate the same patterns that initially led to the intrafamilial abuse. Unless the power differentials in the family can be addressed and corrected, family therapy may do more harm than good.

3. *Working with adolescents and adults*

The treatment of sexual abuse for adolescent and adult survivors is usually a combination of individual and group counselling. When the client is in crisis, individual counselling can provide more time and attention, and thus, allow the client to focus more exclusively on his or her issues. Group counselling not only provides support and a common experience, but it can also help reduce the sense of isolation and distance often experienced by the sexual abuse survivor (Hall, Kassees & Hoffman, 1986). A group experience may also, in some cases, help trigger the memories of those members who have repressed incidents of abuse (McBride & Emerson, 1989). Techniques from the more expressive therapies (eg. Gestalt and Psychodrama) are useful in breaking through client denial and in helping him or her to re-experience the original trauma. The authors have experienced the power of asking clients to stay with the feeling. Often, attending to and experiencing disowned feelings can lead to visual awareness of exactly how and by whom the client was abused. However, counsellors should proceed cautiously, using first those techniques which are less threatening and less intense. The counsellor should avoid techniques and interventions which are controlling or authoritarian so as not to recreate the dynamics of an abusive situation (Courtois, 1988) or limit the client's autonomy (Daniluk & Haverkamp, 1993). Without extensive training in Gestalt Therapy and Psychodrama, counsellors should not use such methods with these clients. Indeed the counsellor is ethically bound not to use methods which will force client recollection before the client is ready to remember his or her abuse (Daniluk & Haverkamp, 1993).

Several authors have suggested that techniques from the cognitive therapies can be useful in treating sexual abuse survivors (Courtois, 1988; Mayer, 1983; Faria & Belohlavek, 1984). Teaching clients how they can change their feelings by changing how they perceive events in the past and present has been found to be an important tool in combatting depression, self-blame, and self-defeating behaviour (Beck, Rush, Shaw & Emery, 1979; Sank & Shaffer, 1984). For example, clients can be encouraged to practice changing self-defeating thoughts by writing down their thoughts and feelings daily, posting signs on mirrors or refrigerator doors which say, "I am O.K. just as I am," or "I have the right to be angry at those who abused my trust!" Clients can also be urged to say and write affirmations, such as, "I deserve to enjoy guilt-free sex," or "I deserve healthy and non-abusive relationships." Sgroi (1988) suggests that it may not be enough to have congitive distortions challenged by counsellors or even other group members. In a group setting, it may be necessary to have the members accept and forgive each other before adult survivors can forgive themselves for being human.

Risk taking and developing better interpersonal skills are behavioural goals especially needed by this population. Adults and adolescents who were sexually abused often have either developed inappropriate ways of relating to other people, or they are so isolated and insulated that they shun contact with their peers. Assertiveness training is also very important for these clients. Sexual abuse survivors often believe that they have no rights; they often do not know what they want and do not have the ability to stand up for themselves in interpersonal situations. Sgroi (1988) recommends practicing communication and interactional skills that will allow for future intimate relationships. This involves developing a capacity for self-disclosure, as well as perceiving accurately the information communicated by another person. Again, practice is the key to mastery for most clients, especially for adult and adolescent survivors who are attempting to replace their dysfunctional coping behaviours with positive ones.

4. *What the counsellor can do*

Counsellors who do not have the knowledge or expertise to work with this population are ethically bound to refer clients whom they either suspect or know were being sexually abused (Daniluk & Haverkamp, 1993). Working with sexual abuse survivors is difficult for experienced counsellors who have had extensive supervision and training for working with this population. Because basic counselling skills alone are not adequate to treat survivors and victims of sexual abuse, inexperienced and uninformed counsellors can cause substantial harm to clients. Continuing education in diagnosing and treating childhood sexual abuse is necessary even for experienced professionals who work with this population (Hibbard & Zollinger, 1990). Ethically, counsellors should acquire additional skill and knowledge by attending seminars and workshops on sexual abuse, reading the professional literature on the subject, and by asking for supervision from a professional who has more knowledge and experience with sexual abuse victims and survivors.

Education and training for helping professionals should also include provisions for greater self-understanding (Pollack & Levy, 1989). Counsellors need to examine their belief systems about violence and sexuality and to openly and sensitively discuss any differences with their clients. Because of the sensitive and often traumatic nature of our clients' abuse history, counsellors need to be aware of the need to take care of themselves. The problem of maintaining boundaries, for example, means learning to take care of oneself (Bass & Davis, 1988). For example, counsellors may need to debrief intense counselling sessions by sharing feelings and experiences with a supervisor in the workplace. Professionals who were abused as children may need individual counselling to be able to separate their issues from those of their clients (Johnson et al.,

1990). Finally, counsellors, in all settings, need to take care of themselves physically and emotionally. For those of us who work with sexual abuse victims and survivors, that need becomes imperative.

CONCLUSION

Sexual abuse victims and survivors present a challenging puzzle for the counsellor with the will and the compassion to persist in unraveling their client's issues. Counselling clients who have been sexually abused will challenge the counsellor to examine his or her own issues in regard to abuse, sexuality, boundaries, skill, and knowledge. Clients who have been sexually abused may be difficult to work with, at times, but they can also provide an experience which will challenge counsellors to grow both personally and professionally. These clients may force counsellors to stretch the limits of their beliefs about human behaviour, skills, and tolerance for what human beings can do to one another while also strengthening the belief in the ability of individuals to grow beyond mere survival.

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